Care Quality Commission

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Whitegates Care Home

Inspection report

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Hampshire
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Ratings

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

Overall summary

Whitegates Care Home can accommodate up to 21 older people with a variety of care needs. At the time of inspection, there were 13 people living at the home and one person who was staying for a respite break.

This was an unannounced, comprehensive inspection carried out over two days on 7 and 8 July 2015.

There was a registered manager at the home at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The manager explained to us that particular circumstances had meant they had not been able to fully undertake their role. They explained this had impacted upon staff support, including supervisions and training and their ability to check that people were receiving a high quality service. This was evidenced by the findings of the inspection.

Summary of findings

We found a number of breaches of the Health and Social Care Regulations 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the back of the full version of this report.

The feedback we received from people was that care workers were kind and they were happy living at Whitegates Care Home. Some of the individual comments we received included, "I am very well looked after here and I am happy" and, "They do their best and their best is good" and, "The overall picture is good". The inspection findings showed that staff knew people well and understood their likes, dislikes and what was important to them.

There were systems in place to reduce the risk of harm to people using the service. Risks to people were assessed and plans put in place to ensure staff safely supported people.

Recruitment systems were robust and made sure that the right staff were recruited to keep people safe. New staff did not commence employment until satisfactory employment checks such as Disclosure and Barring Service (DBS) certificates and references had been obtained.

Medicines were kept within their recommended temperature ranges and the service had processes and record for obtaining and disposing of medicines. Storage for some medicines was not compliant with the relevant legislation. When administering medicines, the care workers lacked a process to secure medicines if they had to undertake another task.

The Medicines Administration Records lacked clarity around the time "when required" medicines had been administered and therefore we could not be assured that the minimum interval between doses had been maintained or the total daily dose for two "pain killers" taken "when required" had not been exceeded.

The management team undertook a variety of audits to check the environment was safe. However, these audits did not identify some environmental issues we saw during the inspection.

We saw that people had an individual plan, detailing the support they needed and how they wanted this to be provided. The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence and control over their lives.

Staff had not received supervision in accordance with the home's policy and in addition, a significant amount of training was either out of date or not competed. This meant we could not be sure that staff had been supported to understand how to safely and effectively meet people's needs.

People chose what they wanted to do. Some people spent time in the communal lounges and others preferred to spend time in their rooms. Where people spent time in their rooms they had the equipment they needed to maintain their independence.

Whitegates Care Home did not have an effective system for listening to, recording and acting on people's feedback to drive improvements to the quality and safety of the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

People were not fully protected against the risks associated with medicines. We have made a recommendation about the management of some medicines.

Assessments were undertaken of risks to people who used the service. Written plans were in place to manage these risks. There were processes for recording accidents and incidents. We saw that appropriate action was taken in response to incidents to maintain the safety of people who used the service.

Requires improvement

Is the service effective?
The service was not fully effective.

Staff had not received support and training in accordance with the providers' policy and procedures.

People's changing healthcare needs were responded to and staff worked with health and social care professionals effectively to meet people's needs.

Requires improvement

Is the service caring?
The service was caring.

People told us they liked the care workers and confirmed that they were consulted about their needs and how they would like to have them met.

Staff supported people in a person centred manner and their privacy and dignity was promoted and protected.

Good

Is the service responsive?
The service was responsive.

A range of activities were available in the home.

Care plans were in place outlining people's care and support needs. Staff were knowledgeable about people's support needs in order to provide a personalised service.

There was a satisfactory complaints policy and procedure in place and people told us they felt able to speak out if they had any concerns.

Good

Is the service well-led?
The service was not always well led.

The service did not have robust systems in place to seek meaningful feedback from people, staff and others to drive improvement and check people were happy with the way they were helped or supported.

Requires improvement

Summary of findings

Although there were systems to assess the quality of the service provided in the home we found that these were not always effective. The systems had not ensured that people were protected against some key risks described in this report in relation to the environment, staff training and support.

Whitegates Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection carried out over two days on 7 and 8 July 2015.

One inspector and a specialist pharmacy inspector carried out the inspection.

There were 13 people living at Whitegates Care Home at the time of the inspection and we talked with 11 people to learn about their experience of living at the home. We also spoke with one relative, the registered manager, 10 other members of staff and two healthcare professionals.

We looked at two people's care and support records in full and sampled other care and support records where we looked at specific aspects of people's care or support for a further seven people. These included daily monitoring records, Medicine Administration Records (MAR) and care plans. We also looked at documents relating to the overall management of the home which included staffing rotas and four recruitment records, audits and maintenance records.

Before our inspection, we reviewed the information we held about the service including the Provider Information Return (PIR) which the provider completed before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at information about incidents the provider had notified us of, and information sent to us by the local authority.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe living at Whitegates Care Home; however we identified some shortfall relating to medicine management and the safety of the premises which may place them at risk.

Whilst medicines were stored within their recommended temperature ranges, they were not always safely kept. Storage for some medicines did not comply with relevant legislation, which the manager confirmed they would address. When administering medicines, care workers lacked a process to secure medicines if they had to undertake another task

Medicines administered to people were recorded on Medicine Administration Records (MAR). However the records of "pain killers" taken "when required" often lacked a time of administration and for one resident on three occasions the records indicated five doses were administered in one day. Therefore, we were not assured that the minimum time interval between doses was being maintained or that the maximum daily dose had not been exceeded. A care worker explained how they applied creams to the residents as part of their personal care. The care worker showed us the records they kept. The administration records and creaming plans reflected the frequency of creaming described by the care worker except for two products used to protect skin, which lacked application plans.

We recommend that the service update their practice on administering and recording "when required" medicines in accordance with the National Institute for Health and Care Excellence, Managing medicines in care homes.

Information was available to support the administration of medicines. Information on, allergies, "if required", "variable dose" and if the resident was aware of their needs and could request medicines were documented.

The effectiveness of medicines were appropriately monitored. We reviewed four resident's records who were prescribed a medicine that required monitoring. Test results, dose changes and subsequent tests were scheduled for these residents. We reviewed the MAR and care plan for one resident who was prescribed two medicines if their health deteriorated, whilst the medication had not been required the plans contained information about the medication and how it should be used.

The registered manager explained to us how they requested repeat prescriptions from the GP practices, collected and checked the prescriptions. Once checked, the prescriptions were forwarded to their preferred community Pharmacy. They also explained how they received, checked and recorded the medicines from the community Pharmacy. We were shown the records kept of medicines returned to the community Pharmacy for destruction. These records were kept for each resident and each consignment of waste medicines.

All the staff we spoke with understood what safeguarding adults meant and what action they would need to take if they were concerned or worried about someone. There was a safeguarding adults policy and the home had been subject to two safeguarding alerts in 2015, neither of which had been substantiated.

There were systems in place to reduce the risk of harm to people using the service. Risks to people were assessed and plans put in place to ensure staff safely supported people. Records showed a range of risk assessments around areas such as falls, bed rails, and nutrition and pressure area care. There were environmental risk assessments in place such as for the kitchen and bedrooms, slips and trips, and safe working at night.

Whitegates Care Home had a system in place to learn from accidents and incidents. For example, people were monitored for 24 hours following a fall, and accidents were always reported to the person's GP. The provider had implemented a system for checking accidents and incidents on a monthly basis to ensure people were supported safely and patterns or trends identified and acted upon.

Records such as staffing rotas and our observations demonstrated there were usually enough staff on duty. The morning time appeared particularly busy with three care workers on duty to administer medicines and to support people to get up, washed and dressed. We asked the manager whether they felt there were enough staff on duty

Requires improvement

Is the service safe?

during this period. They confirmed they usually had four care workers for the morning period and were in the process of recruiting an additional member of staff to cover the peak period.

We spoke with an agency care worker who confirmed they were supported by care workers and by reading care plans to ensure they understood how people wanted or needed to be cared for.

Recruitment systems were robust and made sure that the right staff were recruited to keep people safe. New staff did not commence employment until satisfactory employment checks such as Disclosure and Barring Service (DBS) certificates and references had been obtained. There was a system in place to check agency workers were suitable. The manager explained the action they would take if a staff member was not performing in accordance with their role and responsibilities. They told us about one example that showed they had acted within the provider's policy and procedures of performance management.

The home was clean and free from any malodour. The manager was the infection control lead. A care worker commented to us, "It's a very nice home, it's clean and tidy".

Bathrooms and toilets had hand cleanser, paper towels and pedal operated bins. A cleaner told us they had the right equipment and enough time to ensure the home was clean.

The management team undertook a variety of audits to check the environment was safe. However, these audits did not identify some environmental issues we saw during the inspection. One toilet that people used on the ground floor did not have an effective lock, and two other bathrooms required repairs to the flooring to ensure it was an easily cleanable surface. Some of the first floor windows were not restricted which could have posed a risk to people. The manager undertook all the works we identified during the inspection.

There were arrangements in place to address a foreseeable emergency. Fire drills had been completed, and staff who worked at night knew what to do in the event of an emergency.

The home had emergency contacts telephone numbers to make sure staff could gain support in the event that the home was unable to function.

Requires improvement

Is the service effective?

Our findings

People told us that staff knew how to support them and that they were able to make decisions about what help they wanted and how they wanted to spend their time.

Whitegates Care Home had identified staff required training in key areas to support their knowledge of best practice in providing care and support. Their training policy stated that staff required, "A planned program for the training and development of staff". However, a significant amount of training was either out of date or not competed. For instance, two people living at the home were diagnosed with diabetes but only six of the 15 care workers had received training in diabetes management. Other training that required attention included person centred care which only three care workers had completed, health and safety where five care workers had either out of date training or none, food hygiene where seven care workers had either not completed or which was out of date and safeguarding vulnerable adults. In addition, eight of the fifteen care workers had not completed training in equality and diversity, first aid and diet and nutrition. This meant the manager could not be sure that care workers understood how people needed to be supported to maintain their safety and welfare. The manager wrote to us following the inspection and told us they were going to ensure staff training was updated.

Care workers told us they supported each other. One commented, "We all work together as a team". Some staff felt able to get ad hoc support from the manager; however few staff had received more formal support. The manager confirmed that only two of the 15 care staff had received supervision in 2015. Care workers were unable to recall having an appraisal of their work. We asked the manager and they told us that no staff had received an appraisal in the past 12 months due to the pressure of work the manager had experienced. This meant staff did not have a formal opportunity to discuss either their training or support needs. The manager wrote to us following the inspection with their plan to ensure staff received effective supervision and appraisals.

The failure to support staff to receive appropriate training, supervision and appraisal was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

Some staff had received training on the key requirements of the Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards. People living at the home had capacity to make day to day decisions and told us they made decisions about their lives and were not restricted in any way by the home. Records such as support plans were signed by people who had capacity to consent indicating they agreed with the guidelines and instructions provided to staff about their care and support needs. Other records such as reviews and consent to the administration of medicines were also signed by people.

Deprivation of Liberty Safeguards (DoLS) are part of The Mental Capacity Act 2005 and ensure that where someone may need to be deprived of their liberty it is the least restrictive option and in their best interests. The manager knew when and how to make applications to deprive someone of their liberty. At the time of the inspection nobody who lived at Whitegates Care Home was deprived of their liberty.

The home purchased pre-prepared meals that were steam cooked from frozen. The manager told us they had chosen this system because of the nutritional content of the meals. People were offered a choice of lunches and suppers. However, there was limited availability of other freshly made choices such as salads or sandwiches. People had biscuits with their hot drinks and the manager told us they sometimes had cakes. However, there were no freely available snacks including fresh fruit available around the home in accordance with best practice guidance. The manager told us people could choose to have tinned fruit or they could make a specific request to the manager who would purchase fruit for their personal consumption. Following the inspection the manager reviewed the nutritional choices people had. They wrote to us and explained what they were going to do to ensure people could have a choice of meals and readily available snacks.

Records confirmed people accessed a range of health and social care services when they needed to. People were supported to access their GP, district nurse and dentist. Health care professionals told us staff sought help appropriately and followed their instructions. Communication was aided by a verbal handover each day between care staff. A GP told us, "Staff are well informed and helpful".

Good

Is the service caring?

Our findings

People said care workers were kind and helped them. We received a range of comments specifically about care workers including, "very caring", "All very good", "They're lovely, they really are; I can't speak highly enough of them, it is wonderful what they do" and, "It's lovely here, the people are so nice, you only have to say what you want and before you know it, it's here".

People told us that they made choices about their lives and about the support they received. They said the staff in the home listened to them and respected the choices and decisions they made.

One person was very distressed during the inspection because they had experienced a recent loss. They told us care workers understood the way they wanted to be supported, and were respectful of their need for privacy, using an individual approach. They told us about the care worker who had told them about the death of their loved one and said, "No-one could have done it better".

Staff knew people well and understood their likes, dislikes and what was important to them. For example the catering assistant told us about foods particular residents did and didn't enjoy. Records showed the home had learned about people's personal history. This made sure that staff knew about people's family, careers, interests and other things that were important to the person. For example, one person's personal history identified that they enjoyed sewing but not knitting. This detail supported care workers to understand how they might best support or help someone.

Our discussions with care workers showed they were committed to providing a high quality, caring service. One said, "I am very passionate about my job and I love to look after the residents", and another told us, "The residents come first".

Staff had a good understanding of confidentiality, privacy and dignity and we saw examples of where they knocked at people's doors, asked permission before entering and maintained people's confidential records securely. Care workers described how they supported people, for example commenting, "I would go at the resident's pace, it's their home".

People were provided with information about the home when they came to live there. There was a guide to the home which included a description of the service, how to make a complaint and the home's commitment to equal opportunities and dignity and privacy. We spoke with a relative whose family member was admitted to the home during the inspection. They told us that the manager had provided them with all the information they required in order to make a decision about the home.

Records showed that people were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by palliative care specialists.

Good

Is the service responsive?

Our findings

People told us that care workers responded to their needs promptly.

The care home assessed peoples need before they moved in to make sure they were able to offer them the right care and support. One person had been admitted during the inspection for respite care. We looked at their assessment and this showed they had assessed the person's health, mobility, personal care, sleep and communication needs. We spoke with this person and they told us they felt well cared for. We also spoke with this person's relative and they said the assessment had been thorough commenting, "So far I have been very impressed".

Care plans were person centred and provided in-depth guidance to staff about an individual needs, wishes and routines in specific areas such as eating and drinking, medicines, continence care, washing and dressing, skin care, mobility and night time needs. When we spoke with staff they were able to accurately describe how they needed to support specific individuals. They commented that the care plans were easy to read and helpful.

Staff were kept up to date through daily handovers and the communication diary. We observed a handover where staff discussed people's changing needs and checked they understood any action they needed to take to ensure people were cared for or supported appropriately. No written records of handovers were kept although staff told us they kept themselves up to date by reading people's daily records of care and talking to other members of the team.

The home told us and a healthcare professional confirmed they had worked in partnership to care for one person who was very poorly. They said that because care workers stayed with them when they visited someone they were able to effectively communicate care instructions to other members of the team. They commented, "They're pretty good, they always seek advice". We saw examples of other aspects of partnership working such as hospital admission forms that summarised individuals care needs, current medicines, medical history, communication and mental capacity. This ensured that other providers such as hospitals could safely care for people because they had been given the right information.

People's support needs were reviewed each month and any changes were updated to make sure staff had up to date guidance about what care the person required. These were generally signed by people indicating that they had been involved in the review.

People chose what they wanted to do. Some people spent time in the communal lounges and others preferred to spend time in their rooms. All the people's bedrooms that we saw were highly personalised with things that were important to the person. Where people spent time in their rooms they had the equipment they needed to maintain their independence and their call bell was close to hand to enable them to summon assistance.

The home orientated people to the day, season and weather through information in the reception area. Communal areas were homely and had magazines and games for people to pick up and use or read. The home provided organised activities most afternoons including singing, music and dance, physiotherapy and exercise, manicures and quizzes. People told us there was enough going on at the home.

Necessary services and equipment were provided as and when needed. Staff confirmed there was enough equipment to enable them to support people. Some people who lived at Whitegates Care Home walked independently or with a small amount of supervision and assistance. We observed people moving freely around the building, choosing where they wanted to go and what they wanted to do. We saw staff offered assistance in a way that maintained people's dignity and independence. People were neatly dressed and had any aids they required to promote their independence such as glasses or walking aids.

All the people we spoke with knew how to make a complaint. One person said, "I don't have any problems", and another person told us, "I've no complaints, little niggles of no consequence".

We saw the home's complaints procedure was displayed in the reception hall. We reviewed the complaints and comments Whitegates Care Home had received in 2015 and saw these had been investigated and resolved.

Requires improvement

Is the service well-led?

Our findings

Whitegates Care Home had sought formal feedback from people who used the service in August 2013. The feedback had not led to any action or development plans from the service. The manager told us they asked people informally for feedback although they did not record any feedback and there were no action or development plans. The care home did not hold resident meetings. This meant there was not an effective system of listening to, recording and acting on feedback to drive improvements to the quality and safety of the service.

The manager told us they did not have staff meetings or seek the views of staff through surveys. The manager told us that as a small service they did not need to have formal staff meetings. As previously described in this report staff had not had formal supervision or appraisals. This meant staff did not have an opportunity to comment on the service to enable the provider to drive improvement through listening to their staff.

Although there were systems to assess the quality of the service provided in the home we found that these were not always effective. The systems had not ensured that people were protected against some key risks described in this report in relation to staff training and support. The service was in the process of scheduling a community pharmacy audit, as the previous audit was over a year old. We were shown two medicines process audits and one audit of the Medicines Administration Records, these lacked action plans or cross-referencing. The health and safety audits the management team had completed did not identify the issues previously referred to in this report.

The failure to actively seek the views of people and staff about their experience of, and the quality of care and treatment, and failure to assess, monitor and mitigate risks relating to the health and safety of service users was a breach of Regulation 17 (2) (b) and (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

The home had a call bell monitoring system that enabled the manager to check the length of time taken to respond to someone. During the inspection we noted that call bells were answered promptly. The home also completed care plan and infection control audits where they had identified actions that they were working on to address. The provider checked maintained and serviced their equipment to make sure it was safe to use.

The manager showed us the new system of policies, procedures and audits that they were implementing at the time of the inspection. They were confident the new system would support them to more effectively ensure that people received a safe and effective service. The manager told us about other improvements they had made including more effective links between themselves, GPs and the pharmacist. The manager told us they toured the home daily to pick up on issues and check the quality of the service.

The manager told us they kept themselves up to date with good practice and developments in care by reading new guidance and through their membership of a national forum for registered managers.

Peoples records were maintained and kept securely although they were easily accessible to staff. Records included care plans, monitoring records and daily reports. One record we read contained some inappropriate information which we drew to the attention of the manager.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.** **The provider failed to support staff to receive appropriate training, supervision and appraisal.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (2) (b) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.** **The provider failed to actively seek the views of people and staff about their experience of, and the quality of care and treatment and failed to assess, monitor and mitigate risks relating to the health and safety of service users.**