Pearl Blossom Limited

White Gables Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

White Gables Care Home 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 home is registered to provide accommodation for up to 20 people, including older people and people living with dementia.

We inspected the home on 10 and 25 April 2018. The first day of our inspection was unannounced. On the first day of our inspection there were 20 people living in the home.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers ('the provider') they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We last inspected the home in August 2015 when we rated it as Good. In January 2017 we re-registered the home to reflect a change in ownership. This was our first inspection of the re-registered home and we were pleased to find that service quality overall had been maintained by the new owners and in some areas enhanced. The rating remains as Good.

Staff worked well together in a mutually supportive way and communicated effectively, internally and externally. Training and supervision systems were in place to provide staff with the knowledge and skills they required to meet people's needs effectively. There were sufficient staff to meet people's care and support needs and the recruitment of new staff was safe. Staff knew how to recognise and report any concerns to keep people safe from harm. Staff understood the principles of the Mental Capacity Act 2005 (MCA) and supported people to have maximum choice and control of their lives. Staff supported people in the least restrictive way possible and the policies and systems in the home supported this practice.

Staff worked closely with local healthcare services to ensure people had access to any specialist support they required. Systems were in place to ensure effective infection prevention and control although some improvement was required to ensure people's medicines were managed safely at all times. People's individual risk assessments were reviewed and updated to take account of changes in their needs.

Staff were kind and attentive in their approach. People were provided with food and drink of good quality that met their individual needs and preferences. The new owners had upgraded the physical environment and facilities in the home to ensure they reflected people's requirements. People were provided with physical and mental stimulation appropriate to their needs. Staff provided end of life care in a sensitive and person-centred way.

Although she had only been in post for a few months, the registered manager had established a positive organisational culture and won the respect and loyalty of her team. The provider had a commitment to

continuous quality improvement and a range of audits was in place to monitor service provision. Systems were also in place to promote organisational learning from significant incidents and events. Formal complaints were rare and any informal concerns were handled effectively.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People's medicines were not always managed safely.

There were sufficient staff to meet people's care and support needs.

New staff were recruited safely.

People's risk assessments were reviewed and updated to take account of changes in their needs.

Effective infection prevention and control systems were in place.

There was evidence of organisational learning from significant incidents.

Is the service effective?

Good

The service remains effective.

Is the service caring?

Good

The service remains caring.

Is the service responsive?

Good

The service remains responsive.

Is the service well-led?

Good

The service remains well-led.

White Gables 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. The inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We visited White Gables Care Home on 10 and 25 April 2018. On 10 April our inspection team consisted of an inspector, an expert by experience and a specialist advisor whose specialism is nursing. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On 25 April our inspector returned alone to complete the inspection. The first day of our inspection was unannounced.

Before the inspection, the provider completed a Provider Information Return (PIR) and we took this into account when we made the judgements in this report. The PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information that we held about the service such as notifications (events which happened in the service that the provider is required to tell us about) and information shared by other organisations, including the local authority contracting and safeguarding teams.

During our inspection we spent time observing how staff provided care for people to help us better understand their experiences of the care they received. We spoke with six people who lived in the home, two visiting friends and relatives, the registered manager, the lead nurse, the care home manager (the senior administrator in the home), two care staff and the cook. We also spoke to one local healthcare professional who was visiting the home on the first day of our inspection.

We looked at a range of documents and written records including six people's care files and staff recruitment and training records. We also looked at information relating to the administration of medicines and the auditing and monitoring of service provision.

Requires Improvement

Is the service safe?

Our findings

Everyone we spoke with told us they felt safe living in the home and that staff treated them well. For example, one person said, "I always feel safe with the carers." Another person's relative told us, "[Name] is definitely very safe here."

Staff were aware of how to report any concerns relating to people's welfare, including how to contact the local authority safeguarding team or CQC, should this ever be necessary. Advice to people and their relatives about how to contact relevant external agencies was provided in the information booklet that was given to people when they first moved into the home.

The provider maintained effective systems to ensure potential risks to people's safety and wellbeing had been considered and assessed, for example risks relating to skin care and nutrition. Each person's care record detailed the actions taken to address any risks that had been identified. For example, staff had assessed one person as being at risk of choking. Specialist advice had been sought and a range of measures put in place to reduce the risk. Senior staff reviewed and updated people's risk assessments on a monthly basis to take account of any changes in their needs.

The home was clean and odour free and the provider had effective systems of infection prevention and control. The housekeeper had taken on the role of infection control lead and, together with the registered manager, attended information sharing events organised by the local authority's infection control team, to ensure the provider was up to date with best practice in this area. Describing the infection control lead's positive impact on practice within the home, one member of staff said, "[Name] keeps us up to date with any changes. [And] once a month she observes our hand-washing technique."

Almost everyone we spoke with told us that there were sufficient staff to keep them safe and meet their care needs in a timely way. For example, one person said, "They are good at answering the bell. [And there are] no problems at all with help at night." One member of staff commented "[Staffing] in the morning is absolutely fine." Another staff member said, "We have enough staff in the morning [but] I think we need [more] in the afternoon." We shared this feedback with the registered manager who told she kept staffing levels under regular review and that an additional member of staff had just been recruited to work in the kitchen, to help relieve pressure on care staff in the afternoon. The registered manager told us that she had also recently doubled the number of hours worked by the activities team in the home, to provide people with additional mental and physical stimulation.

We reviewed the provider's recruitment practice and saw that the necessary pre-employment checks had been completed correctly to ensure that any new recruits were suitable to work with the people who used the service.

However, when we reviewed the arrangements for the storage, administration and disposal of people's medicines we found that these were not managed consistently in line with good practice and national guidance. At lunchtime on the first day of our inspection we saw that a member of the nursing team brought

two prescription medicines to a person in their room but did not stay to ensure that the person had taken them, increasing the risk that the person may not have received all of the medicines they had been prescribed. There was no record in the person's care file to indicate that staff had assessed the person as being capable of taking their own medicines without supervision. When we discussed this incident with the registered manager on the second day of our inspection she told us that she felt "surprised [and] really let down" by the actions of the staff member concerned. She also said she had already taken a number of actions with the individual concerned and the nursing team as a whole to ensure something similar would not happen again in the future. More positively, we saw that people who had been prescribed 'as required' medicines for occasional use were able to exercise their right to decline these medicines whenever they wished. Regular checks were made to ensure the medicines storage room was at the correct temperature and arrangements were in place to ensure the safe use of any 'controlled drugs' (medicines which are subject to special storage requirements).

The registered manager told us, "I am still learning. Every day is a school day." Reflecting this philosophy, the provider maintained a systematic approach to reviewing any significant incidents which occurred in the home to identify if there were lessons that could be learned for the future. For instance, following a recent incident which had been considered under local adult safeguarding procedures, the registered manager had organised additional training and introduced a new falls management protocol for all staff to follow.

Good

Is the service effective?

Our findings

Everyone with spoke with told us that staff had the right knowledge and skills to meet their needs effectively. One person said, "I'm confident with the carers." Another person's relative told us, "I don't have any concerns about the care [name] receives."

New members of staff participated in a structured induction programme which included a period of shadowing experienced colleagues before they started to work as a full member of the team. Commenting positively on their induction, one staff member told us, "I had about a day's [initial training] with [the registered manager] and then I did about three shadow shifts. They were helpful as they [teach] you the clients' little ways." The registered manager was aware of the National Care Certificate which sets out common induction standards for social care staff and was the process of integrating this into the provider's induction arrangements.

The provider maintained a record of each staff member's annual training requirements and organised a range of courses to meet their needs. Additional training opportunities were also available to staff on a regular basis. For example, one member of staff told us, "At the moment I am doing the end of life course. A notice went up and you could choose which course [you wanted to do]. Quite a few [of my colleagues] are doing all sorts of different courses at the minute. [And] we've got infection control this afternoon." The provider also encouraged staff to study for nationally recognised qualifications. One member of staff said, "[The registered manager] is looking at NVQ Level 4 … for me [and a colleague]. I [told the registered manager] I wanted to have extra knowledge."

Staff received regular one-to-one supervision from senior staff and an annual appraisal from the registered manager. Talking positively about their recent appraisal, one member of staff told us, "[With the previous registered manager] I asked for end of life training for three years [but] never got it. With [this registered manager] … I got it straightaway. She definitely listens."

In addition to their training and supervision, staff had access to a range of publications and other information sources to ensure they were aware of any changes in good practice guidance and legislative requirements. For example, as described elsewhere in this report, infection control procedures were regularly reviewed and updated in line with the local authority's requirements. The provider was also a member of the National Activity Providers Association (NAPA) and the local care providers' association, both of which the registered manager told us were a useful source of information and guidance.

Staff from the various departments within the home worked well together to ensure the delivery of effective care and support. Describing the flexible approach of staff, the registered said, "We do work well together. There is no them and us. [Some] carers [work as] domestics and domestics are carers as well. [This means] they can see both sides. And the nurses will muck in as well." To further enhance team working and communication in the home, the registered manager was about to introduce a new 'full-staff' meeting, in addition to the regular departmental meetings which already took place.

Staff were aware of the principles of the Mental Capacity Act 2005 (MCA) and understood the importance of obtaining consent before providing care or support. The 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. Describing their approach in this area, one staff member said, "[Even] if someone doesn't have [full] capacity … I still ask them … what they want to eat and drink. They can normally respond."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection the provider had been granted DoLS authorisations for six people living in the care home and was waiting for a further eight applications to be assessed by the local authority.

Senior staff made use of best interests decision-making processes to support people who had lost capacity to make some significant decisions for themselves. For example, people who were unable to leave the building safely on their own. Although we were satisfied that that people's rights under the MCA were properly protected, the registered manager agreed to amend the documentation used to record best interests decisions to make it clear exactly what decisions were in place for each person.

People told us they enjoyed the food provided in the home. For example, one person said, "I have cereal and toast for breakfast. The food is nice. I am always happy with the choices [and] we can always ask for something different." People were provided with a range of hot and cold options at breakfast time. Describing people's preferences, the cook told us, "Some like poached or scrambled eggs on toast. One lady likes a bacon sandwich." The provider had recently introduced a new lunchtime menu which had been developed in consultation with people who lived in the home. This provided two main course choices, although kitchen staff said they would always make an alternative if requested. For example, the cook told us, "Some don't like lamb or pork so [when] they are on the menu, I give them a different choice of meat." Staff had a good understanding of people's nutritional requirements, including people who needed their food pureed to reduce the risk of choking and people who were living with diabetes. For example, the cook told us, " I make homemade cakes every day. It's a Victoria sponge today. I use Canderel in [all my cakes] so people with diabetes can have the same thing [as everyone else]."

Since our last inspection, the new owners of the home had updated and improved the physical environment and equipment in the home to ensure they remained suitable for people's needs. For example, floor coverings had been replaced and a rolling programme of bedroom redecoration introduced. A new electronic care monitoring system had also been implemented to make it easier for staff to review and update people's individual care plans. Looking ahead, the registered manager told us the provider was committed to further improvements including a new staff training room; a new medicines storage cupboard and enhanced signage to help people living with dementia find their way around the home.

The provider continued to ensure people had the support of local healthcare services whenever this was necessary. From talking to people and looking at their care records, we could see that their healthcare needs were monitored and supported through the involvement of a broad range of professionals including GPs, district nurses and therapists. One local healthcare professional who visited the home regularly told us they had no concerns about the care being delivered and that staff were always helpful and supportive.

Good

Is the service caring?

Our findings

Almost everyone we spoke with told us that the staff who worked in the home were kind and attentive. One person said, "The carers keep an eye on me." Another person's relative told us, "The staff are very friendly and welcoming."

Describing her personal philosophy of care, the registered manager told us, "[It's about making sure] that everybody is treated individually. As I would want to be treated myself. And as I would want my parents to be treated."

This commitment to supporting people in a caring, person-centred way was clearly understood by staff in all departments. For example, reflecting on her relationship with the people who lived in the home, one member of the care staff team told us, "You get to know about people's little ways. For example, [name] will ask me to come to her room and help her set it for when she goes to bed. And [name] likes playing his mouth organ in his room. I go in and listen sometimes." Describing her approach to helping people celebrate their birthday, the cook told us, "We make a cake. I don't always make the same. Not many have fruit cake. Chocolate cake tends to be more popular. And if [the person] has one of those, everyone can have it. Some people can't eat fruit [due to the risk of choking]." The lead nurse added, "For big birthdays such as 80 or 90, [people] get a bouquet of flowers. On [name]'s 90th birthday we did a tea for the family. There was no charge." Commenting positively on the thoughtful approach of some care staff, one person with a visual impairment said, "The carers help me by cutting up sliced meat … and tell me how the plate is set out using a clock. So I know meat is at 6 o'clock, potato at 3 o'clock, etc."

Staff also understood the importance of promoting choice and independence and reflected this in the way they delivered people's care and support. For example, one person told us, "I can get up when I want and go to bed when I want." Another person said, "We have a very good cook and get a good choice [of meals]. I can eat in my room or with the others [whichever I prefer]." Describing their approach in this area, one member of staff said, "It's little things [like] cutting up meals to [enable people] to eat it themselves. If you take their independence away they are more likely to lose motivation."

The staff team also supported people in ways that helped maintain their privacy and dignity. For example, with one isolated exception, we saw that staff knocked on doors to private areas before entering. Staff were also discreet and sensitive when supporting people with their personal care needs. Describing their approach in this area, one member of staff told us, "I [make sure] the door and curtains are shut [and cover the person] with a towel. [I also] shut the window so they're not cold." Bedroom doors were lockable and people could request a key if they wanted to lock their room when they were out. The provider was aware of the need to maintain confidentiality in relation to people's personal information. People's care plans were stored securely and computers were password protected. The provider had also provided staff with guidance to ensure they did not disclose people's personal, confidential information in their use of social media platforms.

Information on local lay advocacy services was included in the booklet given to people when they first

moved into the home. Lay advocacy services are independent of the service and the local authority and can support people to make decisions and communicate their wishes. Senior staff told us that no one currently had the support of a lay advocate but that they would not hesitate to help someone secure one, should this be necessary in the future.

Good

Is the service responsive?

Our findings

If someone was thinking of moving into the home, the registered manager or the lead nurse normally visited them to carry out a pre-admission assessment to make sure the provider could meet the person's needs. Talking about the importance of managing this process carefully, the lead nurse told us, "Although we are in the fortunate position [of having] a waiting list … we have to be sure we can meet the person's needs. We do turn people down." Once the person had moved in, the registered manager prepared an interim care plan to provide staff with key information on the person's key needs and preferences. Over the course of the next week or so, this was developed into a full individual care plan.

Since our last inspection, the new owners of the home had introduced an electronic care planning system which staff accessed through tablet and laptop computers. Although there had been some teething problems, staff told us they welcomed the new technology. For example, one member of staff said, "It's a lot easier [than the paper-based care plans]. Particularly [for those of us] who are used to smart phones. We have to update them daily with our care notes [and details of] turns and fluids [consumed]. Now we've got them to hand [via the tablets] rather than having to go to the office."

We reviewed people's plans and saw that they were well-organised and provided staff with detailed information on the person's wishes and requirements. For example, staff were instructed to use a rubber spoon when supporting one person to eat, to reduce the risk of damage to their teeth. We observed staff supporting this person at mealtimes and saw that a rubber spoon was used as specified in the care plan. Another person had indicated that they occasionally liked a drop of brandy added to their evening drink. Staff told us they found the care plans a helpful source of information. For example, one member of staff said, "They normally have some background on [the person's] life .. which is helpful [particularly] with new people." Despite this comment, we noted that some people's plans lacked details of their life history. The registered manager told us these gaps had already been identified and were in the process of being addressed. Senior staff reviewed the care plans on a quarterly basis in discussion with people and their families, if they wanted to be involved.

Staff clearly knew and respected people as individuals. For example, talking of the importance of understanding and responding to people's personal preferences, one staff member told us, "You adjust the care as to how they would like it. [Name] likes her top on before her skirt. Others like their skirt on before their top. [Name] calls everyone 'mate' and so I call him 'mate'. I wouldn't say that to everyone." Commenting positively on the provider's proactive, responsive towards their loved one, a relative said, "[They are very] attentive … and [created the opportunity] for him to move to [a room in the main building] so he could be [more involved with] the activities. This was done on the initiative of the home." Talking about the recent celebration of Easter in the home, one member of staff told us, "We had some eggs that hatched. I've never seen a chicken born before [but] some of the residents used to work on farms and we chatted to them about that. Me and [name] sat together and watched them [hatching]. It was nice bonding time."

Since our last inspection, the new owners had increased the number of hours in the activities team. Two

activities coordinators were now employed who, between them, maintained a programme of regular activities and events to provide people with physical and mental stimulation. This including gardening, craft activities and outings to local pubs and visitor attractions. On the second day of our inspection, one of the activities coordinators led an interactive musical reminiscence quiz which was clearly enjoyed by everyone present. Talking positively about the provider's approach in this area, one person said, "There's monthly armchair aerobics that I really like [and] four of us were taken to the Easter service at the church. I really enjoyed that. They do try and vary things. The activities coordinator has asked me for ideas." Another person's relative told us, "He does the activities and enjoys them. He keeps the plan in in his wardrobe." Although many people clearly valued the opportunity to join in these communal activities, others were happy to pursue their own individual interests. For example one person said, "I mostly stay in my room … but if I do want to go to the lounge they wheel me along." On the first day of our inspection we saw one member of staff had been deployed to spend one-to-one time with people who were being nursed in bed or preferred to stay in their room, something that was clearly valued by those involved.

The provider's responsive, person-centred approach was also reflected in the way staff supported people at the end of their life. Outlining the provider's approach, the lead nurse told us, "We [work] with Macmillan and Marie Curie [nurses]. We [also] create an [end of life] care plan [to cover areas such as] mouth care and pain management. We have a portable bed which we use to accommodate relatives [who wish to spend as much time as possible with their loved one]. They can have lunch and dinner [if they wish]. There's no charge." Following the recent death of their relative, a family member had written to the registered manager to say, "[We] would like to thank you for [the] care that you gave to [name]. Also for all the love and support you gave to us during Mum's time with you, especially in the final hours."

The registered manager was unaware of the new national Accessible Information Standard (AIS) which provides best practice guidance in communicating with people in ways that meet their individual needs and preferences. However, she told us he would research the AIS and incorporate it into the provider's approach in the future. In the meantime, during our inspection we observed staff use a variety of strategies in response to people's individual communication needs. Additionally, the cook was in the process of developing a photographic menu to help some people living with dementia choose what they wanted to eat.

Information on how to raise a concern or complaint was included in the information booklet people received when they first moved into the home. Formal complaints were relatively rare and senior staff told this was because they were well-known to everyone in the home and were committed to resolving any issues informally whenever possible. The registered manager said, "We are very open about things. The door is always open and quite a lot of relatives make a point of coming in [to discuss any issues]. We are able to sort things quickly." Commenting on the provider's proactive approach to communication one relative told us, "I … get phone updates. They are very good at knowing what [name] needs so I know what to bring [when I visit]." The registered manager kept a record of any formal complaints that were received and ensured these were managed correctly in accordance with the provider's policy.

Good

Is the service well-led?

Our findings

People we spoke with told us they thought highly of the home. For example, one person's relative said "I've never had cause to complain about anything." Describing the atmosphere in the home, one person's friend told us, "It's quite homely. This has helped [name] settle in very well. He likes it here."

The registered manager had been appointed by the new owners and, at the time of our inspection, had been in post for about seven months. During this time she had established a positive organisational culture and won the respect and loyalty of her team. For example, one staff member said, "[The registered manager] is nice. I can talk to her and she will listen if you have any problems. It's a lot better, more organised [since she came]. I am happy here." Another member of staff told us, "[The registered manager] is lovely! Very approachable. But if you need to be told off [she] can pull you up. You need a manager who is there for you but who will tell you when you have done wrong. In an appropriate way!" Describing her leadership style the registered manager said, "I am firm but fair. I like staff to know that they can come to talk to me, whether it is about work or home life. You need to treat your staff fairly. [But] if I have asked for something to be done I like it to be done well. I don't rule with an iron rod but I will come down [on people] if I need to." Throughout our inspection senior staff demonstrated an open, reflective approach as demonstrated in the registered manager's prompt and robust response to the shortfalls in medicine administration practice described in the Safe section of this report.

Under the leadership of the registered manager and her senior team, staff worked together in a well-organised and mutually supportive way. One member of staff said, "There's a friendly atmosphere [in the staff team]. We go out at Christmas and on birthdays. The managers come. You see a more relaxed side to them [then]. You get a voucher for your birthday. For my 21st we had a party here with all the residents. [Name] played his mouth organ." Another staff member told us, "I like coming to work. It's well led and friendly. Everyone … gets on well. At Christmas we each got two bottles of wine from [the owners] which was a nice touch." Shift handover sessions and regular team meetings were used to facilitate effective communication. Talking of their experience of attending team meetings, one staff member said, "We go over things and raise any queries. The managers come. The last one was about five weeks ago. And you get the minutes to see what went on if you can't make it."

The new owners were committed to the ongoing improvement and development of the home and, as described elsewhere in this report, had made a number of further enhancements to the service since our last inspection. Looking ahead, the registered manager told us she was committed to further improvements including the appointment of a 'dignity champion' to provide staff with additional advice and guidance in this area and supporting the nurses to gain 'train the trainer' qualifications to enable them to pass on more of their knowledge to care staff by leading some in-house training.

To assist in the process of continuous quality improvement, the provider conducted regular surveys of people, their relatives and staff to measure satisfaction with the service provided. We reviewed the results of the most recent survey of people and relatives and saw that satisfaction levels were high. The results had been reviewed by the registered manager and any suggestions for improvement had been followed up. For

example, a suggestion that more fresh fruit be made available in the home. People's satisfaction with the service provided was also reflected in the many letters and cards received from family members and friends. For example, one family member had written to the registered manager to say, "I am writing to thank you all for making the last few years of Mum's life happy. It is a testament to you all that she saw it as her home. She was able to be independent but the same time she enjoyed being looked after. Mum always said who hard you all work, which indeed you do."

The provider maintained a comprehensive suite of audits to monitor the quality of the care provided, including regular medication, infection control and premises audits. The provider was also aware of the need to notify CQC or other agencies of any untoward incidents or events within the home.