Warwick Park House Limited

Warwick Park Care Home

Inspection report

17 Butt Park Road
Plymouth
Devon
PL5 3NW

Tel: 01752772433
Website: www.warwickpark.co.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The overall rating for this service is 'Inadequate' and the service is therefore been placed into 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We carried out an unannounced comprehensive inspection on 24 and 25 May 2017. The overall rating improved from inadequate to requires improvement, therefore the service came out of 'special measures'.

We told the provider to make improvements to how people's medicines were managed and to how people's care needs, and risks associated with their care were recorded and known to staff. To ensure people's call bells were answered promptly, and to document people's mental capacity. In addition, we told the provider to improve their quality monitoring processes, to help identify when improvements were required.

Following our inspection, we met with the provider to ask them how they would improve the service for people. They told us they would strengthen their governance processes.

The Commission considered its enforcement policy, and took enforcement action, which was to impose a condition on the provider's registration. This meant on a monthly basis, the provider was requested to carry out an audit of people's medicines and of care records. Submit a summary of their findings to the Commission, and demonstrate what action was being taken to improve the service and to meet regulation. Since July 2017 the Commission had been receiving and reviewing the provider's monthly returns, which

had demonstrated ongoing improvement at the service. However, the findings of this inspection determined the information which had been provided had not always been fully accurate and did not always reflect of the current regulatory position within the service.

We carried out an unannounced comprehensive inspection on 14 and 15 November 2017. Our inspection was brought forward because we received information of concern about how people's medicines were managed, how people were being supported with their mobility and that there was a delay in staff responding to people's call bells. We were also told, people were not always effectively supported with their nutrition and continence needs, and staff did not always know how to support people, or have access to their care records. In addition, repairs were not always carried out promptly and the environment was not always clean and tidy. During this inspection we looked at the concerns which had been raised, and found some improvements were required.

Warwick Park Care Home is registered to provide accommodation for nursing and personal care for up to 50 older people. The service also provides assessment and rehabilitation when people are discharged from hospital, usually for a period of up to four weeks. This is known as 'Discharge to Assess' (DTA). The assessment and rehabilitation of people staying in a DTA bed is overseen by a DTA team, which includes external community physiotherapists and occupational therapists. At the time of the inspection the service had four DTA beds, and two were occupied.

Accommodation and facilities are spread over two floors, with access to the lower and upper floors via stairs or a passenger lift. There are shared bathrooms, shower facilities and toilets. As well as two lounges, a dining area, a conservatory, a garden and decked seating area. On the days of our inspection there were 35 people living at the service.

There was a registered manager in post. 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 2008 and associated Regulations about how the service is run.

People's medicines were not always safely managed. People did not always get their medicines on time or as prescribed. People living with long term healthcare conditions did not always get the help and support they needed.

People, who had risks associated with their nutrition, did not always receive the correct diet and professional advice was not always followed. People who were at risk of losing weight were not effectively monitored to ensure prompt action was taken to recognise weight loss and to seek advice. People told us the quality of food was variable, however the registered manager had already started to obtain people's views in order to make improvements.

Overall, the environment was assessed to ensure it was safe. Equipment used by people, such as hoists were serviced in line with manufacturing guidelines. However, a cleaning trolley had been left unattended which contained cleaning products, and we found nutritional supplements in people's bedrooms. Both, posed risks to people if consumed. People who required assistance to move were not always supported safely, when being assisted with moving and handling equipment.

People were not always protected by the provider's infection control procedures. The service was clean and odour free.

Overall, people were cared for by suitable numbers of staff. Staff told us the registered manager was responsive to making staffing alterations when necessary. However, the weekly use of agency nurses meant people's clinical needs were not always met with consistency. The registered manager told us, that the recent appointment of three new clinical leads would shortly be making a great difference.

People told us they felt safe living at the service. People were protected from abuse because the staff knew what action to take if they suspected someone was being abused, mistreated or neglected.

People's care and support was not always based on best practice guidelines, helping to ensure the best outcomes for people. This demonstrated nursing staff required updating on current best practice.

People had access to external healthcare professionals to ensure their ongoing health and wellbeing, but did not always receive an organised and prompt response to their changing health and social care needs.

Overall, people were cared for by staff who had received training. However, staff had not all completed courses specific to people's individual needs. Nursing recruitment was ongoing, which had resulted in clinical competence not being effectively monitored within the service.

Staff received an induction prior to commencing their role, to introduce them to the provider's ethos and policy and procedures.

The Mental Capacity Act 2005 (MCA) was not always followed in respect of the management of people's medicines, which meant people's human rights were not always upheld. Staff, were heard to verbally ask people for their consent prior to supporting them and had a good understanding of the Mental Capacity Act 2005 (MCA). Deprivation of liberty safeguards (DoLS) applications to the supervisory body had been made when necessary. However, people's mental capacity and best interests decisions had not always been recorded that showed how their human rights had been upheld.
People lived in a service which had been designed and adapted to meet their needs. People were consulted and encouraged to get involved in the ongoing changes to the environment.

Overall, people were cared for by staff who showed kindness. However, some staff, displayed more compassion than others. People were not always treated with dignity and respect and given emotional support. People's individual preferences were not always recorded which meant staff may not know how people wanted to be supported.

People's equality and diversity was respected by staff. Staff told us people were not discriminated against, on grounds of their culture or sexuality. People's privacy was respected. Staff, knocked on people's doors prior to entering their rooms.

People's families and friends were welcome to visit at any time. People and/or their families were involved in decisions relating to their care. When people did not have a family, or anyone to act on their behalf, advocacy services were considered.

Overall, people had care plans in place which provided staff with information about how they wanted, and needed their health and social care needs to be met. However, some care plans had not been fully completed and some clinical care plans lacked detail. This meant people could be at risk of receiving inconsistent support.

Overall, people's communication needs were assessed. People had care plans in place to help guide staff

about how to effectively communicate with people who had individual communication needs. However, some staff did not always know how to effectively support people.

People were not always supported effectively at the end of their life. For example, one person who was coming to the end of their life had no individualised care plan. This meant the person's wishes were not recorded to help ensure staff knew how they wanted to be cared for. The person did not have prescribed essential medicines present with them in the home, which meant there could be a delay in them receiving essential pain relief.

People had access to a call bell to ask for assistance. However, although the registered manager had monitored call bell times, we could see from records some people had had to wait over 20 minutes before they received assistance.

Overall people and their families told us there were opportunities for social engagement. A new activities co-ordinator had been recruited, and action was being taken to increase opportunities for people to visit local attractions.

People's comments and complaints were viewed positively and used to help improve the quality of the service. People's confidential information was not always stored securely.

When things went wrong, investigations were carried out to identify what action was required to prevent it from happening again. However, actions from investigations were not always embedded into practice, which meant reoccurrence of mistakes, was likely.

The provider visited the service three to four days each week to monitor the service. However, despite the provider carrying out such monitoring, their checks had not been robust in identifying areas requiring improvement. Their checks had also not identified that the information which was being submitted to the Commission on a monthly basis, was not accurate. This meant the provider's governance framework was inadequate in ensuring regulatory requirements with the Commission, were met and understood.

The registered manager told us they had been working tirelessly to improve the service, and displayed commitment, determination and passion to get it right. However, the systems and process which they had implemented and used to help monitor the quality and safety of care people received had not always been effective, in identifying areas requiring improvement.

People did not live in a service which was continuously and positively adapting to changes in practice and legislation. Clinical staff deficiencies within the service meant best practice relating to people's nursing care was not always followed.

People did not live in a service whereby the provider's values helped to promote an open, inclusive, empowering and person-centred culture. The registered manager told us, they were in the process of revising the organisation's values.

The registered manager told us, they felt the service was moving in the right direction, but recognised changes were not always being positively received by staff, and embedded into culture and practice. Therefore, a new staff induction had been created. Its purpose was to define staff roles, expectations and professional accountability.

People, relatives and staff spoke positively about the leadership of the service. People benefited from a

registered manager who worked with external agencies in an open and transparent way.
People were encouraged to provide their views to help develop the service. The registered manager kept their ongoing practice and learning up to date and told us they felt supported by the provider.

Following our inspection, the registered manager submitted a detailed action plan to the commission. The action plan set out how they intended to make urgent changes regarding the safe management of people's nutritional needs.

We recommend the provider carries out a review of clinical competence and leadership within the service. In line with best practice, set out by the Royal College of Nursing (RCN) and the Nursing and Midwifery Council (NMC).

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's risks associated with their care continued to not always be safely managed or monitored.

People's medicines continued to not always be managed safely.

People's confidential information was not always stored securely.

People were not always protected by the provider's infection control procedures.

People were cared for by suitable numbers of staff. However, the weekly use of agency nurses meant people's clinical needs were not always met with consistency.

When things went wrong, investigations were carried out to identify what action was required to prevent re-occurrences. However, the actions were not always embedded into staff practice.

People told us they felt safe living at the service.

People were protected from abuse.

Is the service effective?

Inadequate

The service was not effective.

People's care and support was not always based on best practice guidelines, helping to ensure the best outcomes for people.

People continued to not be effectively supported with their nutrition.

People had access to external healthcare professionals to ensure their ongoing health and wellbeing, but did not always receive an organised approach to their changing health and social care needs.

People were not always cared for by staff who had received training to meet their individual needs.

The Mental Capacity Act 2005 (MCA) continued to not always be followed to help ensure people's human rights were upheld.

People lived in a service which had been designed and adapted to meet their needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was not always respected.

People were cared for by staff who showed kindness. However, some staff showed more compassion than others.

People's privacy was promoted, and their equality and diversity respected.

People and/or their families were involved in decisions relating to their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans continued to not always be up to date and reflective of how their health and social care needs should be met, which meant they may not receive consistent care.

People's communication needs were not always fully assessed, and staff did not always know how to effectively support people.

People were not always supported effectively at the end of their life.

People's comments and complaints were viewed positively and used to help improve the quality of the service.

Is the service well-led?

Inadequate

The service was not well-led.

People continued to live in a service which was not effectively monitored by the provider to help ensure its quality and safety.

The provider's governance framework was inadequate in

ensuring registration requirements with the Commission, were met and understood.

The systems and process which the registered manager used to help monitor the quality and safety of care people received had not always been effective, in identifying areas requiring improvement.

People did not live in a service which was continuously and positively adapting to changes in practice and legislation.

People did not live in a service whereby the provider's values helped to promote an open, inclusive, empowering and person-centred culture.

People, relatives, external professionals and staff spoke positively about the leadership of the service.

People were encouraged to be involved in the development of the service.

The registered manager kept their ongoing practice and learning up to date to help develop the team and drive improvement.

People benefited from a registered manager who worked with external agencies in an open and transparent way.

Warwick Park 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 checked 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.

We visited the care home on 14 and 15 November 2017. The first day was unannounced. The inspection team consisted of one inspector, a specialist advisor of nursing care for older people and an expert by experience - this is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection we reviewed the information we held about the service. We reviewed notifications of incidents the provider had sent us since the last inspection. A notification is information about important events, which the service is required to send us by law. In addition, we also contacted Healthwatch Plymouth, the local authority quality and service improvement team, and the Clinical Commissioning Group (CCG). Their feedback can be found through-out the inspection report.

During our inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed how people were supported at lunchtime.

We spoke with 14 people who lived at the service, three relatives, seven members of staff, the head of care and the registered manager. We also spoke with two local authority DTA assessors.

We looked at 20 records which related to people's individual care needs. We also looked at 28 records that related to people's medicines, as well as documentation relating to the management of the service. These included auditing records, policies and procedures, accident and incident reports, training records, equipment and service records, and kitchen menus.

Following our inspection, because of concerns identified, we raised four individual safeguarding alerts with Plymouth City Council. We also contacted a Speech and Language Therapist (SLT) and a community district

nurse, for their views about the service. We have included their views in the body of the report.

Inadequate

Is the service safe?

Our findings

At our last inspection on 24 and 25 May 2017 we rated this key question as requires improvement because, people's medicines were not always managed safely, and risks associated with people's healthcare were not always recorded and known to staff. During this inspection we looked to see if improvements had been made, and found action was still required.

At our last inspection in May 2017, people's medicine administration records (MARs) were not always completed, therefore records were not always an accurate account of what medicines people had been receiving. People's medicines were also not being ordered on time, which meant they did not always receive them as prescribed. At this inspection we found people's medicines were still not always managed safely.

People's MARs were not always completed accurately, and had not always been completed in line with NICE guidelines. For example, handwritten entries had not always been double signed, to help minimise errors, and there were gaps on signatures on the MARs which indicated medicines may not have been given. Following the inspection the registered manager informed us that this was due to an increased usage of agency nurses, who had not complied with the home's requirements. However, it remains the responsibility of the registered person's to ensure medicines are administered and recorded safely.

People did not always receive their medicines as prescribed. A new checking process had recently been put into place. However, this had not been effective in identifying medicines requiring ordering, and the checking process was not being used by all staff. The registered manager told us they were also being let down by delays from the GP practice and pharmacy. They told us they had been pro-active in arranging a meeting with both parties to discuss this in further detail, and had also been considering making a safeguarding alert to the local authority. However this issue had still not been resolved and left people at risk of unsafe care. For example, four people were found to have run out of one of their medicines. For one person, they had experienced a delay of four days in receiving one of their essential medicines, relating to a long term healthcare condition. We were informed by a nurse that when the person's medicines arrived the person was reported to have been experiencing breathlessness, which may have been as a consequence of them not having their medicines on time. Another person had run out of a medicine they needed for their mental health.

One person, who required a medicine at a precise time, did not always have the timeframes defined and documented on their medicine administration records (MARs). This meant they may not receive their medicines at the correct intervals, which could have a negative impact on ongoing health conditions. For example, one person was prescribed medicines for Parkinson's. This medicine should be given at exact intervals otherwise the person may experience unnecessary tremors, or stiffness. The timing of this type of medicine is individual to each person, however the times detailed for administration, were generalised and not time specific. Another person, who had been prescribed anti-biotics over a period of eight hours, had not been receiving them at the correct times, in line with prescribing guidelines.

Three people living with diabetes did not have their medicines managed in a safe way because the dose of insulin was not always clearly documented on their MARs. When changes to people's insulin had been made by GPs, this had been handwritten on the MARs by a nurse, but not checked and counter signed to check it was correct. This practice was not in line with National Institute of Clinical Excellence (NICE) guidelines. In addition, people did not have individualised care plans which detailed their injection site, or what action to take if their blood sugar level became a concern. Therefore, people were at risk of receiving incorrect or unsafe care. Following the inspection the registered manager told us they had a record to use for injection sites but this was not in place at the time of the inspection. They also told us they were in the process of reviewing diabetic care plans with an external professional.

People were prescribed medicines to be taken when required, such as paracetamol. Although, staff could explain when they might offer these medicines to people, there were no care plans in place to provide information to guide staff in their administration; such as what symptoms to look for, the gap needed between doses or the maximum dose. Staff did not monitor or record the outcome of giving a 'when required' medicine, so could not be sure that it was effective. This meant people may not receive their medicines when they actually required them, for example to help manage pain.

People's medicines were not always managed safely and their medicine records were not always accurate. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's mental capacity had been considered in relation to their medicines. However, the Mental Capacity Act 2005 (MCA) had not been fully followed. For example, it had been decided, for one person that it would be in their best interest to give their medicines disguised in food (covertly) if needed, rather than them not taking them at all. But, instead of a multi-agency discussion taking place, involving the person's advocate, there was a hand written entry on the persons MARs to determine covert administration was appropriate, as agreed by the person's GP. This meant the MCA had not been followed correctly to ensure the appropriate people had been consulted to protect and consider the person's rights. One person, who took their medicines covertly, did not have a care plan about how medicines should be given and whether they had been checked with the pharmacy to ensure they were safe and effective when mixed with food.

The Mental Capacity Act 2005 (MCA) had not always been fully followed in relation to the management of people's medicines when a person lacked capacity. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were stored safely. People's topical medicines (creams) were administered and robust records were in place to provide staff with information about how, when and where to apply them. Staff received training and an assessment of their ongoing competency. People were given their medicines in a kind and respectful way. The provider had a medicines policy which defined the medicine procedures expected of staff. The registered manager advised us that the policy was in the process of being updated to reflect changes in line with NICE guidelines.

At our last inspection in May 2017, risks associated with people's nutrition were not being safely monitored, and people did not always have risk assessments in place to help staff know how to safely support people. At this inspection we found this continued.

People, who had risks associated with their nutrition did not always receive the correct diet and staff, were also not aware of how to correctly support people. One person who had been hospitalised prior to moving to the service, because of their complex diabetes, was not always given a diabetic diet. Their care plan

stated they should receive a "sugar free, diabetic diet". However, on day one of our inspection, we observed this person to be given tinned peaches and pouring cream. A member of staff told us, "(…) likes (…) sweet things, (…) has a sweet tooth". The person's food records also indicated that they had received the incorrect type of diet, on other days too.

One person was at risk of choking, however they told us they did not always receive the meals they should. They explained they had received sandwiches with the crusts on, which whilst they could leave, the reason for why they could not manage them, was because they should have been receiving a soft diet. We looked at the person's care plan to confirm what diet they should be receiving, however the recorded information about their dietary needs, was conflicting. In one part it stated they ate a normal diet, but requested a soft diet. In another part, there was information from a speech and language therapist (SLT) stating the person should have a certain textured diet. The person also did not have a risk assessment in place, to provide guidance and direction to staff about what action to take, should they happen to choke.

People who were at risk of losing weight were not effectively monitored to ensure prompt action was taken to recognise weight loss and to seek advice. For one person, it had been requested, by an external professional that they should be weighed on a weekly basis, however this had not always taken place. The person's records detailed they had been losing 6kg over a period of four months. The person's care plan showed they had requested a pureed diet on 12th May but during the inspection they had been offered an omelette and sandwiches, both of which they had declined. This person had also been prescribed nutritional supplements but there was confusion amongst the staff team about whether the person had been taking them or not. It was established, the person had not been taking them, because they did not like the taste, there were no records to show what alternatives had been tried. Following the inspection, the registered manager informed us the GP and Nurse Practitioner had both seen the person but the person had refused to accept changes to medication, including supplements.

Another person's care plan also detailed they had lost 4kg over a five month period, but no action had been taken to address this. It was also recorded in their care records that they had been seen by a speech and language therapist (SLT) on 09 August 2017 and "If intake is poor" to contact the SLT team. However, this had not been done. An external professional told us the management of people's nutritional needs was not always met consistently by staff. They explained, they did not feel there was an individualised approach to nutrition within the service. Following the inspection, the registered manager informed us they believed one of the weights recorded was an error. However, they also told us there was no evidence staff had attempted to re weigh the person.

Because of the concerns identified in respect of people's nutritional risks, we raised four safeguarding alerts with the local authority safeguarding team, and asked the registered manager to provide us with immediate assurance as to how they would ensure people were safe. By day two of our inspection, the registered manager had started to commence a review of nutrition across the service. Two care plans had started to be updated, and GPs and a social worker had been contacted. Following our inspection, the registered manager also submitted a detailed action plan, telling the Commission how they intended to address the failings identified, and ensure the ongoing safety of people.

Overall, people's skin care was monitored by staff to help ensure risks were quickly identified. People had care plans in place to help provide guidance and direction to staff, and people used pressure reliving equipment. However, whilst there was no one living at the service with skin damage, the mitigation of risk relating to people's skin was not always safe. For example, three out of 13 mattress settings were found to not be on the correct setting for people's weight and three out of four re-positioning charts were not always completed accurately. Following the inspection, the registered manager informed us they had already been

aware these charts were not being completed accurately and were in the process of introducing a different format. This had not been introduced at the time of the inspection.

People who required assistance to move were not always supported safely. On day one of our inspection, we observed two members of staff not following safe moving and handling practices. One person was being transferred from their wheelchair to a lounge chair. However, the breaks on the hoist were not put on when the person was waiting to be lowered. This meant the hoist could have tipped over. The person they were assisting was also left hanging in a hoist sling, while both staff members rearranged furniture to give themselves more room. This meant the person, was at risk of falling from height. We also observed breaks on wheelchairs were not always put on before people were assisted to stand up, meaning people were at risk of falling backwards. We provided feedback to the registered manager about what we had observed. By day two of our inspection, correct moving and handling practices were carried out within the service.

Overall, people had moving and handling risk assessments in place to help provide guidance and direction to staff. However, one person's moving and handling risk assessment had not always been completed, which meant staff may not always be correctly or safely supported.

People's needs were not always met in a safe way. Risk assessments were not always in place to help provide guidance and direction to staff. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Overall, the environment was assessed to ensure it was safe. Equipment used by people, such as hoists, were serviced in line with manufacturing guidelines. The fire system was checked, and weekly fire tests were carried out. However, for approximately ten minutes, a cleaning trolley, which contained cleaning products, had been left unattended in a corridor outside people's bedrooms. We also found nutritional supplements in people's bedrooms. Both, posed risks to people if consumed. Immediate action was taken by the registered manager, by locking the products away and by speaking with staff.

People's confidential information was not always stored securely. The provider wanted care plans to be kept in bedrooms, so people, families and staff could refer to them. So they had considered the Data Protection Act 1998, and had carried out a risk assessment. However, we found two care plans out of 35 had not been stored securely, but had been left out in the person's bedroom and not locked away. We also found four MARs files left out on top of four medicine trolleys which were in corridors people and visitors accessed frequently.

People's confidential information was not always stored securely. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected by the provider's infection control procedures. We were informed at the beginning of our inspection that there were no infection control risks within the service. However, during our inspection, we found one person had been diagnosed with Methicillin-resistant Staphylococcus aureus (MRSA) in a wound. However, there was no care plan in place to provide staff with preventive guidance, and no personal protective equipment (PPE) outside of the person's bedroom, to help ensure the unnecessary spread of infection. The person's care records did not detail the actions required of staff to manage and monitor the wound. Information recorded in the person's care records and MARs also conflicted with what we had been told by nursing staff.

People shared moving and handling hoist slings. However, there was no system in place to ensure the regular washing of slings to help prevent the spread of inspection. Slings would be washed as and when

necessary.

People were not protected by the provider's infection control procedures to mitigate the risk of the spread of infection within the service. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was clean. Staff received infection control training and wore PPE when carrying our people's personal care. Following the inspection the registered manager informed us the provider had an infection control policy but the internet was used to access the most up to date information to supplement the policy.

Overall, people were cared for by suitable numbers of staff. One relative told us, "You always see lots of staff about". The registered manager carried out a staffing dependence assessment of requirements within the service. Staff told us, the registered manager was responsive to making staffing alterations when necessary. The registered manager had recently implemented additional staff to administer people's medicines, to help give nursing staff more time in the morning. The registered manager told us, the weekly use of agency nurses meant people's clinical needs were not always met with consistency. However, recruitment of three new clinical leads had taken place and they were all due to commence employment by the end of December 2017. Until then, to assist with the safety and continuity of people's care, the registered manager and/or head of care told us they attended each staff handover and requested the same agency staff. However, whilst this was a useful approach, we found this did not always have a positive impact on people's care. For example, in helping to ensure people's medicines were being managed safely and their nutritional needs met.

People told us they felt safe living at the service, telling us "I feel safe because I see a lot of staff", "I feel safe because the carers are spot on at spotting things", and "It's just having so many people about that makes me feel safe".

People were protected from abuse and avoidable harm. This was because staff understood the provider's up to date safeguarding policy and received training about what action to take if they suspected someone was being abused, mistreated or neglected. Staff spoke confidently about how they would protect people by raising their concerns immediately with the registered manager or with external agencies, such as the local authority safeguarding team or police. Staff, were recruited safely to ensure they were suitable to work with vulnerable people.

Inadequate

Is the service effective?

Our findings

At our last inspection on 24 and 25 May 2017 we rated this key question as requires improvement because, people's mental capacity was not always recorded to help ensure their human rights were upheld. In addition, when people had individual nutritional needs, this was not always recorded so staff would know how to support them correctly. During this inspection we looked to see if improvements had been made. We found further action was still required.

At our last inspection in May 2017, people's nutritional needs were not always recorded to enable staff to support people in line with their individual needs. At this inspection we found this continued.

People were not always effectively supported with their nutrition and hydration. Six people required their meals and drinks to be recorded to ensure they were eating and drinking enough; but these records were not always being completed. This meant staff could not determine if people were getting enough to eat and drink. However, action had already commenced to improve documentation and training was being implemented for staff.

The registered manager told us they were in the process of recruiting a new chef, so in the meantime an agency chef was working within the service. To help ensure they knew what people's needs, likes and dislikes were, a nutritional information file had been created for them. However, this was not being used, which meant people were not always receiving the correct diet. For example, one person's care plan detailed they had been prescribed a specialist diet, however, they were not receiving this. The 'resident meal requirement record', used by the agency chef to inform them about what meals to prepare, stated the person was on a normal diet. We reviewed the person's food records from 06 November 2017 to 14 November 2017, which recorded the person had been receiving a mixture of different types of meals during this period.
People told us the quality of the food was variable, commenting, "Some meals are alright and some are arrrrgh!", "The food is not as it should be", "There's a good choice of food, but it's not very good" and, "The foods ok". The registered manager told us people's views were currently being sought, by the completion of a questionnaire and by one to one discussions, so improvements could be made and a new menu created. There was a flexible approach to meals with people telling us, "I had a ham and cheese omelette yesterday instead of what was on the menu" and, "I know if my relative wants something that's not on the menu, they quickly rustle up something else."

People had access to external healthcare professionals to ensure their ongoing health and wellbeing, but did not always receive an organised approach to their changing health and social care needs. People's care records detailed professionals were involved in people's care, such as GP's, community nurses, and chiropodists. However, when people's healthcare was changing staff did not always make referrals to external professionals promptly. For example, one person's mobility had changed, which meant they could no longer safely stand, so staff were now using moving and handling equipment. However, no referral had been made to the person's GP to seek advice about the cause for the decrease in the person's mobility. During our inspection, we asked that action was taken to speak to relevant healthcare professional, to

ensure the person's needs were being met.

People's changes in healthcare were not always recognised and referred promptly to external healthcare professionals. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care and support was not always based on best practice guidelines, helping to ensure the best outcomes for people. For example, people living with diabetes and Parkinson's were not always being effectively supported and did not always have individualised clinical guidance in place. Following the inspection, the registered manager informed us an external professional was assisting with a review of people's diabetic needs and related care plans. However, nursing staff employed by the home should have been aware of and been following best practice guidelines.

We recommend the provider carries out a review of clinical competence and leadership within the service. In line with best practice, set out by the Royal College of Nursing (RCN) and the Nursing and Midwifery Council (NMC).

Overall, people were cared for by staff who had received training. The provider made sure the staff team completed training courses which they deemed as mandatory. Training courses included, fire safety, moving and handling, and food hygiene. An external professional told us they felt some staff were more competent that others, telling us when they provided feedback about people's healthcare needs, some staff had a better understanding than others. Following the inspection, the registered manager informed us some staff had also completed dementia and diabetes training but not as many as had completed the provider's mandatory training.

People did not always have their needs met safely by staff that had the right skills and competence. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received an induction prior to commencing their role to introduce them to the provider's ethos and policy and procedures. Staff who had no experience in the sector completed the care certificate. The care certificate is a nationally recognised qualification for care workers new to the industry. The registered manager told us, to help improve practice within the service current staff would also be receiving a new induction, helping to try and change culture and support staff to understand their role and the regulations which underpins their practice.

At our last inspection in May 2017, we asked the provider to ensure they worked within the principles of the Mental Capacity Act 2005 (MCA). 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. People can only be deprived of their liberty so that they can 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 this inspection, we found staff had received training in respect of the legislative frameworks and had an understanding of how to support people effectively. However, people's mental capacity and best interests decision were not always recorded in a way that assured us their human rights had been upheld.

The Mental Capacity Act 2005 (MCA) had not always been fully followed. This is a breach of Regulation 11 of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People lived in a service which had been designed and adapted to meet their needs. There was a passenger lift so people could access the upper floors, and specialist equipment in bathrooms meant people with mobility difficulties could use bath and shower facilities with ease. People were involved in ongoing changes to the environment. For example, people had been asked to help design the new dining room, by choosing the colour scheme and furniture.

Requires Improvement

Is the service caring?

Our findings

People were not always treated with dignity. People were given plastic aprons to protect their clothing and not napkins. The aprons provided, were the same aprons the staff wore. People were not asked if they were satisfied with these, and if they were comfortable to wear one. One person, who had not been given an apron, was concerned they may spill their meal down their top so asked a member of staff for a napkin, but was given a magazine to protect their clothes instead.

People's preference, regarding their personal appearance was recorded in some people's care plans. For one person, who was partially sighted, it detailed how important it was for them to ensure their clothes were co-ordinated, and that their jewellery was put on. By looking at the person, we could see staff had taken time to do this. However, the person had long facial hair, and staff had not asked the person if they wanted it to be removed. Three out of eight people sitting in the lounge were not wearing socks with their shoes. When we asked the registered manager why this was, they told us a family member had also asked them the same question. They told us, it was probably because people did not have any clean socks to put on, but accepted this was not an appropriate excuse.

Overall, people were cared for by staff who showed kindness. People told us, "The staff are as good as gold", "I have good banter with the staff", and "The carers come in and have a chat, and I think that's lovely". However, some staff showed more compassion than others. On day one of our inspection, staff, were more focused on carrying out tasks rather than spending time with people. Two members of staff were also observed to talk between themselves, whilst supporting someone. However, on day two the atmosphere in the service positively changed. Staff took time to speak with people, to make them smile and laugh. Staff spoke fondly of the people they cared for, telling us "I like knowing I am helping people" and "It's all about the person, to make sure they have a happy and peaceful life".

Overall, people's communication needs were assessed. People had care plans in place to help guide staff about how to effectively communicate with people who had individual communication needs. A member of staff told us how one person found it difficult to hear, so explained "Sometimes it is easier to write it down so that (…) can hear it", and we observed staff doing this in practice. However, some staff did not always know how to effectively support people. One person who was partially sighted was given inconsistent care from staff. Some staff reassured the person about where they were, when they were being assisted from one room to another, whereas others did not. Some staff helped to guide the person to their lunch, explaining what was on the plate, and where it was on the table. Whereas some staff were not as vigilant.

There was a board in the lounge which displayed the day and the weather. Its purpose was to help remind people who had memory loss. However, for the duration of our inspection, on day one, the board displayed the incorrect day. This meant people suffering with memory loss, could become more confused.

People were not always treated with dignity and respect. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always given emotional support. One person was sometimes very low in mood and was on medicine to assist with this. The person was observed to spend time alone, and their care plan did not detail how staff should effectively support them, in a holistic way to ensure their mental wellbeing.

People's privacy was respected. Staff knocked on people's doors prior to entering their rooms. One person had a note on their door informing staff not to enter their room without seeking their permission first, which we observed staff doing. Staff described how they covered people's body as much as they could when supporting them with intimate care. People were also supported discretely and kindly when being prompted to visit the toilet. An external professional told us, people always looked well cared for.

People's families and friends were welcome to visit at any time, with one relative telling us, "The staff, always make me feel welcome when I visit". People and/or their families were involved in decisions relating to their care. When people did not have a family, or anyone to act on their behalf, advocacy services were considered.

People's equality and diversity was respected by staff. Staff told us people were not discriminated against, on grounds of their cultural or sexuality. The registered manager had created an equality, diversity and human rights (EDHR) information sheet for staff, and told us they used staff handovers to help discuss EDHR and to help promote and embed it within the service.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 24 and 25 May 2017 we rated this key question as requires improvement because, people's care plans and records were not always kept update. This meant staff did not always have the right information about how to support people. During this inspection we looked to see if improvements had been made. We found some action had been taken, but further action was still required.

At our last inspection in May 2017, we found people's care plans were not always up today. At this inspection, we found that although action had been taken to improve people's care plans action was still required to ensure they were an accurate reflection of people's individual care needs.

Overall, people had care plans in place which provided staff with information about how they wanted, and needed their health and social care needs to be met. Some care plans also recorded what people's religious and spiritual preferences were. Staff told us they felt care plans were informative and provided the necessary information in order to meet people's needs. However, 15 care plans had not been fully completed or effectively updated. For example, one person had moved into the service on 15 September 2017 and required support to mobilise, by the use of moving and handling equipment. However, their moving and handling assessment had not been completed. Four clinical care plans lacked detail. For example, one person had a catheter, however their care plan did not provide guidance to staff about the a-septic technique when emptying catheter bags and of, the importance of adhering to infection control practices. This meant people could be at risk of receiving inconsistent support.
People's care records were not always accurate or complete, to fully reflect how they wished and needed their needs to be met. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported effectively at the end of their life. For example, one person who was coming to the end of their life had no individualised care plan. This meant the person's wishes were not recorded to help ensure all staff knew how they wanted to be cared for. The service had not consulted with person's GP about 'just in case medicines', medicines which are essential to support and assist with sudden deterioration or the development of distressing symptoms. This meant there could be a delay in the person receiving essential pain relief. Following the inspection, the registered manager told us the person's 'just in case' medicines remained with a family member as their condition was stable. However, when people are at the end of their life, it is important for any medicines to be in the same location as the person.

People's individual preferences were not always recorded which meant staff did not know how people wanted to be supported. For example, care plans did not detail how people preferred to be addressed by staff, or if they had a preference of a male or female member of staff, to carry out their personal care. When people's preferences had been recorded, staff did not always acknowledge them. On day one of our inspection, the music playing in one person's bedroom was not what they liked as recorded in their care plan. However, by day two, the person's radio had been adjusted to take into account their preference.

People's care was not always designed and delivered to ensure it met their needs, wishes and preferences.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to a call bell to ask for assistance. People and their families told us, "They make sure I always have my call bell by my side", and "My relative always has his call bell on hand". Although, the registered manager monitored call bell times we could see some people had had to wait over 20 minutes before they received assistance. The registered manager recognised response times still required improving, but action was continually being taken and improvements were steadily being seen. During our inspection, people's call bells were answered within 10 minutes.

Overall people and their families told us they were opportunities for social engagement, comments included, "I enjoyed making the Christmas cards", "I love it when we play bingo and we get prizes" and "I enjoyed having my nails done today". People were also able to continue with their own interests. One person told us, "I am doing an Open University course online". A new activities co-ordinator had been recruited, and action was being taken to increase opportunities for people to visit local attractions. A recent trip to see fireworks had been a great success.

People's comments and complaints were viewed positively and used to help improve the quality of the service. For example, people had said they would like more seating in their bedroom so when their visitors came to see them, there were enough chairs. So the provider had taken action to order more furniture. People told us, "You can talk to anybody if I have any questions" and "The staff are very responsive if we have any concerns". The provider had a complaints policy which underpinned how complaints were investigated. The complaints policy was displayed within the service, however the policy may not have been in a suitable format for everyone to understand. Staff, were being trained on the importance of recognising a complaint, and their role in dealing with complaints. Advocates were also used when required.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 24 and 25 May 2017 we rated this key question as requires improvement because, the provider did not have effective systems and processes in place to help monitor the service, and identify where improvements were required. During this inspection we looked to see if improvements had been made. We found further action was still required.

Following our last inspection, the Commission considered its enforcement policy, and took enforcement action, which was to impose a condition on the provider's registration. This meant on a monthly basis, the provider was required to carry out an audit of people's medicines and of care records. Submit a summary of their findings to the Commission, and demonstrate what action was being taken to improve the service and to meet the regulations. Since July 2017 the commission had been receiving and reviewing the provider's monthly returns, which had demonstrated ongoing improvement at the service. However, the findings of this inspection determined the information which had been provided had not been inaccurate, and was not reflective of the current regulatory position within the service. For example, we had been informed medicines management was now being robustly overseen by a dedicated member of staff, and positive action had taken place regarding the monitoring of people's diabetic care. However, our inspection found failings in respect of the management of medicines and of diabetes. We had also been informed people's weight and nutrition were now much more robustly monitored, but we found this was not occurring. Following the inspection, the registered manager informed us they had recognised these failings and were taking action to address them.

The provider had a governance policy, its purpose was to, "To meet the legal requirements of the regulated activities that Warwick Park is registered to provide: The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014". However, this had not been effectively implemented, which meant this had failed to happen.

We asked the registered manager about the involvement of the provider in the monitoring of the service. We were told the provider visited three to four days each week. Their visit consisted of speaking with people, staff and checking the completed care audits which had been carried out by the management team. However, despite the provider carrying out such monitoring, their checks had not always been robust in identifying areas requiring improvement. Their checks had also not identified that the information which was being submitted to the Commission on a monthly basis, was not always accurate. This meant the provider's governance framework was not fully adequate in ensuring regulatory requirements with the Commission, were met and understood.

The registered manager had been working to improve the service, and displayed a commitment, determination and passion to get it right. However, the systems and process which they had implemented and used to help monitor the quality and safety of care people received had not always been effective, in identifying areas requiring improvement. For example, audits which were in place to ensure care plans were accurate had failed to identify five people had not been referred to external healthcare professionals in a timely manner.

When things went wrong, the registered manager was pro-active. Investigations were carried out to identify what action was required to prevent a re-occurrence. However, actions from investigations were not always embedded into practice. For example, medicine concerns had been reported by one family. So as a result of this, a new checking process had been put into place. However, this had not been effective in identifying medicines requiring ordering, and the checking process was not being used by all staff.

People did not live in a service whereby the provider's values helped to promote an open, inclusive, empowering and person-centred culture. The provider's mission statement was "Through friendly, flexible, person-centred informed partnerships, our staff embrace supportive nursing care promoting and respecting every individual daily aspiration of independence and potential of reablement". However, the providers systems and processes to monitor the culture were not effective. For example, on day one of our inspection the atmosphere and culture of the service was task orientated and staff, were hesitant to engage with us. By day two there was a change in atmosphere. The registered manger told us that they had taken time to speak to staff about their approach and to reassure them about the inspection process.

The registered manager told us, they were in the process of revising the organisations values. One person had told the registered manager that they felt the home lacked a feeling of 'family'. So the registered manager was going to be working with people in order to determine what 'family' meant to everyone, so the feelings could be created within the service. The registered manager had already started to ask staff to think about the aims and objectives of the service, and to consider their responsibility in being able to deliver them.

The provider's governance framework, to help monitor the management, leadership and culture of the service, as well as the ongoing quality and safety of the care people were receiving was not effective. Newly designed systems had not always been robust in identifying areas requiring improvement. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us, they felt the service was moving in the right direction, but recognised changes were not always being positively received by staff, and embedded into culture and practice. So a new staff induction had been created and had just started to be rolled out. Its purpose was to define staff roles, expectations and professional accountability.

People, relatives and staff spoke positively about the leadership of the service. Commenting, "The manager and staff are all approachable if I have any worries" and, "She (the registered manager) is amazing, she's always got time to speak to you".

People were encouraged to provide their views to help develop the service. Questionnaires were freely available for visitors, families and professionals. There was also a secure post box which people could leave messages regarding complaints, suggestions, ideas and comments. Feedback was listened to, as people had told the provider that meals were sometimes cold, so the provider was purchasing two hot food trolleys.

The registered manager kept their ongoing practice and learning up to date. The registered manager told us they enjoyed attending events such as the dignity in care forum and the local manager's network. These helped to share best practice, experiences and to learn from each other. Following a recent meeting, the registered manager had considered staff awareness of equality, diversity and human rights (EDHR), and had created an information sheet for staff.

People benefited from a registered manager who worked with external agencies in an open and transparent

way. Two external professionals told us, they felt the registered manager was professional in their approach, and willing to adapt and find solutions to problems