Bupa Care Homes (ANS) Limited

Warren Lodge Care Home

Inspection report

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Date of inspection visit:
23 February 2017
24 February 2017

Date of publication:
05 April 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 23 and 24 February 2017 and was unannounced.

Warren Lodge is registered to provide nursing and personal care for up to 64 people .There were 63 people using the service during our inspection; who were living with a range of health and support needs. These included; diabetes, catheter care, dementia; and people who needed support to be mobile.

Warren Lodge is a purpose built premises situated in Ashford, Kent. The service had very large communal lounges/dining rooms available on each floor; with armchairs and TVs for people and a separate, quieter lounge, where people could entertain their visitors.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.
Warren Lodge was last inspected in October 2015. At that inspection it was found to require improvement. We issued requirement actions about the storage of medicines, recruitment checks, fire drills, diabetes management and quality assurance processes. At this inspection some of these areas had improved, but there remained shortfalls in diabetes management and quality assurance. We also found other issues which needed to be addressed to protect people's health, safety and well-being.

There were no assessments about choking for people who were known to be at risk, and no guidance for staff about actions to take in the event of a choking incident. Staff did not raise the alarm appropriately when a person fell; delaying nurse input. Assessments about other types of risk however were detailed and offered staff advice about reducing the likelihood of them happening.

Staff had not always followed the provider's processes for reporting incidents to the registered manager, which meant some had not been discussed with the local safeguarding authority. Most safeguarding concerns however were referred appropriately.

There were enough staff on duty to meet people's needs, but staff training could be improved in some areas.

Some aspects of people's healthcare required improvement to ensure people received consistent care and treatment, but other areas were well-managed. People enjoyed nutritious meals and were offered plenty to drink. Referrals were made in a timely way to dieticians when necessary but people's individual needs were not always considered to ensure they received a reasonable level of intake.

There were scant records about people's hopes and wishes for the end of their life; although the provider introduced new paperwork relating to this during the inspection. People's individual needs were not always met because care plans contained confusing information.

Quality assurance processes had not picked up and addressed the issues we found during this inspection.

We recommend that the provider obtains from a reputable source: diabetes, epilepsy and end of life care training for staff.

We recommend the provider carries out a full review of PEEPS to ensure they are completely legible.

We recommend that the provider ensures that people's hopes and wishes for the end of their life are individually discussed and documented wherever possible.

Medicines were well-managed and safely administered by staff. The service was maintained to a good standard and all equipment was routinely safety checked. People had individual emergency evacuation plans and staff knew the location of fire exits and assembly points.

Staff received regular supervision and completed the Care Certificate induction programme. There was a robust recruitment system in operation and all necessary checks had been made prior to taking on new staff. Staff were kind and considerate and treated people with dignity and respect.

People's consent had been sought formally and verbally for day-to-day care tasks. Staff were knowledgeable about the Mental Capacity Act (MCA) 2005 and worked within its principles. The registered manager had made applications for deprivation of liberty safeguards (DoLS) and received authorisations for some of these.

There was a wide and varied range of activities available to people, delivered by knowledgeable activities staff who were passionate about supporting people to be seen as individuals rather than people living with dementia.

Complaints had been properly recorded and managed and people and relatives knew how to raise concerns. Feedback was sought through a variety of sources and was acted upon.

The registered manager was well-respected by staff, people and relatives and staff described an open culture where they could safely raise concerns or make suggestions for improvement.

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

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.

Individual risks to people had not always been assessed nor actions to minimise risks considered.

Staff had not consistently followed safeguarding procedures.

Medicines were safely managed.

There were enough staff deployed to meet people's needs.

Recruitment processes were robust and helped ensure the suitability of applicants.

Environment and equipment safety checks had been regularly undertaken.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all aspects of people's healthcare had been effectively managed.

Staff had received a range of training but needed further, specific courses to support them in their roles.

People enjoyed a choice of meals and received support to eat but more consideration was needed to ensure people's individual needs were met.

Staff understood the principles of the mental capacity Act (MCA) 2005 and acted accordingly. Deprivation of Liberty safeguards (DoLS) applications had been made when necessary.

Is the service caring?

Requires Improvement

The service was not consistently caring

People's hopes and wishes were not always sought when providing end of life care to ensure they were met.

Staff delivered care and support with consideration and kindness.

People's privacy, dignity and right to confidentiality were respected.

Staff encouraged people to be independent when they were able.

Is the service responsive?

Requires Improvement

The service was not responsive in every area.

Care plans were generally person-centred and documented individual needs; but these were not always clear or followed through in practice.

There was a wide range of activities on offer, delivered by well-informed and passionate staff to meet people's needs for stimulation and interaction.

There was a robust complaints system in place and people and relatives knew how to voice concerns if necessary.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality assurance processes had failed to identify shortfalls in some areas, but some issues highlighted at our last inspection had been resolved.

Feedback had been sought from people, relatives and staff and was acted upon.

The registered manager was approachable and visible in the service and people, relatives and staff said they could speak to them with concerns.

Warren Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.
This inspection took place on 23 and 24 February 2017 and was unannounced. Two inspectors, a specialist nurse advisor and an expert by experience carried out the inspection. The specialist nurse advisor had nursed older people and the expert by experience had personal experience of caring for older people living with dementia.

Before our inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at any safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met with eighteen people who lived at Warren Lodge. Not everyone was able to verbally share with us their experiences of life in the service. We therefore spent time observing their support. We spoke with 10 people's relatives. We looked at the environment including the bathrooms and some people's bedrooms. We spoke with three nurses, five care workers, two domestic staff, two hostess staff, the registered manager and the regional support manager.

We 'pathway tracked' nine people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the service where possible and made observations of the support they were given. This allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed other records. These included three staff training and supervision

records, three staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us that they felt that they or their relative were receiving safe care at the service. One person said "I feel safe, I have two staff to help me in and out of bed and I am able to have my door locked at night so any residents wandering about don't come in". Another person told us "Staff are available at all times, all very good. I cannot speak too highly of them". A relative commented "I have no doubt about [Person's name] safety, I've never seen anything untoward and I'm more than happy they're being cared for."

However, we found that some risks to people's safety had not been properly assessed or minimised. For example; during the inspection one person fell over in the first floor lounge, hitting their head. A member of domestic staff was the first to attend to the person and did their best to comfort them. However, they did not press the emergency alarm in the lounge to make sure nursing and care staff were aware of the incident. Afterwards they told us that they had approached two nurses in the minutes following the fall, but one had been engaged in an important phone call and another was giving out people's medicines and could not immediately attend. Nurses later told us that they had no idea this was potentially an emergency situation because the alarm had not been used and domestic staff had not made the urgency clear to them. As a result it was more than five minutes before the person was examined and assessed by a nurse. Although the person was not badly injured, this time delay could have been critical in different circumstances. The registered manager told us that they would conduct supervisions with all domestic staff to ensure they understood emergency procedures in future.

Some people's care files documented that they were at risk of choking, but there were no individual assessments in place to show how the risk could be reduced. Neither was there any guidance for staff about how to manage choking; despite one person having had a serious choking episode last year. However, staff were able to satisfactorily describe the actions they would take if a person choked. Another person's care plan documented that they were at risk of choking and that they needed their drinks thickened, but we found a jug of un-thickened squash in their bedroom. This person was able to move around independently and there was a risk that they might drink this squash; which could cause them to choke. A further person had been assessed by a speech and language therapist (SaLT) as needing a special type of mug to help them swallow liquids safely, but we observed this person using a spouted beaker. We asked staff about the special mug but they did not know if there was one available in the service or what the purpose of it was. Professional advice intended to support this person to drink comfortably and safely had not been followed.

The failure to consistently assess and minimise known risks to people is a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risk assessments were detailed and provided staff with a good level of information and guidance to enable them to support people safely. For example; assessments about people's pain were made regularly and there was evidence that staff had acted promptly if pain had increased or changed. One person had started to report low level pain and staff had contacted the GP to ask for pain relief to be prescribed on a 'When needed' basis (PRN). Another person was unable to communicate verbally and the risk assessment

gave step-by-step directions for supporting this person; including making eye contact, using straightforward and clear sentences and giving the person time to process information. We observed staff following this guidance in practice during the inspection.

Processes designed to protect people from abuse or harm had not been consistently followed by staff. We found records of a number of behavioural episodes between people, which had resulted in some people being hit or slapped for example. Not all of these had been documented as incidents and some had not been passed to the registered manager for review in line with the provider's safeguarding system. There were at least two such incidents which the registered manager said they would have discussed with the local safeguarding authority (LSA) had they known about them. The LSA had not been involved at the time of the inspection and had not had the opportunity to consider whether investigations were necessary. However, feedback from the LSA confirmed that the registered manager usually discussed and referred any safeguarding issues correctly. There had been a breakdown in the way safeguarding protocols were followed by some staff. The registered manager told us that they would be taking disciplinary action against the staff who had failed to report incidents appropriately and they contacted the LSA immediately we brought the matters to their attention.

The failure to effectively and consistently operate systems and processes to protect people from abuse is a breach of Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the temperature of the medicines room did not meet manufacturers' guidelines for the storage of some items. At this inspection the issue had been resolved and records showed that the medicines room had been kept at a consistently appropriate temperature through the addition of an air cooler. Medicines had been managed safely and records showed that people had received their prescribed medicines and creams regularly and in line with GP directions. Medicines about which there are special legal requirements were stored correctly and stocks were closely monitored. Two staff signed a register each time people received these medicines to confirm the correct doses had been given and record the stock remaining. Staff ensured that people swallowed their medicines before signing medicine administration charts (MAR) to confirm they had been taken. This was good practice. Where people sometimes refused to take their medicines, this had been clearly documented and the GP made aware promptly so that any risks to people's health could be monitored and managed. People told us that they received their medicines at the right times. One person said "I have one pill at breakfast time. The nurse always finds me when it's time for my eye drops and drops in my ears." A relative commented "[Person's name] Always gets their medicine and always looks well."

At our last inspection we had concerns about processes around Disclosure and Barring checks (DBS), as additional steps had not been taken to ensure staff with negative DBS results were suitable for the role. A DBS check identifies if prospective staff have a criminal record or were barred from working with children or vulnerable people. At this inspection, processes were in place to discuss and make enquiries about any negative DBS check, which were recorded to ensure it was a fair and in depth process. Staff records viewed showed that there was a thorough recruitment process in place which ensured that all necessary checks were completed prior to the staff member commencing their employment. An application and interview process was in place, and checks included, two references, proof of personal identity, a photograph, and evidence that gaps in employment histories were explored at interview. A medical health declaration was also in place to provide assurance that the prospective staff member was mentally and physically fit to undertake their role. These checks helped the provider to ensure that a safe recruitment process was in place.

At our last inspection, fire drills had not been carried out regularly. At this inspection we found that fire drills were conducted in line with the provider's fire safety policy. This was to test how people, staff and visitors could be safely evacuated in case of fire or another emergency. Personal emergency evacuation plans (PEEPS) were in place for people and had been individualised to show which equipment and staff numbers would be needed to support them safely. Some PEEPS had been hand written and were not fully legible which might mean staff could not follow them if they needed to.

We recommend the provider carries out a full review of PEEPS to ensure they are completely legible.

Fire safety equipment such as extinguishers, emergency lighting and the fire alarm system had been routinely checked and maintained. All staff had received fire safety training and those we spoke with could point out fire exits and assembly points. Other equipment like hoists, special baths and the passenger lift had regular safety tests to ensure they remained fit for purpose. The service was clean and well-maintained; providing a comfortable and safe environment for people to live in.

There were enough staff to meet people's needs. One person told us "I just press the buzzer and staff appear to come quite quickly, I always see someone walking past". Another person said "Staff are available at all times". A relative added "I come in at different times and there are always loads of staff around when I visit".

Our observations showed that people received prompt attention when they called or buzzed for staff. People were living with a range of health and support needs. These included; diabetes, catheter care, dementia; and people who needed support to be mobile. In the mornings one 'Hostess' worked on each floor to give people their breakfasts and serve drinks. This freed up nursing and care staff to support people to get up and dressed and provide any clinical care needed, such as Insulin injections. There were two nurses and six care staff on each floor in the mornings and two nurses and five care staff in the afternoons with two nurses and three care staff on each floor overnight. Most staff felt that there were enough of them to support people. One staff member told us "It's busy but I don't feel it's understaffed".

Staffing levels were calculated on a monthly basis using a dependency tool to assess each person's care needs. The registered manager informed us that she recruited 20% more staff than was needed to ensure there were enough staff to cover shifts, holidays and sickness .This meant that there were always sufficient permanent staff to work so that agency staff were not required and people received continuity of care from staff they knew and recognised. This was especially important for people who were living with dementia who may have difficulty remembering new staff.

Requires Improvement

Is the service effective?

Our findings

People and relatives gave us positive feedback about the health care they received. One person said "If I need the doctor I just ask to be put on their list. Doctor comes on Friday and nurse comes Tuesday". A relative told us that their loved one had been taken ill recently and that "The ambulance was called straight away, a member of staff went with them in ambulance to the hospital so they weren't distressed". Another relative fed back that they had seen great improvement in their loved one's health since they began living in the service. They said "Mum's condition is much better than previously and she's looking so much better in herself".

At our last inspection, the management of people's diabetes had not always been effective. At this inspection we found this area had not been consistently improved. We reviewed the care and treatment plans of three people living with diabetes. One person had a specific care plan about diabetes which mentioned that they enjoyed some sugary snacks. Blood glucose monitoring for this person showed that it had risen to high levels on one day during February 2017. Insulin had been given to them but there was no record of other important checks and observations such as of their urine, temperature or pulse or any details about whether the person had eaten any sugary foods that day. This information would have helped staff understand the possible reasons for high blood glucose readings and determine the best way to manage them going forward.

A second person's care plan for diabetes gave details of the frequency of blood glucose monitoring and the safe upper and lower levels for the results. However, there was no information about how staff should deal with any episode of high or low blood glucose levels. Although one nurse was able to competently describe what action to take in these situations another nurse was not as sure. The third person's care plan and notes showed that their blood glucose levels had been very well-managed. However, instructions for staff about what to do in the case of low blood glucose levels was hand written and illegible to both Inspectors and the nursing staff we asked to read it. This record was not fit for purpose and created a risk that staff would be unable to decipher it if needed. There were no records about diabetic foot care in any of the care notes we reviewed. People living with diabetes are susceptible to foot problems brought about by poor circulation and should have regular checks to maintain foot health.

We looked at other areas of health care to see how these had been managed. We reviewed the records of two people who experienced seizures. One of these contained a good care plan with a detailed description of how seizures presented. There was also good information for staff about how to manage the seizure. However records for the second person were not as comprehensive. There was no description of how the seizure presented and although notes stated that the person would be monitored for the rest of the shift there was nothing documented about what checks had happened. 'Seizure charts' were in place to record the dates, times and durations of them. The charts were designed to provide an overview of people's seizures so that they could be monitored for frequency and any changes, but the chart had not been completed following the seizure we case tracked.

Individual care plans were in place where people had urinary catheters These identified when catheter and

bag changes were required for example, but gave no guidance about general catheter care, such as how to clean them. Minutes of a recent staff meeting showed that catheter cleaning had been raised as an issue because one had been found in a soiled condition. There was no instruction in the catheter care plan for staff to check the colour, odour and consistency of urine when emptying catheter bags; which might indicate infection.
The failure to minimise risks through having adequate assessment and guidance for staff is a continued breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Wound care had been well-managed in the service. Where people were at risk of pressure wounds, special equipment was in use to help prevent these occurring. People were offered drinks frequently; which is important for promoting healthy skin; and they ate nutritionally-balanced meals for overall well-being. Staff were knowledgeable about the need to for people to be supported to reposition regularly to relieve pressure. Any wounds had healed well and quickly. One person told us "I cannot fault the treatment I have had here. I came to the home with a bad bed sore but they have done wonders it's nearly fully healed".

People were able to see a doctor or nurse practitioner when needed. They routinely visited twice a week and outside these times if necessary. A visiting GP told us that communication was good and that concerns about people's health were raised promptly. People had access to chiropodists, physiotherapists and dental appointments and professional input was received from dieticians, SaLT and mental health teams to help maintain people's health and well-being.

Staff completed a programme of mandatory training and refreshers in a wide range of subjects to support them in carrying out their roles effectively. Courses included subjects such as; behaviour that challenges, dementia awareness and nutrition and hydration. People and relatives felt confident in staffs' ability. One person told us staff were "Well trained, very cheerful they all seem to work well together". A relative said "Staff are skilled and seem to know how my relative likes to be comfortable." However, feedback received from a professional stated that some of the nurses lacked confidence in areas such as diabetes management, and were over-reliant on GP intervention when some clinical decisions could be made by registered nurses.

Many of the health care assistants had achieved National Vocational Qualification (NVQ) 2 or above. The NVQ is a work based qualification which recognises the skills and knowledge a person needs to do a job. Some staff had not received additional up-to-date training about diabetes management, epilepsy or end of life care. Our inspection highlighted that staff knowledge in these areas was not consistent and was an area for improvement. Staff told us that they felt they would benefit from focussed training about these subjects because some people living in the service had these conditions or were reaching end of life.

We recommend that the provider obtains from a reputable source: diabetes, epilepsy and end of life care training for staff.

All new staff underwent a five day induction and participated in four 'Shadow' shifts before they were rostered as on duty. They were expected to complete the Care Certificate, which is a set of standards that social care workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers. This meant staff had a good basic understanding about their roles and expectations before they began. Staff received regular supervision to discuss development and training needs. Nurses received clinical supervision from the deputy manager who is a registered nurse. Qualified nursing staff provided supervision to health care assistants who said 'The nurses listen: they are good and supportive'.

People had been referred to a dietician if they had lost weight and their advice had generally been followed in practice. However we observed one person eating a breakfast of cereal at 11:30am on both days of the inspection. They were then given a full cooked lunch at 12:30pm but did not eat any of it as they had only had breakfast an hour before. Food charts for this person showed that they often refused their lunch but sometimes ate cake or a snack mid-afternoon because they regularly chose to have a very late breakfast. We spoke to the registered manager about this and they told us that the kitchen was open 24-hours a day so this person could be offered their lunch mid –afternoon so there was a greater gap between their mealtimes. However, this idea had not been explored until we raised it during the inspection. This person had lost significant weight in the last few months and had been seen by the dietician. Staff had missed the opportunity of making adjustments to this person's mealtimes to ensure they received a nutritious, balanced meal at a time to suit them.

Some people needed their drinks to be thickened to help with swallowing. Information about this in people's care plans was scant and sometimes inconsistent between records. For example, three people's care plans about nutrition documented that thickened fluids were required, but gave no indication of the appropriate thickness or correct amount of special thickening granules to use in drinks. Care plan summary sheets did not record that these people took fluids in this way. Staff were not all sure about which people had which consistency of drink, although one hostess knew exactly who should receive what thickness. A list was held in the serving areas which showed which people had thickened drinks, but again this did not state how thick they should be for individuals. This created a risk that staff might give drinks that were too thin and could cause a choking hazard. The registered manager showed us new chart templates introduced by the provider during the inspection which required staff to document which people had thickened fluids, the consistency of these and how much thickener should be used to achieve that thickness.

People were offered a choice of meals each day and we observed staff on both days asking people what they would like to eat. Many people were living with dementia but no photos or picture menus were used to support people to make their selection. The registered manager told us that picture menus were available but these were not used by staff during the inspection. Menus were displayed outside the dining room and on tables but these were presented in average sized print and could have been improved for older people who may have impaired sight.

The lunch time meal was a relaxed occasion for people, with music playing in the background in the ground floor dining area. People were able to come into the dining room when it suited them and were able to choose where they sat. Tables were laid with glasses, condiments, serviettes and water. As people sat at the table staff offered juice or hot drink as alternatives. Several people were supported to eat by their visiting relatives and others by staff. People who had softer meals had each item on their plate individually pureed so that the meal appeared more appetising. People were encouraged to feed themselves where possible.

People and their relatives gave positive feedback about the meals provided. One person told us "I always have a cooked breakfast, fried bread, tomatoes and bacon along with a cup of tea. All cooked in the kitchen". Another person said "Meals are very edible, usually a choice of meat or vegetarian and a choice of 4 vegetables. I can have salad bits as well and I never go hungry". One relative commented "Staff chop the food up so my relative can still manage to feed themselves with their fingers. They always get support from staff with the puddings" and another added "Night staff often give [Person's name] a snack in the middle of the night if they are hungry".

Staff gave gentle encouragement and showed consideration when they supported people to eat. They sat beside people, gave good eye contact and as they offered food they chatted with the person, asking them what they would like next. Staff gave people time to savour each mouthful and gave praise throughout; "'Did

that taste nice? You're doing well". One person decided that they didn't want their chosen chicken dish and was immediately offered omelette which they accepted. Staff encouraged people to eat and checked with them that they had finished before they removed the plate. One person left their pudding and a staff member asked them "Did you not like that, would you prefer yoghurt instead".

People's consent to some aspects of their care and treatment had been formally sought. Verbal consent was sought by staff for day-to-day matters like asking permission to go into people's bedrooms or when giving people medicines. Some people lacked mental capacity to make some decisions and in these cases, a detailed mental capacity assessment had been made. These are necessary to comply with the principles of the Mental Capacity Act (MCA) 2005. The Mental Capacity Act is to protect people who lack mental capacity, and maximise their ability to make decisions or participate in decision-making. Staff had received up-to-date training about the MCA and worked in accordance with it. For example, staff offered one person straightforward choices by showing them two sets of clothing. This allowed the person to continue to express their choices, with staff support. Where people lacked capacity for more complex decisions, best interest meetings had taken place with family and other professionals, to agree the right course of action to take on the person's behalf.

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 are called the Deprivation of Liberty Safeguards (DoLS). The registered manager understood their responsibilities around (DoLs) and had made a number of applications to the proper authority.

Requires Improvement

Is the service caring?

Our findings

People and their relatives gave us positive feedback about staff. One person told us "Staff are very attentive. They keep an eye on everyone. I feel quite pampered". Another person said "I cannot fault the care I have had. The staff are all very kind". A relative told us "Staff seem very caring; my relative is always washed and dressed in the morning. Sometimes [Person's name] doesn't want to get washed but staff don't force it and will try later on". A thank you card from the relative of a person who had received care at the end of their life said 'I wanted to let you know how much I valued the care and love you demonstrated to Mum. Each and every one of you showed a commitment to my Mum's care that I will be forever thankful for and will never forget.'

There was one person receiving end of life care during our inspection. Their care plan about end of life was not person-centred and did not contain any information about the person's individual preferences for this time or any instructions for staff about special considerations. The registered manager explained that booklets about people's hopes and wishes for the end of their lives had been withdrawn by the provider. New and detailed paperwork was introduced by the provider during the inspection but this was not useful for the person who was currently in their final days. The registered manager told us that they had spoken with this person's family on the first day of our inspection and they had said they were happy with the care provided to their loved one.

Staff said that they had not received any specific end of life care training. Although they were able to tell us that it was important to provide people with comfort and dignity in their last days, they were not able to provide us with more detail about what this would mean in practice; other than providing mouth care. This is an area for improvement so that the provider can be sure that people's wishes are followed through where at all possible and staff are fully equipped with appropriate knowledge about best practice in this field.

We recommend that the provider ensures that people's hopes and wishes for the end of their life are individually discussed and documented wherever possible.

There were many kind and caring interactions between staff and people during our inspection. For example, when one person appeared quite agitated and could not settle, a staff member suggested taking them for a walk and offered their hand for support. Another person had spilled some food on their trousers. A staff member noticed the stain and spoke to the person discreetly and respectfully saying "Oh dear have you spilled some of your dinner on your trousers? Let's wipe if off together before it stains". The person happily went back to their room with staff gently supporting them. Staff sometimes used terms of endearment when speaking with people which appeared to soothe them. For example, staff added cold milk before giving one person their cup of tea saying "I don't want you to burn yourself my darling".

The registered manager had made adjustments to meet the needs of a person who did not have English as their first language. Two care staff had been employed specifically for their ability to speak this person's own language, so that they would not become isolated. Some signage around the service had been written in both English and this person's birth language to make it easier for them to orientate themselves. This

showed thought and consideration of how it might feel to live in a foreign country with limited ability to communicate.

Staff acted to protect people's dignity. One person walked around with their trousers in their hand. Staff noticed quickly and responded in a kind and caring way. Other staff prompted people to use the toilet quietly and considerately so as not to draw attention to their conversation. When people were supported to move with a hoist, staff covered people's legs to ensure they were not exposed; and offered warm and constant reassurances during the manoeuvre.

People appeared clean and well- groomed and had the opportunity to have the hairdresser do their hair in their own room or in the hair salon. Some people had been supported to continue to wear make- up or jewellery. One person told us "I have always worn makeup and staff help me now". Relatives said that their loved ones were assisted to choose their clothes and would be wearing co-ordinated tops and skirts/trousers. People were supported to present themselves in the way they liked, which helped to promote their self-esteem.

People or their relatives told us that staff encouraged people to remain independent for as long as possible. One person said that they liked their own company and preferred to stay in their own room. They said "I can sit here and read or draw and watch television as I choose". A relative said that their loved one was "Able to walk about without any restrictions being put on them", which was important to them. Care plans listed what people were able to do for themselves and which areas they would need support from staff. One person's care plan recorded that they were able to make their own bed with support and we observed them doing so. Other people could eat independently if staff cut up their food. People's individual abilities and preferences had been considered so that they were able to maintain a level of independence that was right for them.

Records about people's care were kept confidentially and locked away when staff were not using them. Staff were mindful of confidentiality when speaking with us and checked that is was acceptable to discuss people's care needs. Relatives told us that they could visit anytime they wished and that the quiet lounge was made available for them to have private time with their loved ones. Relatives said that they were kept informed of any changes or developments in people's care or treatment and most told us that they felt reasonably involved.

Requires Improvement

Is the service responsive?

Our findings

People's care plans contained information about their former lives. This had been sensitively prepared and gave good insights into people's individual achievements and personalities. Short family trees had been produced to illustrate people's family connections and relationships to help staff understand people's social backgrounds. However, some details in care plans were contradictory and created a confusing picture of people's current needs. For example, one person's care plan summary stated that they walked with a stick but in other places in the care file it had been documented that they did not use a stick or could walk with staff holding their hands. Staff told us that this person used a stick, but they did not do so on either day of the inspection. This person had been assessed as at high risk of falls so it was especially important that they had equipment to hand to support them when they mobilised. Staff told us the stick must have been left in the person's room but when we checked it was not there. Staff later found it in another person's bedroom, but there was clearly some confusion about this person's specific needs, which meant there was a risk that they would not be consistently met.

Another person's care plan recorded that staff should ensure they were wearing their spectacles but they did not have them on throughout the inspection. We asked one staff member about this but they did not seem to be aware that the person needed spectacles. Another staff member went to look for them but they could not be found before the end of the inspection. A further person's care plan about eating documented that they needed a plate guard to prevent food from being pushed off the plate but this was not in place when we observed lunch being served. This made it difficult for the person to maintain their independence and meant that care plan directions were not always followed by staff in practice; in order to meet people's individual needs.

People's care did not consistently meet their assessed needs which is a breach of Regulation 9 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a team of three activities staff, led by one coordinator who had carried out extensive research from reputable sources about engaging people who live with dementia. This coordinator was also qualified as a 'Person First, Dementia Second' trainer. This is the provider's publicised model of care which encourages staff to develop an understanding of people as individuals, and through this, support them better in living with dementia. Information about people's interests, hobbies and routines was gathered when people began living in the service. Activities staff then observed people's behavioural patterns and triggers to determine the best way to work with them. Baby dolls had been introduced for three people who had previously been quite unsettled, for example, and two other people became animated and engaged when activities staff showed them maps and spoke about where they had lived and worked in the past.

Activity plans had been produced for each person, based on their own needs, preferences and participation levels. Every person received individual time with activities staff as well as having the opportunity to join in with a range of entertainment like music or visits from pets and animals such as dogs, Shetland ponies and even a llama. Some activities had been adapted so that they were suitable for people who remained in bed. For example, a quoits game was changed so that it could be placed on a person's bed and the quoits

themselves were made lighter to enable people to throw them more easily and safely. This showed that consideration had been given to people's particular needs and abilities so that they could join in. Other people had poetry read to them while they were in bed. One person clearly responded to this stimulation by reaching out and touching the activities staff face and saying "Lovely".

Most people and their relatives gave positive feedback about the activities offered. One person told us "The activities lady has been to see me to ask me to join in. They know I like birds and worked with other residents to prepare me a chart of birds for my wall". Another person said "There are quite a few activities at the home such as TV, music, sing along, cutting out shapes, bingo and church afternoons. The activities co-ordinator is very willing and often asks would I like to join in". A relative told us "My relative likes the musical activities. She listens and taps her hand on the chair and really looks as if they are enjoying the music". The activities staff were passionate about involving people and improving their quality of life through social interaction; which had been tailored for them. One activities staff told us "People often see the dementia and not the person; we look for ways to bring the person out from behind the dementia".

The service received many positive comments from relatives and from some visiting professionals. One card read 'Thank you all for your help and support and your kindness and understanding' and another said 'I believe Warren Lodge to be one of the best care homes in Kent'. Further feedback stated 'Staff are outstanding; cheerful, concerned and helpful'. A comments box was provided in the reception area and the registered manager regularly checked and responded to any suggestions or concerns.

We looked to see how complaints were managed. The provider's complaints procedure was clearly displayed in the reception area. The registered manager maintained a complaints log which recorded actions taken and whether concerns were resolved or escalated. People we spoke with said they knew how to complain if necessary and relatives commented positively about the service their loved ones received. One relative told us that they had made a compliant in the past but this had been dealt with efficiently and thoroughly.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, the provider's quality assurance processes had not been sufficiently robust to consistently identify and resolve shortfalls in the quality and safety of the service. At this inspection the situation had not improved. Although the temperature of the medicines room had been rectified and fire drills had taken place and been documented, the management of diabetes still required greater input to ensure that people always received appropriate standards of care and treatment.

At this inspection assessments had not been undertaken where people were known to be at risk of choking. This meant that no actions to reduce those risks had been documented and there was not clear guidance in place for staff to follow in the event of a choking incident. Some staff had failed to follow the provider's safeguarding processes, resulting in at least two incidents being overlooked until we brought them to the attention of the registered manager. Training needs in some areas, such as end of life care and diabetes management had not been recognised or addressed and care plans were not always followed in practice. One care plan in which we found conflicting information had been the subject of an audit in January 2017 but the issues had not been picked up. A suite of audits and other quality assurance processes were in use. This included a monthly provider home review and manager's and clinical walkarounds. However, these had been ineffective in drawing attention to some of the areas which required improvement.

The failure to operate effective quality assurance systems is a continued breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Feedback had been sought from people and their relatives about their experiences of care at the service through a survey. The results of the most recent of these showed that the majority of people and relatives were either satisfied or extremely satisfied with all aspects of the service including food, staff and activities. 100% of survey respondents felt the service was safe and secure, that they were treated as individuals and with dignity and respect.

Resident and relative meetings took place regularly and minutes of these recorded positive feedback on most occasions. Where suggestions or comments were made, there was evidence that the provider and registered manager had taken swift and appropriate action. For example; relatives asked for more parking spaces and a further three bays were made available. Comments were made that there was a lot of wastage from the large birthday cakes made for people by the kitchen to celebrate their special day. The registered manager spoke to the cook and a small cake tin was purchased to address this concern. People and relatives were listened to and their input was valued.

Staff had regular meetings and were able to contribute to the agendas if they wished. Minutes of these meetings evidenced that staff were given the opportunity to raise concerns in an open forum. Most of the staff we spoke with said that they felt appreciated by the registered manager and that they could approach them with any concerns or suggestions to make the service better for the people living there. Staff told us that they worked well as a team and felt supported by the registered manager and deputy. One staff member described their colleagues as a "Second family".

The registered manager was well-respected by people, relatives and staff. They demonstrated during the inspection that they were quick to take action if staff performance fell below acceptable standards. Relatives told us that the registered manager had an 'Open door' policy and always made themselves available to chat or speak with people about any concerns. One person told us "She [Registered manager] is always approachable, always here, office door always open". A relative said "I quite often see the manager and she will always make time to talk even if it is only pleasantries". Another relative told us they had moved their loved one to the service from another care home and that "At the last place I felt as if I was on my own trying to make [Person's name] life more comfortable. Here the manager and staff work with me. I feel as I can go to them and vice versa".

The registered manager kept themselves informed of developments within social care by attending local forums and presentations set up by the local authority and Clinical Commissioning Group (CCG).They also attended meetings held by the provider at which good practice ideas were shared between home managers; and received input and guidance from regional support managers. There was a deputy in place who is a registered nurse; who assisted the registered manager in assessing and monitoring the clinical effectiveness of the service.

Local students of medicine, psychology or social care visited the service on a weekly basis to spend time with people. Some students shared an enjoyable time talking about maps with some people and having a cup of tea with others. One of the students told us that the experience was invaluable to them and that they hoped their time and company gave people pleasure too. They explained that the activities team helped the students to understand people's body language and said "This home is innovative in the way it encourages this level and type of interaction. Everybody benefits and that can only be a good thing".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's assessed needs were not consistently met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Known risks were not always minimised. Some aspects of healthcare were not sufficiently well-managed to ensure people's safety and well-being.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems for ensuring people were safeguarded from abuse or neglect had not always been operated effectively.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Quality assurance processes had not identified shortfalls in the safety and quality of the service.

The enforcement action we took:

We issued a warning notice to the provider.