Lorven Housing Ltd

Warren Court

Inspection report

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21 April 2017

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Warren Court is a care home registered to provide accommodation and personal care for up to 19 older people, many of whom were living with dementia. Accommodation is arranged over three floors and there is passenger lift access. At the time of our inspection there were 18 people using the service.

This inspection took place on 20 and 21 April 2017, the first day was unannounced. At the last inspection in February 2015, the service was rated Good. At this inspection we found the service remained Good overall. The service demonstrated they continued to meet the regulations although we found improvements were needed in relation to meeting people's social needs and choices. In the key question 'Is it responsive?' we have therefore rated the service 'requires improvement'.

Although there were organised social activities, these were not always arranged according to people's preferences and individual needs. We have made a recommendation about improving the activities to provide more engagement and stimulation for people, particularly those living with dementia.

People using the service and their relatives told us they felt safe and well cared for. Staff knew how to recognise and report any concerns they had about the care and welfare of people and how to protect them from abuse and harm. Where risks were identified, there was guidance on the ways to keep people safe in their home and in the local community.

Warren Court continued to be safely maintained and people had the equipment they needed to meet their assessed needs.

Staff received an induction and relevant training to support people with their care needs. This was followed by ongoing refresher training to update and develop their knowledge and skills. Staff also undertook training courses specific to people's needs such as dementia awareness. They were supported though an appraisal and supervision system to check they remained skilled in their roles.

There were positive and caring relationships between staff and people who lived in the home and this extended to relatives and other visitors. People who used the service and their guests were treated with respect and courtesy. Staff were caring, patient and maintained people's privacy and dignity.

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

People received care and support which was based on individual assessments of their care needs and took into account each person's ability, need and preferences. People's wishes, choices and beliefs were reflected in their care plans. There was information about people's social links and relationships with family and friends. Staff were responsive when people's support needs or circumstances changed and care records were updated appropriately.

People were encouraged and supported to eat and drink well. When people were at risk of poor nutrition or dehydration, staff involved other professionals such as the GP or dietician.

Medicines were managed safely and people received their medicines as prescribed. The service worked closely with external professionals to promote people's health and wellbeing and meet their needs. Appropriate referrals were made when people became unwell or required additional services.

People and their relatives felt involved in the way the home was run and were encouraged to express their views and opinions. They knew how to complain and make suggestions, and were confident their views would be acted upon.

The registered manager continued to provide effective leadership and staff felt supported. The provider had systems in place that continued to be effective in assessing and monitoring the quality of the service. Where improvements were needed or lessons learnt, action was taken.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service remains Good.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Improvements were needed in relation to meeting people's social needs and choices. Although activities and entertainment were available, these were organised in a task led way and not meaningful for people living with dementia.

People's needs were assessed before they came to live at the service and their needs were monitored and reviewed accordingly. Staff responded promptly when there were changes to people's health or wellbeing.

People received individualised care that was tailored to their needs and preferences. Care records were person centred and described people's needs and risks and how to manage these.

Arrangements were in place for dealing with complaints and responding to people's comments and feedback.

Is the service well-led?

Good

The service remains Good.

Warren Court

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.

Before the 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. Due to technical problems a PIR was not available and we took this into account when we inspected the service and made the judgements in this report. Prior to our visit we also reviewed the information we held about the service. This included inspection history, any safeguarding or complaints and any notifications that the provider had sent to CQC. Notifications are information about important events which the service is required to tell us about by law.

This inspection took place on 20 and 21 April 2017 and the first day was unannounced. The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with seven people using the service, two relatives, the registered manager, the operations manager and four members of staff.

We reviewed care records for five people who used the service. We checked three staff files and the records kept for staff allocation, training and supervision. We looked around the premises and at records for the management of the service including quality assurance audits and health and safety records. We also checked how medicines were managed and the records relating to this.

Following our inspection the operations manager provided us with information we had requested about managing complaints and quality assurance findings.

Good

Is the service safe?

Our findings

People told us they felt safe living at Warren Court and that staff were kind and treated them well. One person said, "Yes extremely" when asked if they felt safe. They also spoke about staff as, "Good people they have all the time in the world for me." Another person told us, "I'm warm, comfortable and well fed." Relatives we spoke with were confident that staff kept their family members safe.

People were protected from the risk of abuse and avoidable harm. Staff understood what to do if they suspected anyone was at risk of harm or abuse. They had attended safeguarding training and updated this every year. Staff confirmed they would have no hesitation in reporting any concerns to the registered manager or provider and were confident that action would be taken to protect people. Contact numbers were displayed in the home that staff, people who used the service or visitors could use to report any concerns regarding abuse.

Risks to people's health and welfare were identified and managed appropriately. Risk assessments had been put in place in response to people's care needs related to falls, nutrition and moving and transferring people. These explained the level of risk to the person and what action staff should take. To reduce the risk of falls, actions included making sure people had their walking aids, checking the environment was clear of obstacles and that the person was wearing suitable footwear. People had other risk plans specific to their needs. For example, where people were at risk of social isolation, developing pressure sores or leaving the premises unaccompanied. Staff showed knowledge of the risks people faced and how to minimise these. On one occasion however, we observed a member of staff used an unsafe hold whilst assisting a person to walk to the toilet. A second member of staff immediately intervened, using the correct technique to support the person. We brought this to the attention of the registered manager who told us that they would arrange for the staff member to be retrained. At other times we saw that people were supported to move and transfer safely.

People and relatives felt there were enough staff and they did not have to wait for attention. Our observations supported what they told us. Staff responded promptly to people's call bells and staff regularly visited people who chose to stay in their rooms. Staffing allocation included a minimum of three throughout the day with three waking night staff. Separate domestic staff were employed with one member of staff assigned to organise activities for people. When we inspected, care staff were responsible for cooking as well as supporting people with their care needs. Management told us this was a temporary arrangement and recruitment was underway for a new chef. We found that staffing levels were safe although we saw instances where staff were not present in the lounge during the activity sessions.

The premises were maintained and checked to help ensure the safety of people, staff and visitors. Appointed contractors completed regular checks and servicing of fire, gas and electrical safety and equipment was checked that it was safe for people to use. Records were up to date and staff completed health and safety checks which included a walk around the building to monitor for any hazards. A handyman was employed to undertake essential repairs and maintenance where necessary.

There were arrangements in place to deal with unforeseen events. Staff told us they were able to contact the manager or provider on call if there was an emergency out of hours. There were procedures for incidents such as utility failures or fire. People had up to date personal emergency evacuation plans (PEEPs). These outlined the support people required should they need to leave the building in the event of a fire or other emergency.

People told us they received their medicines when they needed them. Staff we spoke with were clear about their roles and responsibilities in relation to medicines and had completed medicines administration training. A senior staff member confirmed the registered manager assessed their competency and practice every year to ensure that they continued to manage medicines safely. We observed a member of staff demonstrate safe practice whilst administering medicines during lunch.

People's medicines administration records (MARs) included details of prescribed medicines and instructions for their administration. Some people were taking specialised medicines and guidance was available to staff to ensure these medicines were administered correctly. Where people needed medicines 'as required' or only at certain times there were guidelines about the circumstances and frequency they should be given. People's prescribed medicines were reviewed by relevant healthcare professionals as necessary. Medicines we checked for people corresponded with their MARs. The records were up to date and there were no gaps in the signatures for administration.

Medicines were managed, stored and disposed of safely. All medicines, including controlled drugs, were stored securely in a locked trolley and a designated room. Relevant temperatures were monitored and recorded daily to make sure that medicines were stored at the correct temperature. The home used a monitored dosage system with medicines supplied by a local pharmacist. The supplying pharmacist had also completed a full medicines audit and we saw their few recommendations had been addressed. Staff completed monthly audits to make sure medicines had been given and recorded correctly.

Good

Is the service effective?

Our findings

People felt confident staff understood their care and support needs. One person told us, "Yes they are trained." Since our last inspection staff had undertaken essential training to keep their knowledge and skills refreshed. Training courses included first aid, fire safety, food hygiene, health and safety, infection control, moving and handling and medicine administration. The registered manager used an electronic training record to monitor the training staff received and check they were up to date. New staff completed an induction which involved shadowing another member of staff. The provider used the Care Certificate which is a nationally recognised framework for good practice in the induction of staff.

Staff confirmed the training offered was relevant to their role and regularly updated. Since our last inspection, the home had accessed local authority training to keep up-to-date with best practice. This had included training in dementia awareness, managing behaviour and infection control. The operations manager told us there were plans for staff to attend further training on nutrition and pressure ulcer prevention over the next few months.

Staff told us they felt well supported by the registered manager and could report any concerns. Staff received supervision every two months and an end of year review to discuss their performance and practice. Records of these meetings included discussions about people's care and support as well as individual learning or development needs.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff understood the need to obtain consent and people's right to refuse. We saw and heard staff explain what they were going to do before providing support. People's feedback also confirmed this. One person told us, "Oh yes, they work together with me."

Where people lacked capacity to make decisions, staff were aware of how to support these people in line with the law. Families and professionals were consulted about people's care so decisions could be made in the person's best interests. The manager had assessed where a person may be deprived of their liberty and submitted applications as necessary to the supervisory body (local authority). For example, the front door was locked and could only be opened by a keypad entry system operated by staff. Appropriate DoLS authorisations were in place for some people as they were under continuous supervision and it was unsafe for them to access the community unaccompanied. Staff were aware of people who were subject to DoLS and the reasons for any restrictions in place.

Care plans included details about people's nutritional needs as well as their favourite foods and specific diets. Records showed that other professionals were involved in people's care if this met an assessed need.

This included visits from speech and language therapy or dietetic services where risks about choking or malnutrition had been identified. When people were at risk of weight loss or gain, charts were used to monitor their food and fluid intake.

People who were able to comment were complimentary about the meals. One person said, "If you don't like it, they will cook something else." A visiting relative told us the food quality was good and there was variety. We joined people for lunch and found that further work could take place to enhance the mealtime experience and promote choice. Staff provided appropriate support when required to help people eat and drink. However, we saw staff served people their meals already plated with no choice given as to the food or quantities being provided. When staff placed the food in front of people they did not always give people information about what they were eating. Some people asked what it was and one person commented they didn't like chicken. A member of staff responded, "I think you do" and the person started eating the potatoes.

Eight people were seated in the lounge and provided with portable tables to eat their lunch. We saw that some people struggled to reach their plates and may have benefitted from sitting at a larger dining table. Pictures on the daily menu board did not reflect what people were eating. We discussed whether the menu could be made more accessible to people living with dementia. For example, providing pictorial menus for the tables so people could see the menu options available to them on a daily basis and showing people plated meal options. The registered manager agreed to review this.

People were supported with their healthcare needs and able to access relevant services for routine checks, advice and treatment when needed. Other professionals were involved in people's care if this met an identified need. Care records reflected individuals' needs and records of all health care appointments were maintained. Where people had specific health conditions such as diabetes, there was information available alongside the care plan which explained more about the condition and how to support someone with it.

Good

Is the service caring?

Our findings

People spoke positively about the care they experienced at Warren Court. One person told us, "All very kind, always listen to what you have to say." Another person spoke about staff telling us, "Yes, all brilliant" and "they treat people individually." Another person said, "Staff are always watching looking and watching, they make sure everyone is fine." Relatives shared similar views about the caring nature of the staff. One relative commented, "Yes the ones who have been here a long time. (Named carer) has a lovely way about her, most of them (staff) understand and I get on with them."

Interactions between staff and people were positive and caring. Throughout our visit staff supported people with kindness and compassion. They showed patience and understanding and staff used touch and facial expression to interact with those who found it difficult to communicate their needs verbally. Staff were attentive when people became disorientated in their surroundings or needed reassurance about their routines.

People told us that staff supported their privacy, dignity and independence. People received personal care in the privacy of their bedroom or bathroom with doors closed. We heard one staff member say, "I'm going to close the door but I'll be here if you need me", when supporting a person to use the toilet. We observed that staff always knocked on people's bedroom doors and waited to be invited in. During meals, people were provided with appropriate protective clothing when eating and drinking.

When people first moved to the service, they were asked about preferred daily routines and what level of assistance they required. We saw information about personal preferences, likes and dislikes, what helped them relax, kept them happy and things that were important to them. People and their relatives were involved in regular discussions about their care and had been asked to contribute to their care records. Care plans included background information about people's lives prior to living at the service. Relatives told us they were asked about their family members' personal histories and interests. Staff showed knowledge about the people they supported and their comments corresponded with what we saw in the care plans.

People were encouraged to maintain links with people who were important to them. People and visitors we spoke with confirmed that they were always made to feel welcome. Relatives confirmed that staff kept them up to date with the health and welfare of their family member.

People were involved in the advanced planning of their own care and these discussions and agreements were recorded. Some staff had undertaken training which gave them the skills and knowledge to provide compassionate care for people nearing the end of their lives. This was facilitated by the local hospice team, who also provided advice and support to the home about end of life care. Information about people's advanced care decisions was included in their care plans. This recorded if they wished to stay in the home or be transferred to hospital and meant that staff and their GPs were aware of how the person wanted to be supported at the end of their life.

Requires Improvement

Is the service responsive?

Our findings

People were provided with activities and entertainment although we found these were not always meaningful and stimulating for people living with dementia. In addition, we found that people were not given a choice of activities.

During a morning art and craft session held for nine people in the conservatory, the staff member left the room several times to find colouring pens and other equipment. This resulted in people losing focus on the activity. We observed two people got up to leave the session and the staff member brought them back telling them to sit down with one person being asked to sit back in their chair three times. This showed people were not provided with a choice and alternative activities were not offered when people did not want to participate. For example, people were asked to colour in their pictures and one person responded by saying, "No, you fix it how you want." Another person was given a picture of a crown to colour and replied, "I've already done that one."

People living with dementia may experience past memories relating to parenthood and we were not assured that staff always recognised this. We saw one person holding a toy teddy bear which they referred to as their "baby." A staff member asked, "What are you doing with that teddy?" and the person replied, "It's my baby, not a teddy." The staff member also told us they had not completed any specific training on activities for people living with dementia.

In the afternoon, the staff member gave out shells and stones and told people they were going to paint them. They then left the room to get paints and sponge rollers while people sat in their chairs looking at the stones, unsure what to do.

The activities programme was displayed behind an indoor dartboard and not accessible to people. We saw there were few pictures, furnishings or other items to provide stimulation and interest for people living with dementia. For example, reminiscence equipment such as memory boxes for people to investigate or dolls and soft furnishings for them to touch and hold.

The approach to activities demonstrated a lack of training and understanding, and resources to enable the service to tailor activities to meet the needs of people living with dementia.

We recommend that the service refers to current best practice guidance around activities for people living with dementia.

People's care and support needs were assessed before they came to live at the home to determine if the service could meet their needs and expectations. The assessment considered all aspects of the person's life, including their background, preferences, past medical history, health and personal care needs and areas of independence. It considered specific care areas such as those associated with nutrition, skin care and mobility. Relatives had also been consulted about their family member's preferences and personal history.

People's files held relevant information about their care and support needs to guide staff. The information included support plans and risk assessments for all aspects of their daily living needs including health, social and emotional well-being. Care plans were individual and provided staff with accurate information about how people liked their care to be given. Plans reflected how specific health conditions might impact upon a person's care and how living with dementia affected people's daily lives. For example, how a person living with dementia communicated and how staff should respond when a person became upset or disorientated. Short term care plans were written when people developed an acute illness such as a chest infection.

People's religious, cultural and diverse needs were recognised and recorded in the care plans. Staff knew how to respond to individual needs and gave examples of meeting these such as providing preferred cultural meals and respecting people's faith or beliefs. One member of staff described how they supported a person with visual impairment to eat again after they started refusing their meals. The staff member explained that the person showed a preference for sweet foods and provided them with a plate of biscuits so they could use touch to identify and eat independently. This had a positive impact and the person regained their appetite.

Records showed people's needs and abilities were reviewed every month and their care plans were updated when their needs changed, for example after a return from hospital. We saw that people's placements and care plans were reviewed regularly. Staff made appropriate referrals on behalf of people who used the service when needed. For example, the service sought the support of healthcare professionals such as the district nurses, falls intervention or community mental health team.

Staff completed daily records for people and shared information at each shift change to keep up to date with any changes concerning their care and support. Where needed, monitoring sheets for behaviour/mood, food intake and positional changes were maintained for people. We observed staff checked on people who were in their own rooms at regular intervals to see if they were comfortable or needed anything.

People and relatives were regularly asked for their views on the quality of the service being provided. After moving to Warren Court, people were offered a satisfaction questionnaire to comment on their initial experiences. Meetings were held monthly to discuss food, activities and to ask how people were feeling. Records did not always show where the provider had acted on people's suggestions or made improvements. The registered manager agreed to follow this up and record outcomes at future meetings.

Aside from one person, people and relatives we spoke with knew how and who to complain to should they need to. One person told us, "Yes, would write it down or verbally tell the people." There was a complaints procedure displayed although this did not include accurate information about who to refer complaints to. We discussed this with management who agreed to update the procedure with details of the local authority ombudsman. Management told us there had been no complaints raised with them about the service. Since our last inspection a person using the service had contacted CQC in September 2016 to raise some concerns about their care. At our request, the registered manager investigated the complaint and provided us with written evidence to show how the issues were resolved.

Good

Is the service well-led?

Our findings

There was a registered manager at Warren Court. 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.

Since our last inspection, the registered manager had taken on responsibility for managing a second location owned by the provider. He told us he divided his time accordingly between the two services and staff had support from the operations manager in his absence. We noted that the staff rotas did not accurately reflect when the registered manager was working and recorded that the operations manager was 'in' for seven days a week. The operations manager acknowledged that this was not always the case and agreed to amend the rotas. This was addressed during our inspection.

People and their relatives felt the management and staff were friendly and approachable. They gave positive feedback about how the home was run. One person said, "This is the most comfortable I've ever been" and another person commented, "Very good, brilliant" and "they listen to everything." A relative told us they could speak with the registered manager whenever they needed to and that the owner often visited the home.

Interactions between people, their relatives and visitors, the staff and management were friendly and welcoming. We observed that the staff worked as a team to provide people with effective care. The staff team knew people well and told us they felt supported by the registered manager and provider.

Open communication was encouraged with everyone that used the service. We reviewed the most recent feedback surveys sent to people using the service and their relatives in March 2017. Responses were all complimentary about the home and the care and support people received. One person had said, "Care very good, they are very helpful and care about us." Comments from relatives included, "Staff have always dealt with problems calmly and show a good understanding of (my relative's) needs" and "I am contacted by phone regarding any changes in care."

Daily handovers took place so that staff were kept up to date with any changes to people's care and welfare. Staff meetings were held every month and included discussions around the care provided, training and any matters that affected the service, including issues staff wanted to raise. All meetings were recorded and any action agreed to be taken was monitored until completion. At a recent meeting the manager and staff had discussed responsibilities and duties for improving laundry care. Memos and guidelines about people's care needs or staffing matters were available to staff on the office notice board. Staff told us this was useful for keeping them informed of any important changes to people's care and support.

There were a range of audits and checks to monitor the quality of the service. These included checks on aspects of care such as medicines, care plans, staff training and supervision, health and safety and the presentation of the environment. This enabled the manager to evaluate what was working well and what

needed improving in the home. When improvements were needed, action plans were developed. For example, there was an ongoing plan of redecoration and plans to re-lawn the rear garden and install CCTV in the external grounds.

Registered persons are required by law to notify CQC of certain changes, events or incidents that affect a person's care and welfare. For example, when a death or injury to a person occurred. Before our inspection we checked the records we held about the service. We found the registered manager had notified us appropriately of any reportable events and provided additional information promptly when requested.