Lunan House Limited

Warmley House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 20 and 21 December 2017 and was unannounced. The last Care Quality Commission (CQC) comprehensive inspection of the service was carried out in December 2016.

Warmley House Care Home is registered to provide accommodation and nursing or personal care for up to 56 older people, including people living with dementia. There were 49 people when we inspected the service.

The home is divided into three separate units. The three units are known as the Coach House, the Nursing Unit and Sunflower. The Coach House provides mainly residential care for people who do not require on-going nursing input. The communal living area of this unit is on the ground floor with some bedrooms at ground floor level and others on the first floor. Sunflower is home to people living with dementia and is on the top floor of the home. The Nursing Unit is spread over two floors.

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. After having been the acting manager in the home since 22 November 2016, the manager registered with CQC on 1 November 2017.

As a result of our last inspection we rated the service overall as requires improvement.

At this inspection we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and have again rated the service as requires improvement.

There was not always sufficient staff working to keep people safe and meet their needs. The management of medicines was not consistently safe. Individual risks to people had not always been adequately assessed with plans then put in place to keep them safe.

People were not always given choices about what they wanted to eat. Food and fluid charts were not completed thoroughly in order to ensure people received enough to eat and drink. Mealtimes did not always provide a comfortable and dignified experience for people.

People did not always receive a service that was in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Their capacity to make specific decisions had not consistently been assessed and, the provider did not have a system in place to ensure any deprivation of liberty was identified and, the correct authorisations sought.

Care plans were not person centred and did not always provide enough detail for staff on how to meet people's needs. As a result people were at risk of their needs not being met.

Parts of the home were being redecorated when we visited. However one corridor had an offensive smell of urine which the service was planning to sort out early next year. Staff understood how to keep the risk of cross infection to a minimum. However we found several bed rail bumpers in use which were unhygienic, unsightly and disrespectful to the people who were using them.

Quality audits carried out by the registered manager and other senior staff employed by the provider had not been effective in identifying shortfalls in the safety and quality of service provided to people. This was the third consecutive inspection resulting in an overall rating of 'requires improvement'.

Staff had been trained in safeguarding adults at risk. They understood their duty to observe and report any concerns they had about people if they thought they were at risk of abuse. Following concerns previously raised, there had been a safeguarding plan by the local authority in place. The provider had worked with the local safeguarding team to address issues and ensure people were protected.

Staff received a range of training to equip them to meet people's needs; they also received regular supervision from senior members of staff. The provider had effective recruitment procedures to check the suitability and fitness of any staff employed to work at the service.

The provider continued to maintain a servicing programme of the premises and equipment used by staff to ensure those areas of the service covered by these checks would not pose unnecessary risks to people.

The provider demonstrated they could be responsive in making some improvements when needed. During our inspection they made improvements that immediately reduced some of the risks we found to people's safety and wellbeing.

People were supported by caring staff. People and visitors said the staff were caring. People were offered a range of group and individual activities. Staff planned these interests taking into account people's likes, dislikes, hobbies and interests.

The provider sought people's views about the quality of the service and took action to make improvements when these were suggested. However not all visitors or relatives knew how to give feedback to the service. People who used the service and their representatives attended meetings and were asked for their views about the care and service and updated with information about the service.

The registered manager ensured the CQC were informed of significant events in a timely way by submitting the required notifications.

At this inspection we found and have reported on breaches of five of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These are reported on in detail in the full version of our report.

Full information about CQC's regulatory response to any concerns found during inspection is added to reports after any representatives 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?

Requires Improvement

The service was not always safe.

At times there were not enough staff to keep people safe.

Although people received their medicines as prescribed poor working practices increased risks of errors being made.

Risks posed to people were not appropriately assessed and managed.

Staff knew what action to take if they suspected a person was at risk of abuse.

Checks were made on staff when they started work to ensure they were suitable to work with people using the service.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always given choices about what they wanted to eat and drink and aspects of the mealtime experience still need to be improved.

Food and fluid charts were not completed thoroughly in order to ensure people received enough to eat and drink.

People did not always receive a service that was in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Their capacity to make specific decisions had not consistently been assessed and, the provider did not have a system in place to ensure any deprivation of liberty was identified and, the correct authorisation sought.

There was a staff training and supervision programme in place.

People were supported to access ongoing healthcare from relevant professionals.

Is the service caring?

Good

The service was caring.

People and their relatives said they were supported by staff that were kind and caring.

We observed positive interactions taking place and people were supported to make their own choices.

On occasions we saw staff did not protect people's confidentiality when speaking to others about their needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not person centred and did not always provide enough detail for staff on how to meet people's needs.

People were offered a range of group and individual activities. Staff planned these interests taking into account people's likes, dislikes, hobbies and interests.

Systems were in place to enable people to make a complaint.

Is the service well-led?

Requires Improvement

The home was not always well led.

The provider's quality assurance systems had not identified the shortfalls in the safety and quality of care that we found.

This was the third consecutive inspection resulting in an overall rating of 'requires improvement'.

Warmley House 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.

The inspection was unannounced (meaning the provider, manager and staff did not know we would be coming) and was carried out by a team of four people. The team consisted of two adult social care inspectors, a specialist advisor with knowledge of nursing care for older people including those living with dementia 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.

The last full inspection of the service was on 20 and 21 December 2016. At that time we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to; staffing levels, nutrition and hydration. We rated the service as 'requires improvement' overall. The provider sent us an action plan telling us what action they would take to make the necessary improvements.

Prior to this inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We reviewed the Provider Information Record (PIR). This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make.

Due to the number of individual safeguarding concerns regarding this service, they were being monitored under a process of 'organisational safeguarding'. This is a process initiated by the local authority as a result of the number and/or severity of concerns raised with them. CQC had attended the multi-agency meetings prior to this inspection. This meant CQC had been closely involved and communicated with a number of health and social care professionals, social workers and commissioners regarding the service.

We spoke with 15 people using the service. Not every person was able to express their views verbally. Therefore we carried out two Short Observational Framework for Inspection sessions. This framework is a

specific way of observing care to help us understand the experience of people who could not tell us about their life in the home. We also spoke with relatives of 15 people using the service.

We spoke with 12 staff, including the registered manager, regional manager, qualified nursing staff, a senior care worker, activities organisers, care staff and catering staff.

We looked at the care records of nine people living at the service, four staff personnel files, training records for all staff, staff duty rotas and other records relating to the management of the service. We looked at a range of policies and procedures or discussed the principles of safeguarding, whistleblowing, complaints, mental capacity and deprivation of liberty, recruitment, accidents and incidents and equality and diversity.

Requires Improvement

Is the service safe?

Our findings

At our inspection in December 2016 we found the provider had not ensured there were sufficient numbers of staff to meet people's needs.

We noted the provider had taken the action identified in the action plan they sent us and, as a result some improvement was seen at this inspection. However, we found there was still insufficient staffing to ensure people's safety. This was particularly noticeable on the Coach House and Sunflower units, we could also not be assured there was sufficient staffing on the Nursing unit.

On the coach house and sunflower unit's staff said they did not feel there was enough staff on duty to care for people safely and meet their needs. Comments included; "No there's not always enough staff. We should have two carers on each of the Coach House and Sunflower with one senior between the two. We regularly only have three carers and a senior", "We sometimes work with less staff than we need. There has sometimes been just two carers and one senior in the afternoons", "It is hard when there is less than four carers", "There is definitely not enough staff. I have been on when there's been just two staff and a senior for the two floors. We don't have time to sit and talk" and, "There was one time when I had to ask (Person's name) daughter to help. I don't think it's always safe".

Relatives visiting the Coach House and Sunflower units, also said they felt there was not always enough staff. One relative told us "Usually there are enough staff around, however two weeks ago there was only two…….not enough". Another relative told us, "My relative needs two staff to hoist them, a few weeks ago there were not enough staff around so they had to wait until someone came from another area to help". Two relatives told us, "The thing that bothers us most of all, is that there is not enough staff. Sometimes there are staff left on the rota, so it looks like there are enough staff in, but they are not in". Another relative told us "There seems to be a lot of staff around today, it's not always like this, my relative is safe and sound today". People using the service were generally more positive regarding staffing levels. One said; "There are sufficient people around all of the time" and, another person when asked if they felt there was enough staff replied, "Yes".

We checked the records of staffing levels on the Coach House and Sunflower units over the three weeks immediately leading up to our inspection. We saw four occasions where a total of three care staff and a senior were present and two occasions on 10 and 16 December 2017 where only two carers and a senior were available to provide care. We understood the staff dependency tool used by the provider had identified that four care staff and a senior care worker were required over these two units to ensure people were kept safe and their needs met. These staffing levels were not being maintained.

On the Nursing unit staff said they did not feel there was enough staff on duty to meet people's needs. Comments included, "Most of the time we're short staffed" and, "Someone usually goes off sick. The manager will try and get agency staff or we just pull together. I don't think people always have their needs met at the time they want, due to the staffing levels. For example, people sometimes have to wait for the toilet".

We checked the records of staffing levels on the Nursing unit over the three weeks immediately leading up to our inspection. We saw two occasions, the 6 December and 16 December 2017 where only four care staff and two nurses had been available to provide care to people. On the Nursing unit we understood the staff dependency tool used by the provider had identified that seven care staff and two registered nurses were required to ensure people were kept safe and their needs met. These staffing levels were not being maintained.

This meant the provider had not ensured there was always sufficient staff to keep people safe and meet their needs.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

At our inspection in December 2016 we found the provider had taken action to improve the management of medicines and, that people were receiving medicines safely. We noted at the time that those improvements needed to be sustained to ensure people were kept safe from the risks involved in the administration and management of medicines. We stressed this because the management of medicines had been an area of concern at our inspection in May 2016.

At this inspection we found people were at risk as a result of unsafe management of medicines.

Medicines were not always managed safely. We looked at the medicine administration records (MARs) for all of the people using the service and found 39 gaps across both units where staff had not signed to indicate they had given the prescribed medicines. There was nothing documented on the MARs to indicate that staff had either identified the missing signatures or that they had investigated to confirm that the medicines had been given.

Topical medicine administration records were also inconsistently completed by staff. For example, one person had been prescribed a barrier cream to be used as necessary due to incontinence and having been assessed as a high risk of developing pressure ulcers. The topical record had been signed three times during December. This meant there was a risk that people did not always receive their medicines, or their creams and lotions as prescribed.

Some people had been prescribed 'as required' medicines. Although there were protocols in place, these were not person centred and did not provide enough information for staff administering the medicine. For example, some people had been prescribed medicines for periods of agitation, but the protocol guidance was limited to 'for severe agitation'. Despite the template protocol stating that staff should document 'as much detail as possible', this was not seen. There was no guidance for staff on the signs people might display when agitated or what other steps should be taken to reduce the agitation before resorting to the use of medicines. Pain relief protocol guidance was limited to 'for pain' rather than specifying where individual people might experience pain.

Medicines were generally stored safely, including controlled medicines. However, oral medicine bottles had not always been dated when opened. This meant there was a risk that staff would not know when medicines had expired. Creams and lotions had also not been dated when opened which meant that staff would not know when they were no longer safe to use. For example, a tub of cream for one person had been opened but because staff had not labelled the tub with the date when it was opened, there was a risk they would not know when to discard it.

The provider had not ensured the proper and safe use of medicines.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

MAR charts had photographs in place which were dated to confirm they were a true likeness of people. Having photographs in place helps staff that may not be familiar with people identify them. People's allergies had been recorded.

We looked at the latest Pharmacist Advice visit dated 12 December 2017. The majority of the issues we noted had also been identified during the visit. The registered manager said they were working closely with the pharmacist in order to improve medicines management.

Risks to people were not always managed in a safe way. All of the care plans we looked at contained risk assessments for areas such as falls, moving and handling, skin integrity and choking. All of the risk assessments had been regularly reviewed. However, when risks had been identified, the care plans did not always provide enough guidance for staff on how to reduce the risks and the plans did not always contain the most up to date support that was being provided.

From observations we also saw that the limited guidance within the plans was not always followed. For example, one person had been assessed as a high risk of falls and had fallen in the past. The care plan guided staff to ensure the person had their mobility aid with them and that one member of staff should assist 'for safety'. However, we saw this person walking around unsupervised. For another person the plan stated 'Two staff to assist when mobile' and 'Keep Zimmer close', yet we observed the person walking unsupervised without their mobility aid. One member of staff said the person had a sensor mat in place, which was not written within the plan. Another member of staff said the sensor mat was not being used because the person kept unplugging it and that a passive infra-red sensor (PIR) was being used instead. Neither the PIR nor the sensor mat were documented in the plan. We saw that the person's bedroom door was frequently closed during the inspection. It was therefore unclear how the staff were ensuring the person was kept safe. A person living on 'sunflower' needed support to manage some inappropriate behaviour. Some staff shared with us their nervousness regarding this and openly admitted they were not confident in responding to this. This meant the person was at risk of receiving inconsistent support.

The above evidence meant that the provider had not taken sufficient action to ensure risks to people using the service were being managed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

At our inspection in December 2016 we found the provider had taken the action detailed in their action plan sent us to improve the prevention and control of infection. We noted at that time that those improvements needed to be sustained to ensure people were kept safe.

Staff had access to personal protective equipment such as gloves and aprons. We saw these were readily available and observed that staff using them appropriately. The Nursing unit was generally clean; however, several of the bed rail bumpers in place were worn and the plastic covering had come off in places. This meant it would not be possible to keep them clean and free of infection.

The home was clean and tidy but there were some unpleasant odours. There was a strong smell of stale

urine in one area of the home which we were told was due to a person having a 'urine infection'. However more consideration needed to be given to this issue as the odour affected a significant part of a corridor leading into other people's bedrooms. We were informed the care home was undergoing refurbishment and new flooring has been ordered for January 2018.

Some people required assistance with moving and handling. This involved using hoists and specific slings. An assessment of the person meant they were provided with their own individual sling and were moved safely and comfortably. This also limited the possibility of the spread of infection. At this inspection we saw each person who required the use of a sling had one identified for their own use. Staff knew the importance of ensuring people did not share slings. They told us people always used their own sling and these were laundered separately.

We saw the 'sluice rooms' had hand washing facilities. This meant staff were able to wash the bed pans (commode pots) and then immediately wash their hands before leaving the room. Staff told us they had access to the personal protective equipment (PPE) they needed. We saw staff wearing disposable gloves and aprons when required.

Despite the concerns we identified people told us they felt safe, one person when asked if they felt safe said, "Yes definitely" another said, "I am well looked after, when I get up at night the carers come to me". A relative said, "Yes they are safe generally" and went on to say that, "Sometimes there does not seem to be enough staff around...I worry then".

Following concerns previously raised, there had been a safeguarding plan by the local authority in place. The provider had worked with the local safeguarding team to address issues and ensure people were protected. At the time of the inspection there were no outstanding safeguarding concerns. We viewed the service's safeguarding policy and safeguarding referrals had been appropriately raised by the registered manager and staff in the 12 months since our last visit.

The registered manager explained that staff were encouraged to report any issues to the safeguarding team so they could decide if a referral required further investigation. Staff knew about the different types of abuse to look for and what action to take when abuse was suspected. They were able to describe the action they would take if they thought people were at risk of abuse, or being abused. They told us they would report any concerns they had about a person's safety or welfare to the registered manager or 'on call manager'. They knew they could report directly to the local authority, the Care Quality Commission (CQC) or the Police. Staff completed safeguarding training as part of their induction and on-going training programme. Staff knew about 'whistle blowing' to alert management to poor practice. One nurse told us "I've raised concerns before and it was dealt with".

People were protected from the risk of unsuitable staff being employed because relevant checks were carried out before staff started work. These checks included a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check an applicant's police record for any convictions that may prevent them from working with vulnerable people. The provider also carried out checks to ensure qualified nursing staff were registered to practice with the Nursing and Midwifery Council. References were obtained from previous employers. Recruitment procedures were understood and followed by the registered manager.

The home was well maintained throughout with evidence of on-going work. Regular health and safety checks took place. These included environmental and fire checks, regular servicing for gas and electrical installations and lift and hoist servicing. We noted the checks of all the fire doors were not being done weekly and the provider acknowledged this and said they would increase the frequency of these checks.

Plans had been put in place to keep people safe in the event of emergencies. Personal emergency evacuation plans (PEEPS) had been prepared for each person. These set out the level of support the person would need if the building needed to be evacuated. A schedule of regular checks of the safety of the environment and equipment was in place and these were carried out. An annual fire risk assessment had been completed.

The registered manager demonstrated that service improvements which were made when things went wrong. For example as soon as we pointed out the worn and unhygienic bed rail bumpers action was taken to renew them. We were also told of the changes made following the two breaches of the regulations identified at our last inspection.

Requires Improvement

Is the service effective?

Our findings

At our inspection in December 2016 we found the provider had not ensured that people received food of their choosing at an appropriate temperature. We also reported that records to monitor nutrition and hydration were not consistently kept or effectively reviewed.

At this inspection we noted people were still not being offered meaningful choices at mealtimes and nutrition and hydration records were not being properly filled in.

People were assessed for the risk of malnutrition and choking. People's weights were monitored. When further specialist advice was needed this was sought. Records showed that people had been reviewed by the GP for weight loss and the speech and language therapist (SALT) for swallowing difficulties. However, care plans did not always reflect the guidance. For example, one person had been reviewed by the SALT team the week before our inspection, but their recommendations had not been incorporated into the care plan.

Some people were having their food and fluid intake monitored. Charts that we looked at had not always been completed in full, sometimes for whole days, fluid intake targets were not clear, and the charts had not been totalled at the end of each day. It was therefore difficult to see how staff would be able to accurately monitor people's intake. It was unclear how concerns relating to food or fluid intake would be escalated because the records were of inconsistent quality.

We saw that some people had access to drinks but not all. One person did not have a bedside table and their drink was out of their reach at the other side of the room. Staff had documented in the person's care plan on 3 November 2017, 'drinks from a beaker. Make sure fluids in front of her and on the table as she is able to reach'. The fluid chart for this person showed that for the last two days the person had drunk less than one litre of fluid each day. We heard another person sat at the dinner table with no drink in front of him, asking a staff member, "Can I have a drink of water like her". On one occasion staff asked, "Have you finished your drink?" and, before the person could answer, their drink was taken away. One nurse said, "I'm not sure that people always get enough to drink. At handover I always ask care staff to offer regular drinks to people".

We observed a lunchtime session on the Nursing unit. Staff did not ask if people wanted one or both of the vegetables on offer and people were not asked if they wanted gravy; it was poured onto their food by the staff serving the lunch. Several people ate in the dining room and where needed there were staff to assist them. In this area mealtime support was done in a positive way; for example, we observed one member of staff assisting one person. They engaged them in conversation, asked if the food was nice and reassured them to take their time chewing the food. Unfortunately, we also observed the same member of staff then call across the dining room to another member of staff, "Do you want to feed (person's name) while I carry on feeding (person's name)". This showed a lack of respect for the people involved. At another mealtime, we observed staff standing over people whilst assisting them to eat their food, but there was very little conversation from three of the staff we observed.

On our second day we requested the chef to show us the choice of meals offered to people at lunchtime. We were shown meat pie, two types of boiled vegetables and boiled potatoes. We were told vegetarians would get a salad and alternatives for people who did not want the main course were sausages and mash, cheese on toast or burgers. We did not see these snacks a meaningful or nutritional alternative to the one main meal. One person was not eating their main meal, even with encouragement from staff they still refused, so they were offered cheese on toast. One person told us, "The food is good" but added, "A greater choice would be nice and improve matters." Another person said, "The food is ok". Another person told us, "If you don't like the food on offer they will try and get you an alternative" but laughing added, "What happens if you don't like the alternative"? Another person told us, "The food looks really good here" adding, "Plenty of it."

We observed a person sitting at a dining table eating what appeared to be porridge, after a period of time the porridge was removed by staff and replaced with scrambled egg and toast. The egg and toast had already been left on the table for a while so it was clearly cold. We brought this to the attention of a member of staff who apologised to the person and then went to the kitchen to obtain a hot meal and a fresh cup of tea.

Whilst in the lounge we saw a member of the care team offering tea to people, the staff member was called away after they had given out tea to two people. Another member of the team came in to the lounge assumed the tea round had finished and began removing the tea trolley. We intervened and informed the staff member that some of the people had yet to be given a drink.

These identified issues are continued breaches of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

The Mental Capacity Act 2005 (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). 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.

We found that consent to care was not always sought in line with legislation and guidance. Although mental capacity assessments had been completed for some aspects of people's care, they had not been completed for all. For example, we saw that people's capacity to consent to living at the service had been completed, but that people's capacity to consent to the use of bed rails or PIRs had not. Additionally, when some people had been assessed as having capacity to consent, their consent had not always been sought. For example, one person had bed rails in place and the consent form had been signed by their next of kin; yet staff had documented the person was, 'able to make all decisions related to his care'. It was unclear why the person's next of kin had been asked for consent rather than the person themselves.

We looked at two care plans for people with DOLs in place. One of these no longer reflected the restrictions the person had in place because the authorisation did not detail the use of a PIR or a gate. The other person's DOLs had expired on 10 November 2017 and there was nothing in place to show it had been

reapplied for.

This meant the provider had not ensured that people were consenting to care in accordance with legislation and guidance.
We raised the issue of consent to care and people's involvement in deciding what they would like to happen. One person told us, "I agree to everything" adding, "I am easily pleased". Another told us, "They ask me can I do this or can I do that". One person told us they were asked, "A bit" and another person said, "Yes. They were asked for their consent by staff". A relative pointed out there was conflicting information about resuscitating their relative if it was required. One entry in the care plan said there was a 'do not resuscitate' and another entry said there was no decision made on resuscitation. This conflict of information could have serious consequences on people using the service and their families.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

During the inspection we saw that generally staff asked people for their consent prior to assisting them. For example, during the medicines round the nurses asked people, "Is it ok if I give you your medication now?" and before lunch we saw staff asking people, "Shall I take you through for lunch now?"

Despite the concerns we identified people felt their needs and choices were assessed and their independence promoted. For example, when people were able to complete aspects of their care independently, this was encouraged. During the inspection we spoke to a number of people. One person told us that the, "Staff know what they are doing". Another person said, "They work so hard in looking after me". A visiting relative told us, "They're a good bunch here; very patient and caring. My daughter who has been a carer for 20 years says it's a good here".

Care staff were mostly positive regarding the training they received. The training records showed that all of the staff had completed over 90% of their mandatory training. The registered manager was also encouraging staff to continue getting further qualifications. The staff had been on dementia awareness courses and some were going to progress to the next level of training. Staff had also received training on equality and diversity.

Nursing staff said they had completed mandatory training. However, they also said they needed more clinical skills training, such as catheterisation and syringe driver training. A relative told us, "My relative needed to have their ear syringed but there was no one here who could do it, so it was a long wait". The registered manager said they were in the process of arranging dates for nurses to be trained in specific skills. A member of care staff told us, "We have lots of training" adding, "It's all 'e learning' I don't learn much that way". 'E learning' is a term used when training is provided through using a computer package.

Staff gave mixed feedback regarding the support they received. A programme of staff supervision was in place. Supervision meetings are one to one meetings a staff member has with their supervisor. Staff members told us they received regular supervision and records reflected this. Staff knew who their supervisor was. Some staff told us they found their individual supervision meetings helpful. Others said they did not find them helpful but recognised they did provide an opportunity to discuss their performance and raise any concerns they had.

People had access to ongoing healthcare. Records showed that people were reviewed regularly by the GP, SALT, care home liaison team, mental health team, tissue viability nurse, and the optician for example. People were able to attend hospital appointments and we saw that staff escorted them to these. When

people's needs changed, we saw this was discussed with the relevant stakeholders.

Good

Is the service caring?

Our findings

People and their relatives were mostly positive about the care provided at the home. One person told us, "When you feel poorly the staff are wonderful". During the inspection we received many positive comments regarding the attitude of the care staff from people who use the service and their relatives. One person told us, "The staff are excellent" another person, when asked if they felt well looked after, responded, "Oh yes", and another said, "They look after all my needs and wants".

A relative told us, "Sometimes the care here is good, other times not so good, depending on the staff". Another relative said, "Everything is good here... this is a good home". A visitor told us "Everything is wonderful here...nothing is too much trouble for the girls". One person pointed to the staff and said, "You write this down; they are wonderful I love them all". Another relative told us, "They work so hard here; everything is done with a smile".

We saw some positive interactions between people and staff. On one occasion we saw a member of staff speaking with a person who had only recently moved to the service. They sat beside them and took their time to find out what kind of drink the person preferred. On another occasion we saw one person talking to a member of staff about their life before moving to the service. They apologised to the member of staff for 'rambling on' and the staff member replied, "Don't worry; I ramble on all the time". The hairdresser was at the service on one day, and we saw staff encouraging people to have their hair done and then complimenting them on their return.

During the inspection we noted that people were addressed by their preferred name. We heard one person requesting a bath and although it was not their planned bath day, the care team carried out the person's request.

However, despite the examples above, we saw that staff did not tend to spend much time with people. In particular, people who stayed in their rooms had minimal interaction with staff. On one occasion in the lounge the TV was on, but nobody was watching it. Several staff came into the lounge at various points, but nobody asked if people wanted the TV switched off or the channel changed. We also saw that some staff always knocked on people's bedroom doors before entering, but not all did. This requires improvement to ensure people receive care and support that maintains and promotes dignity and respect.

People's confidential personal records were protected. We saw all office computers used for recording information was password-protected and available only to staff with the appropriate access. Some paper records were locked away so that there was restricted access to staff only. Staff records and other management documents were also securely kept. However we noted that on at least three occasions there were breaches of confidentiality when staff were talking about people in public places. For example two members of staff were overheard talking about a person's care needs in the presence of other people. This requires improvement to ensure people's confidentiality is protected.

Requires Improvement

Is the service responsive?

Our findings

Care plans were not person centred and did not always provide enough detail for staff on how to meet people's needs. This was particularly relevant in the cases of people who sometimes displayed behaviours that staff and other people might find upsetting. For example, in one person's plan staff had documented 'confused' and 'verbally and physically aggressive with staff'. The only guidance for staff on how to manage this was that the person needed time alone. There was nothing to inform staff of any triggers or any de-escalation techniques. In another person's plan however, the de-escalation techniques had been documented.

Plans in relation to people's health needs were also not always detailed enough. We looked at the plan for one person with diabetes. Although the insulin dose was documented, the signs and symptoms of hypoglycaemia were not. This meant there was a risk that staff would not know how to identify if the person became unwell. This was particularly relevant because the person was eating much less than usual. A visiting relative said, "My daughter who is a nurse says the care plans are incorrect, giving the wrong information".

Wound care plans contained details of the wound dressing requirements, but photographs of wounds had not been updated. For example, one person had been admitted to the service with two pressure sores. Although the wounds had been dressed and the tissue viability nurse had expressed their satisfaction of the wound management, the latest photographs were dated 21 October 2017. This meant staff might find it difficult to assess for improvement or deterioration. Another person had moved to the service two days earlier with a wound. There was no photograph of the wound available. Staff said no photographs had been taken because the camera had broken and a new one had not been provided.

Although wound care plans detailed wound dressing requirements, when people had been assessed as being at risk of developing pressure sores, the plans lacked detail. Plans did not always specify how often people should have their positions changed for example. Position change charts we looked at had generally been completed in full although not all were up to date. Air mattresses were in use but the required settings had not been written in the care plans. We checked five air mattress settings and four of these were set incorrectly. Although there was a process in place for checking the settings, it was unclear how staff could assess this as the check list in place did not have people's weights recorded. We showed this to the registered manager during the inspection.

Personal care plans did not detail people's preferences for the clothes they preferred to wear, or whether the men preferred a wet or dry shave for example. Psychological plans contained statements such as, 'Likes listening to music' but did not specify which type of music.

Communication plans did not enable staff to know how to communicate with those people who were unable to voice their needs. For example, in one person's plan it had been documented that they communicated 'with facial expressions or body language', but the plan did not detail what these might look like. This meant it was unclear how staff would be able to understand the person they were caring for.

End of life plans were limited to whether people had a do not resuscitate order in place. Although it had been written in one plan that the person did not wish to discuss the subject, this was not seen in all plans. One person had recently transferred to the Nursing unit due to increased frailty and staff had written that the GP had discussed the use of medicines to keep the person comfortable at the end of their life. Despite the fact that the person had been assumed to be nearing the end of their life, there was no detail of their wishes in relation to this. In another person's plan it had been documented on 1 January 2017 'No discussion of advanced planning'. This indicated that staff did not initiate conversations with people or their families about their choices for end of life care.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

The registered provider had developed a Complaints policy to provide guidance to people using the service and / or their representatives on how to raise a concern or complaint. Information on how to complain was on display near the main entrance and had also been included in a guide given to people who are considering moving into the home.

The service recorded complaints which were then audited by the regional manager. The provider's 'complaints index' form showed they had received three complaints over the last six months covering a range of issues. Details of each complaint together with the action taken had been logged on individual complaint analysis forms. Supporting documentation was also available for reference. Where complaints had been partially upheld the service had taken action to avoid a similar incident happening again. When asked who they could approach to talk about the service, one person told us, "The tall man" (meaning the registered manager) comes every day and speaks to me, he is nice".

A relative told us they had raised a number of issues regarding the care their relative had received, the home had listened to these concerns and they have all been sorted out, they said, "The management have been very supportive". However another relative felt they were not being heard when they raised concerns and made to feel they were a nuisance.

All of the relatives were aware of the registered manager and how they could be contacted. One relative told us, "They are supportive" another relative said, "They listen", but another relative stated "They won't listen"; finally another relative stated "You can see them at any time." However one visitor replied when asked if the manager was approachable; "Not really...he has his favourites".

People were offered a range of individual and group activities based upon their hobbies and interests and, likes and dislikes. These were carefully planned and included activities both outside and within the home. The activities team consisted of two activities organisers. Care staff spoke positively about the activities provided. Activities staff told us staff told us care staff were generally supportive of activities and, encouraged people to participate. The home was able to access a minibus for trips out. This was shared between several of the provider's homes. People and relatives gave mixed feedback on the activities provision within the home. Some said there were enough activities others felt there could be more on offer. For example, one person told us, "I am bored here...nothing to do" with another saying, "There is always something to do you never get bored here". During our inspection we saw people engaged in activities and noted the enthusiasm of the activities staff.

Requires Improvement

Is the service well-led?

Our findings

The provider had not identified the breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified in the report of this inspection. These were in areas that the registered manager and provider would be expected to use their quality auditing systems to identify deficiencies and take remedial action. Additionally, this was the third consecutive inspection of Warmley House Care Home where the home had been rated as 'requires improvement'. This shows the provider was not identifying or taking action to mitigate the risks to people of receiving care that was not consistently safe and of a high quality.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

At our inspection in December 2016 we reported on tensions between the nursing staff and care staff. We felt, at that time, that the nursing staff did not seem to be committed to providing effective leadership and management.

At this inspection we saw there had been some improvement in this. However, care staff felt communication between nursing and care staff was not always effective. One relative we spoke with told us of an occurrence that illustrated this. They said that when their relative had a urine infection, "The carers collected a specimen but this was discarded by a registered nurse and had to be collected again. This led to a delay in the commencement of antibiotic therapy". When talking with staff about the day to day leadership and management of the home they gave mixed feedback. For example, one member of staff told us, "Nothing has changed here over the last year", but another member of staff told us it was, "Much better now".

We saw the registered manager had ensured a copy of our most recent report was available at the main entrance of the home. A copy was also easily accessible through the provider's website. This meant people, family members and friends could easily access the most recent assessments of the home's performance. However, we were surprised that when asked very few staff had read the report. We found this concerning as in order to make and sustain improvements the understanding and commitment of all staff is required.

Staff gave mixed comments about the registered manager. Comments included, "I don't feel at all supported. The manager doesn't listen to us. He either stays in his office or comes out and tells us what we haven't done", "I know I can go to the manager with any problems. But, I don't think he will solve them for me" and, "(registered manager's name) is approachable and is trying to improve things here".

Electronic surveys were used with relatives to gauge their feedback about the service using the tablet computer placed on a stand at the main entrance. One relative said they were, "Aware of the iPad in reception" for comments but were, "Not confident in using it". Another relative told us, "I do not use the main reception area and so was not aware of the iPad". Although a good volume of responses were received to the ongoing surveys, we found no analysis was completed and the results were not shared within the service or with the staff.

Resident/relatives meetings were arranged by the home, relatives we spoke with said they did not receive minutes of these meetings. None of the relatives we spoke with mentioned satisfaction surveys. One relative told us, "I've only just found out about the relatives meetings", the person they were visiting had been resident in the home for a long time. Another relative told us," The meetings are more of a listen to than the place for suggesting ideas".

The policies and procedures we looked at were regularly reviewed. Staff we spoke to knew how to access these policies and procedures. This meant that guidance for staff was up to date and easy for them to use.

The registered manager knew when notification forms had to be submitted to CQC. These notifications inform CQC of events happening in the service. CQC had received appropriate notifications from the service during the 12 months before this inspection.

Throughout our inspection we found the managers and staff to be open, honest and transparent with us. They were friendly and welcoming and keen to identify the improvements made, whilst being honest about areas they felt were not as good as they ought to be. Any information we requested was provided and staff made themselves available to speak with us.

At the end of day two we gave feedback to the acting manager and regional manager. They listened carefully to what we said and clearly wanted to ensure the service to people improved.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider had not ensured clear plans were in place to meet the needs and preferences of service users. Regulation 9 (3) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider had not ensured care and support was provided in accordance with the Mental Capacity Act 2005 (MCA). Regulation 11 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not ensured identified risks to service users were managed in order to keep service users safe. Regulation 12 (2) (b). The provider had not ensured medicines were managed safely. Regulation 12 (2) (g).