Care Quality Commission

Tamaris Healthcare (England) Limited

Warrior Park Care Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The last inspection of this home was carried out on 20 and 21 January 2015. At that time we found the provider had breached a regulation relating to the supervision and development of staff. After the inspection the provider wrote to us to say what they would do to meet legal requirements.

We carried out this unannounced inspection on 20 and 21 August 2015 to check whether the provider had met the legal requirement. We carried this out as a comprehensive inspection because we received concerns about the care of people using the service and the lack of action by the provider in investigating safeguarding matters.

Warrior Park is registered to provide care for up to 56 people, but there are only 48 bedrooms following the reduction of shared rooms and conversion of some bedrooms for storage. It is a two storey, purpose-built home with secure gardens. The ground floor provides accommodation for people needing personal or nursing

Summary of findings

care whilst the first floor provides accommodation for people living with dementia who require personal or nursing care. There were 42 people living at the home at the time of this inspection.

There had been four different managers involved in running the service since the last inspection. The home had not had a registered manager since February 2015. 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.

At the time of our inspection there were three safeguarding concerns currently open and being investigated. There was not always evidence to show that home staff had investigated safeguarding incidents, such as reviewing documentation and conducting staff interviews. Where some investigation had taken place it did not always follow a robust and thorough process.

Risk assessments about people's individual needs were either inaccurate or not in place, for example about the use of bedrails. A fire safety risk assessment carried out in October 2014 had identified several shortfalls some of which had still not been addressed.

The records of new staff did not include satisfactory recruitment records, such as application forms, references and disclosure and barring checks (these are checks about criminal convictions and whether applicants are barred from working with vulnerable adults). This meant the provider did not make sure that staff were suitable to work with the people who lived there.

Staff did not know how to make sure people's rights under the Mental Capacity Act 2005 were upheld. (MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests') .In some cases staff had assessed some people as not having capacity but had not identified what major decision the assessment was for. In other cases staff had not assessed people's capacity but had placed restrictions on their lifestyle.

The provider had not made sure people received personalised care. This was because people's individual care records did not accurately reflect their needs or were incomplete. This meant that it was not always possible to be clear if a person was appropriately cared for and supported in the right way.

The provider's quality monitoring processes were not effective in managing risk or making sure people received a safe or quality service. This was because shortfalls that had been identified but no remedial action had been taken so the issues were not addressed.

During this inspection we identified six breaches of regulations. You can see what action we told the provider to take at the back of the full version of the report.

At the last inspection of this home we found the provider had breached a regulation relating to the support and development of staff. This was because staff had not received supervision or appraisals, so they were not being offered support in their role as well as identifying the need for any additional training. During this inspection we found this had improved and individual staff members had taken part in one-to-one session and group supervision sessions with a line supervisor.

People who could express a view, and their relatives, felt the home met their care needs. They told us staff were competent at caring for the people who lived there. One person told us, "They are skilled in what they do. Some [people] are very difficult but the staff know how to distract them and stop them being agitated."

Visiting healthcare professionals told us the staff contacted them at the right times for advice and guidance. They felt care staff were knowledgeable about individual people and were able to spot any changes in their wellbeing.

Staff had access to training in care and in health and safety. Many of the care staff had had training in dementia awareness and knew how to support people who were living with dementia when they became upset. We saw staff supported people in a calm and reassuring way.

People enjoyed a choice of meals at the home and they described the quality of the food as "very good". People and relatives made many positive comments about the caring attitude of staff. One person described the staff as "fabulous". One relative told us, "The staff are very caring, respectful and friendly."

Summary of findings

There were daily in-house activities and occasional entertainment and social events. People had information about how to make a complaint or comment and they felt these were acted upon. People and relatives had opportunities to make other comments and suggestions about the service at resident/relatives meetings and through the provider's new computerised feedback system.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Safeguarding concerns had not been looked into properly by the provider.

Risk assessments about some people's needs were either contradictory or not in place. Requirements from a risk assessment about the fire safety in the building had not been acted upon.

The records of staff recruitment did not include all the required checks to make sure they were suitable.

Is the service effective?

Requires improvement

The service was not always effective. Staff had training in the Mental Capacity Act 20015 but did not know how to apply this in the right way for people who used the service.

The supervision of staff had improved since the last inspection. Staff had access to training in care and health and safety.

People were supported with their meals in a way that met their preferences and well-being.

Is the service caring?

Good

The service was caring. People and visitors felt the staff were caring and helpful.

Staff were attentive and supportive when assisting people. People were given time to go at their own pace and were not rushed when being assisted.

People's privacy was promoted. They were encouraged to make their own choices about their day.

Is the service responsive?

Requires improvement

The service was not always responsive. Care records were not always accurate or complete. This meant some people might not always get the right support when they needed it.

There were in-house activities, social events and some opportunities to go out into the local community.

People and their relatives said they would be comfortable about making a complaint if necessary, and they had information about how to do this.

Is the service well-led?

Requires improvement

The service was not always well led. The provider had carried out regular monitoring of the service but had not identified several shortfalls and had not made improvements when needed.

Summary of findings

There had been four changes to the management of the home in six months and some people did not know who the latest manager was.

People and visitors were encouraged to make comments and suggestions about the running of the home.

Warrior Park Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 over two days. The first visit on 20 August 2015 was unannounced which meant the provider and staff did not know we were coming. The first was from early in the morning until early evening. A second visit on 21 August 2015 was announced.

The inspection team consisted of three adult social care inspectors on the first day and two adult social care inspectors on the second visit.

Before our inspection, we reviewed information about any incidents we held about the home. We contacted the commissioners of the relevant local and health authority before the inspection visit to gain their views of the service provided at this home.

During the inspection we spoke with eight people living at the home and seven relatives and friends. We spoke with four visiting health and social care professionals, including a mental health social worker and a community matron. We also spoke with a peripatetic manager, three nurses, one senior and six care workers, an activity staff member and a cook. We observed care and support in the communal areas and looked around the premises. We viewed a range of records about people's care and how the home was managed. These included the care records of eight people, the recruitment records of six staff members, training records and quality monitoring reports.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

At the time of our inspection there were three safeguarding incidents currently open and being investigated at Warrior Park Care Home. The provider had a written safeguarding policy. This required that the 'Service Manager (the referrer) must produce a written record of any allegation of abuse or concern as soon as possible. This should be clear, factual and relevant… ' and that 'all actions, phone calls and discussions pertaining to cases are fully documented'. We asked the peripatetic manager for records of the investigations to date for each of the safeguarding incidents. Some information was only available for two of the safeguarding incidents but this was not robust and thorough. The peripatetic manager acknowledged there was no evidence that the third safeguarding matter had been investigated even though it had been referred by healthcare professionals to the safeguarding team on 21 July 2015. It was not clear to see in any of the three cases what action had been taken to safeguard the individual people since the incidents had occurred. In some cases agreed actions to safeguard people had not been carried out. For example, at a safeguarding strategy meeting a former manager had agreed to relocate a member of staff to another unit whilst a disciplinary investigation was carried out, but this had not happened.

In this way the provider was not following its own systems and processes to thoroughly investigate

safeguarding incidents and put immediate plans in place to prevent abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at individual risk assessments for eight people who lived at the home. Some risk assessments were incomplete or inaccurate. For example, a monthly falls risk assessment record scored one person as having a high risk of falls. However, there was no management plan in place about this risk. Contradictorily, the care plan about mobility stated the person was at "low risk of falls according to the long term falls risk assessment". Another person was cared for in a bed that was fitted with bedrails. The care staff told us that this person had a tendency to attempt to get out of bed over the bedrails. There was a mental capacity assessment and best interest record about the use of the bedrails. However there was no risk assessment about managing the bedrails or the person's behaviour to make sure this was safe and met their specific needs. We were told that a fire assessment was carried out annually by an external contractor, and that the last visit was on 10 October 2014. We reviewed the fire risk assessment document, which we were told related to that visit. The assessment identified 28 areas of 'risk', eight of which were classified as 'high risk'. The assessment record included an action plan with a status column to show the progress of remedial action to address the required works. All of the actions were listed as either 'overdue planned' or 'overdue completed'. This meant it was not possible to determine which actions had been completed and what the current status was of the fire safety in the home. When we asked about this staff were unable to confirm who was responsible for this or what work had been done. This meant that there the provider could not demonstrate that they had done anything to address the potential risks in order to keep people safe.

These matters were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the last inspection seven new permanent and three new relief staff members had started to work at the home. Some of these staff members had recently transferred to Warrior Park from another nearby care home operated by the same provider. We looked at the recruitment records for six of the new staff, including two of the staff members who had transferred to this home. We found the recruitment records of five staff members who had been appointed or transferred to the home in the past four months were inadequate and incomplete and did not meet the provider's own recruitment and selection procedures. On two staff files there was no evidence of a disclosure and barring list (DBS) check to see whether applicants had a criminal record. Another staff member who had transferred from another care home had part of a DBS clearance but no check of the adults' barred list to show whether they were barred from working with vulnerable people.

Other gaps included lack of application form for one staff member; only one reference for two staff members and illegible references used to appoint a third staff member. There was no evidence of interview notes on five of the files, and no health declaration on three files. One person had been appointed using passport identification that had expired five years earlier. None of the files had a current photograph of the staff member.

Inadequate

Is the service safe?

This meant the provider could not be assured that people were protected because the service had not carried out checks to make sure staff were suitable to work with vulnerable people. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives felt the service was safe for them. One person told us, "I like it here. I can have a bit of a laugh and a joke with staff." A relative commented, "Yes, my family member is safe. They are safer here than they were at home." Another relative told us, "I feel content that [my family member] is alright. They seem very settled here. I know I don't have to worry about them being here." Visiting health and social care professionals told us they had no concerns about the service when they visited. A social worker told us, "It feels safe and staff are very helpful." A community matron commented, "I've never heard anything of concern by staff towards residents."

People residing in the dementia care unit were not able to give us their opinions of staffing levels, but we saw there was good staff presence in this unit throughout the day. Staff spent time engaging with people and regularly checked on people who were in their bedrooms. On the ground floor many people were cared for in bed so there was less obvious presence of staff in communal areas. People and relatives felt staff responded to requests as quickly as possible. We found call bells were answered in a timely way during this inspection.

The relatives we spoke with told us staffing levels were "safe". One relative commented, "They are always on hand." Another relative felt it would be beneficial to have more staff. They commented, "If my [family member] needs the toilet, that's two staff off the floor. But it's safe."

There were two nurses, two senior workers and six care workers on duty during the days of this inspection. Night staffing levels were one nurse, one senior and three care workers. Staff rotas showed this was the typical number of staff at this home. One staff member told us staffing had recently improved through the week but that there was only one nurse on duty at weekends. The staff member said this made it even harder to support people's health care needs as most community health care services were also unavailable at those times.

The provider used a staffing tool, called CHESS, to determine the staffing levels. The tool used the dependency levels of each person (for example, if they had mobility needs or were cared for in bed) to calculate the number of care and nurse staffing hours required throughout the day and night. The staffing tool indicated that the staffing levels provided were sufficient, but we did note that some of the dependency ratings for people were inaccurate. For example, one person was rated as low dependency in several areas of care but their needs had changed and they had high dependency needs. The peripatetic manager agreed to review the dependency levels of people to make sure accurate dependency ratings were being used.

There was only vacant staff post (for a part-time nurse) and these hours were being covered by existing staff. Staff confirmed that the home had only used agency staff on a small number of occasions due to staff holidays and sickness. Senior staff were also able to describe the on-call and contingency arrangements in the case of emergency.

We checked how the staff managed people's medicines and looked at the medicines administration records (MARs) for people using the service. There were photographs attached to people's medicines administration records (MAR) so staff were able to identify the person before they administered their medicines. There was also information about any allergies and the person's GP, date of birth and room number. Staff assisted supported people with their medicines in an encouraging way and made sure they had sufficient drinks to help them at these times. We saw one person was asleep so staff returned to their room a little while later to provide this.

Staff who were responsible for administering medicines had had training in this and a recent competency check. The medicines trolley was taken to people in their bedrooms so that they could receive their medicines individually. People who required nursing care were administered their medicines by the nurse on duty. People who did not require nursing care were administered their medicines by a senior care worker. There were people who required both types of care on both floors. This meant the nurse and senior care worker had to transport the medicines across both floors, and this removed them from their respective units.

There was no clear guidance for supporting individual people with 'as and when required' (PRN) medicines. For example some people, who were unable to express pain due to their cognitive decline, were prescribed 'as and

Inadequate

Is the service safe?

when' paracetamol. The PRN forms stated the paracetamol should be given "for pain" but did not describe how each person might present if they were in pain. The peripatetic manager acknowledged this should be more descriptive.

The security of medicines storage was appropriate. However records showed that the temperature of the medicines storage room had reached 30°C or above on several days over the past month. This was too hot because temperatures above 25°C can affect the efficacy of medicines. The peripatetic manager agreed and told us an air conditioning unit had been requested for this room.

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests'.

The staff we spoke with told us that they had completed training in the Mental Capacity Act (MCA) 2005. However, staff were unclear about what action they needed to take to ensure the requirements of the MCA were followed. We found that staff had completed capacity assessments for some people but these were inaccurate or they did not clearly outline what decisions they specifically related to or why they had been completed. Where people had been found to lack capacity, staff had not always taken steps to complete 'best interest' decisions within a multidisciplinary team framework. For example, we found there was no 'best interest' decision in place around administering covert medicines to one person.

We saw that people who had been deemed to lack capacity had been asked to sign consent forms for sharing their information and having their photograph taken. This was contradictory and staff could not explain the rationale behind these decisions. In some cases relatives had been asked to make decisions for people but the care records did not to show whether relatives had the right to do this, for example whether they had power of attorney for care and welfare or finance. Relatives cannot make decisions about care and welfare unless they have the legal authority to do so and if the person lacks the capacity to make these decisions for themselves.

This was a breach of regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had listed people who were subject to Deprivation of Liberty Safeguard authorisations on white boards in the offices. (DoLS is part of the MCA and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests.) However, we found that the information on the white boards did not always match with the authorisations that had been made. The peripatetic manager told us they had started to draw together a register about who was subject to DoLS authorisations but this was incomplete at the time of this inspection.

We found that some people did have difficulty making decisions; were under constant supervision; and were prevented from going anywhere on their own. We found that staff applied restrictions to almost everyone who used the service around leaving the home unaccompanied. None of the staff we spoke with could tell us how they ensured the home took action to make sure people were subject to the least restrictions or show us evidence that those people with capacity had agreed to these restrictions. Staff had assessed one person as having capacity but had requested an urgent DoLS authorisation to prevent them from leaving the home. (People who are deemed to have capacity cannot have a DoLS authorisation.)

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection of this home in January 2015 we found the provider had breached a regulation relating to the support and development of staff. This was because staff had not received supervision or appraisals, so they were not being offered support in their role as well as identifying the need for any additional training. During this inspection we found this had improved and individual staff members had taken part in one-to-one session and group supervision sessions with a line supervisor. Supervision planners showed there were more supervision sessions planned with individual staff members to meet the provider's own protocols around supervision and appraisal.

The people and visitors we spoke with felt staff were competent to carry out their roles. One person commented, "They are a good set of girls and I appreciate everything they do." A relative told us, "The staff seem to know what they are doing." Another visitor told us, "They are skilled in what they do. Some [people] are very difficult but the staff know how to distract them and stop them being agitated."

The staff we spoke with said they received sufficient training to carry out their roles. Staff told us, and records confirmed, they received necessary training in health and safety matters, such as first aid, fire safety, food hygiene and infection control. The provider used a computer based

Is the service effective?

training system for each staff member to complete annual training courses, called e-learning. The home provided care for people living with dementia and staff had had training in dementia awareness and distress reactions. All care staff, except new staff, had a suitable care qualification such as a diploma or national vocational qualification in health and social care. Nurses had suitable training in nursing tasks such as catheter care, venepuncture and anaphylaxis.

Staff described the behaviours of some people that may challenge others, such as hitting out. Staff told us they dealt with such behaviours by distracting people and diverting their attention to something positive. Staff and relatives felt these instances were managed well, but staff did not have any specific training in breakaway techniques to support their safety and the safety of people when they became agitated.

The first floor unit provided accommodation for people living with dementia. There were lots of items of visual and tactile interest for people around this unit, such as themed areas and reminiscence artefacts. There were visual signs for different rooms and coloured doors to bathrooms and toilets for people to find their way around. There was a popular sitting area in the main corridor so people could see who was coming and going or to have a rest stop if they were walking around. This meant the home had some specific design features that supported people living with dementia, but there were few visual clues for people about which was their own bedroom.

People and relatives felt the quality of the meals was very good. One person thanked the cook after their meal and said they had enjoyed it. A relative commented, “The quality seems very good – my [family member] eats the lot.” Another visitor told us, “My [family member] gets their breakfast in bed if they want. The food must be alright because [the person] eats them out of house and home!”

We spent time with people over lunchtime meals on two days. The food was of good quality. There were two hot main dishes for people to choose from and a choice of desserts. Staff asked people which choice they would like and gave people time to respond. There were soft foods for people who needed their meals prepared in this way. People who needed physical assistance to eat their meal were supported in a sensitive and engaging way. People who needed verbal reminders were encouraged in a supportive way.

Meals were taken to people who were bedfast or preferred to eat in their rooms. These meals were covered with a plastic lid to keep them hot. The dining room on the ground floor was a pleasant place to dine, for example it was bright, spacious and tables were laid nicely. Menus were on tables, although on the first day of the inspection the menus were out of date by two days.

People’s individual preferences were catered for and in discussions the catering staff knew people’s likes and dislikes as well as any dietary needs. We saw that people were given a choice of meal, and that staff showed them plates of the two main options to help them decide. One member of staff told us, “People can have what they want. Choices are on the menu but we ask before they choose as they might change their mind.” We saw that people who had a particular dietary needs recorded in their care plans received the appropriate meals.

During meals and at intervals through the day people were offered a variety of drinks including cold drinks, tea and coffee. However during the early morning of the first day’s inspection we saw night staff had to leave the first floor unit to get flasks of hot drinks from the main kitchen on the ground floor. This left only one member of staff on the unit to support people who were getting up. The first floor dining room had a kitchenette area but no facilities for making drinks. The peripatetic manager acknowledged this and stated that a lock was to be fitted to a cupboard in the dining room to safely store kettles so, in the future, staff would be able to make drinks for people living on this unit.

Records were kept if people required their food or fluid intake to be monitored to make sure any health needs were identified. The nursing and senior staff used these to calculate people’s daily amounts. People’s weight was recorded on at least a monthly basis, unless they were at risk of poor nutrition when it was recorded more frequently. We found that some people’s care files did not contain recent weight records, however the peripatetic manager stated that all monthly weights were reported to her and a record kept so that she had an overview of people’s nutritional well-being. She agreed the weight record should also be kept up to date in care files for easy access by staff and healthcare professionals.

Requires improvement

Is the service effective?

Relatives felt people were supported with their health care needs. They told us that they had been contacted by home staff if their relative was ill. People's care records showed when other health professionals visited people, such as their GP, dentist, optician, podiatrist and dietitian.

A community matron told us, "The staff always get in touch with us for the right reasons. They always write the plans down of the treatment we advise. I'm confident that they follow our advice and guidance." Another visiting care professional told us, "The staff can always tell us exactly whether there have been any changes to my client and get in touch when there have."

Good

Is the service caring?

Our findings

People and relatives made many positive comments about the caring attitude of staff. One person described the staff as "fabulous". One relative told us, "The staff are very caring, respectful and friendly." A visitor told us, "The staff all deserve medals." Another relative commented, "I don't feel I have to come as often because the staff are very good."

The visitors and relatives we spoke with felt they were made to feel welcome and said staff were "friendly" and "helpful". One relative told us, "I can talk with any of the staff. They always let me know how my [family member] has been and they take the time to talk to me."

We saw many examples of positive interaction between staff and the people they were supporting. Staff were attentive, well-mannered and friendly when assisting people. One visitor told us, "My family member can't talk anymore but you always see him smiling at the staff and they seem to love him."

We saw staff promoted people's privacy by ensuring that curtains and doors were closed if they were supporting them with personal care in their bedrooms.

A visiting mental health professional told us, "From what I've seen people are cared for very well. [The person] has been very settled here so staff are meeting their needs."

One staff member told us that they felt staff knew each person very well. They told us that when a new person came to live at the home the staff made a point of introducing themselves and getting to know the person, and what they do and don't like. The staff member said, "I treat the residents how I would like my family to be treated."

We saw that staff knew the people they were caring for and supporting. They were able to described people's preferences, and used that knowledge to provide personalised care. For example, during a musical exercise activity we saw that staff omitted a particular song. When we asked about this a staff member told us, "[The person] doesn't like that song as it upsets them, so we skip through it."

At lunchtime we saw a person sleeping in the lounge and we asked when they would get their food. Staff told us that the person liked to sleep around lunchtime and that the cook knew to wait until early afternoon to make something fresh for them. Later in the day we saw that this had been done. We saw staff assisting people living with dementia to enjoy their meals. Staff were supportive and encouraging, and let people choose their own pace.

Staff respected people's choices. For example, one person chose to sit in the lounge part of the dining room at lunchtime. Staff asked the person if they wanted lunch and they said no (this was usual for this person). Staff asked her if they would like a cup of coffee and they agreed to this.

During a meal in the ground floor dining room staff asked people if they wanted the TV on or some music. The majority of people wanted music so staff put the radio on. Staff asked people if they wanted condiments, such as salt and vinegar, and supported those that were not able to manage this themselves. People's individual preferences were catered for and in discussions the catering staff knew people's likes and dislikes very well.

The staff we spoke with described the care as "very good" and one staff commented, "The care staff are genuinely caring." One nurse described how the care staff encouraged people to remain well. They told us, "Staff try everything to help people, especially with meals. They go back and back to try to encourage them. If someone decides not to have breakfast then staff take them sandwiches in between meals to try to help build them up."

Requires improvement

Is the service responsive?

Our findings

We looked at eight people's care records. We found plans about the delivery of care and treatment for people were incomplete or contradicted assessments about their needs. For example, one person received one-to-one support for agitation. The care files contained no pre-admission assessment of their needs. There were no admission details, for example when they moved to the home or why. A 'needs assessment' carried out after their admission was incomplete, undated and unsigned.

We found that the care records for people with mental health needs did not detail the triggers, history and impact of their mental health. Staff told us that one person's mental health had deteriorated to the point where they felt an admission to a mental health hospital was required. From our review of the care records we found that the lack of information about the person's history and triggers meant staff could not evidence a difference or deterioration in the person's health. The lack of records meant the staff were not able to support their assertion that the person needed to be admitted to hospital.

One person's care plan about support with medicines stated they were being given medicines in a covert way. The care plan stated they could be given the medicines in food, but did not describe how this could be achieved or in which foods. This meant staff may support the person in an inconsistent way that may not meet their needs. Some of the monthly evaluations in care plans were generic and did not address people's particular goals or progress. For example, the monthly reviews of one person's medicines care plan in March, April, May and June 2015 reported that the person was "not always compliant with medication" and encouraged staff "to go back and try again". There was no evidence of alternative strategies being considered or used.

Another person was prescribed an anti-anxiety medicine that had sedative effects. The medicine was prescribed to be given 'as and when required'. Staff told us the medicine was used when the person became agitated. There was no specific support plan or guidance for staff to determine when the person was agitated to the degree that they needed to take this medicine. This meant staff had no guidance to make a consistent judgement about supporting this person in a personalised way that met their individual needs.

The incomplete or contradictory information in people's care plans meant that we could not be sure that people received personalised care that was specific to their individual needs. In addition the lack of guidance about how staff should be supporting people could lead to inconsistencies in care delivery. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had recently developed new care records and these were being introduced at this home. Six people's care records had been transferred to the new care records format and seven members of staff had had training in the new records. The staff we spoke with felt the new care records would be an improvement on the current format. In discussions staff acknowledged that care recording could be improved, but felt the care delivery by their colleagues was good. One staff member told us, "The care is very good. We did get behind with records but people get all the support they need with physical and medical needs."

Relatives and visitors felt the support people received was personalised and individual. For instance, one relative commented, "If I need to know anything about how my [family member] has been, I ask the staff and they can tell me everything about them." A health care professional told us, "The staff know the residents exceptionally well and know the slightest change in their needs."

There was an information board at the front entrance of the home with details about the week's activities and social events. The home employed an activities member of staff who arranged games, social events and leisure type activities within the home with the support of care staff. These included pamper day, sing-a-long, hairdressing, lunch clubs, trips out, coffee morning, movies, church service, floor games, dominoes, cards and bingo.

The home had introduced 'Thirsty Thursday' sessions each week, which consisted of non-alcoholic cocktails and exotic fruit juices in a lounge on the first floor. The lounge contained a bar and was set out like a pub. We saw this activity was well attended by people and staff and was a very sociable occasion that also supported people to keep hydrated. One relative told us, "There is always something going on, even if it's playing with balls or staff having a chat with them."

People and relatives had information about how to make a complaint and this was displayed in the front entrance.

Requires improvement

Is the service responsive?

One person told us that if they had a problem with anything they felt comfortable about discussing it with staff. They told us, "If things weren't up to scratch I would speak to the staff and I know they would sort things." A relative commented, "If I had a problem or complaint I would go to the staff. I've nothing to hide from them and they are a good set of girls."

Relatives felt the outcome of any comments they had made were listened to and acted on. For example one relative told us they had had concerns about their family member's appearance and not getting a newspaper they liked. The relative told us that the problem "was sorted straight away" and the family member was much happier.

There had been two complaints recorded since the last inspection. One had been dealt with through safeguarding processes and the other was being investigated by the peripatetic manager. Complaints were now recorded on the provider's datix (management reporting tool) so that the provider could analyse complaints for any trends and make sure that outcomes or actions were completed.

Requires improvement

Is the service well-led?

Our findings

At the time of this inspection a peripatetic manager and an acting manager were responsible for the home's management. There had been four different managers involved in running the service since the last inspection. The home had not had a registered manager since February 2015. The peripatetic manager told us she and the acting manager would only be supporting the home for a few weeks as the provider intended that a permanent appointment would be made for a manager in that time. Three of the six relatives we spoke with were unaware of the most recent change in management. One relative commented, "I've only just found out by accident that the last manager went a few weeks ago. I've no idea who is managing now."

The provider had a quality audit system that included internal audits by home staff, and regular visits to the home by senior managers to check the quality and safety of the service. However we found several shortfalls in relation to the safety and welfare of people living at the home, including poor responses to safeguarding, inadequate care records and safe recruitment procedures not being followed.

The recruitment records of six staff members who had been appointed or transferred to the home in the past four months were inadequate and incomplete. The recruitment records had been audited by the provider's HR manager on 15 May and 8 August 2015. Their audit record also noted gaps in the required recruitment records. However there was no action plan, and no evidence that work was being carried out to address these shortfalls. There were no risk assessments about how to supervise those staff in the meantime.

During the inspection we found plans about the delivery of care and treatment for service users were incomplete and contradicted assessments about their needs. This demonstrated a lack of adequate systems for reviewing care plans as it would be expected that such contradictory information would be identified and addressed by an adequate audit procedure.

An annual fire safety risk assessment had been carried out by contractors in October 2014. The assessment report identified 28 areas of 'risk', eight of which were classified as 'high' risk. Following the inspection the peripatetic manager submitted an updated version of the fire safety risk assessment. This identified that four areas of high risk were still outstanding 10 months later. This meant the provider's assessments to monitor the safety of the service did not lead to timely action to address identified shortfalls.

In these ways the provider had not operated effective systems to assess and monitor the quality of the service provided and identify, assess and manage risks relating to the health, welfare and safety of people who used its service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a number of monitoring tools that should identify and prompt when statutory notifications should be submitted to the CCQ. These monitoring tools included a monthly management report regarding people's wellbeing, an accident/incident reporting system called datix, and a register of deprivation of liberty safeguard authorisations. However, we identified that despite the existence of these monitoring tools, the provider had failed to ensure that statutory notifications were submitted to the CCQ in relation to the deprivation of liberty safeguards for 14 people and the serious injuries of grade three pressure wounds of two people. This is a failure to notify and we are dealing with outside of the inspection process.

The provider sought to gain the views of people who used and visited the service. The provider had introduced a new 'quality of life' feedback system in its services, including Warrior Park Care Home. People, relatives and other visitors could leave their comments about the home at any time on a computer that was sited in the entrance hallway. The comments would be 'live' so that any critical comments would be emailed immediately to the manager for action and this would be recorded on the system.

Residents/relatives' meetings had been held which offered people an opportunity to get information about the running of the home and to make suggestions and comments about the service. For example at the most recent residents/relatives meeting in August constructive comments had been raised about people's hydration needs and asked about water coolers, access to tea/coffee, jugs of drinks and care plans to reflect hydration needs, cutlery on tables not clean However the minutes of that

Requires improvement

Is the service well-led?

meeting were not on display in the home. Some relatives who had missed the meeting commented that they were unaware of any changes to management or the purpose of the new machines in the entrance.

Staff acknowledged that there had been a several challenges recently including the many changes of management but felt the service was good at caring for people and involving relatives. Staff we spoke with felt the areas that needed improvement were records, nursing staff at weekends and managing the needs of people with mental health needs who reached crisis point.

Some staff had additional roles such as infection control lead and dementia care champion. These staff took responsibility for keeping up to date in relation to current best practice or initiatives relating to those areas. There were some opportunities for staff to attend meetings. The last meeting was held early in August 2015 to discuss the care delivered at the home. Prior to this meetings had been led in April and May 2015, although we saw those meeting minutes were identical.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 11 HSCA (RA) Regulations 2014 Need for consent Staff were not always acting in accordance with the Mental Capacity Act 2005 and were unclear about people's capacity to consent to care. Regulation 11(3)

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 People were not always protected from risks because the provider had not done all that was reasonably practicable to mitigate against risks. Regulation 12(2)(b)

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 protecting people from abuse were not always in place and investigations of safeguarding incidents were not timely or documented appropriately. Regulation 13(1),(2) and (3) People were at risk of being deprived of their liberty without proper authorisation. Regulation 13(5)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Robust recruitment and selection processes had not always been used to ensure that suitable staff were employed.** Regulation 19(3)

This section is primarily information for the provider

Enforcement actions

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

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 were not protected from the risks of unsafe or inappropriate care and treatment because care records were not always accurate or complete to ensure their needs were met.

The enforcement action we took:
We issued a Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider's quality monitoring system was not effective in assessing or addressing required improvements to the quality and safety of the service.

The enforcement action we took:
We issued a Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider has failed to notify the Commission, without delay, incidents of injury to service users and of requests to a supervisory body for a standard authorisation to deprive a service user of their liberty. Regulation 18(2)(b) and(c)

The enforcement action we took:
We are taking action about this matter outside of the inspection process.