Bupa Care Homes (ANS) Limited

Warren Lodge Care Home

Inspection report

Warren Lane
Ashford
Kent
TN24 8UF

Tel: 01233655910
Website: www.bupa.co.uk

Date of inspection visit:
20 July 2017

Date of publication:
05 September 2017

Ratings

Overall rating for this service	Requires Improvement
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 23 and 24 February 2017. The provider was served with a Warning Notice for a breach of regulation 17 of the Health and Social Care Act.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. We undertook a focused inspection on the 20 July 2017 to check that they had followed their plan and to confirm that they now met the legal requirements.

This report only covers our findings in relation to the well-led domain and the warning notice we served. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Warren Lodge Care Home' on our website at www.cqc.org.uk'

Warren Lodge is registered to provide nursing and personal care for up to 64 people .There were 60 people using the service during our inspection; who were living with a range of health and support needs. These included; diabetes, catheter care, dementia; and people who needed support to be mobile.

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

A registered manager was not in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager had been appointed in May 2017 and had started the process for applying with The Commission for their registration; they were present throughout the inspection.

At the previous inspection in February 2017 there were shortfalls in diabetes management and quality assurance processes. We also found other issues which needed to be addressed to protect people's health, safety and well-being.

The provider had taken action to address some of the concerns raised at the previous inspection. However, further work was required to ensure safeguarding incidents were robustly monitored and reported and behaviour which could challenge others was managed positively. Quality assurance processes had not been wholly effective in identifying risks to people in these areas.

People that were at risk of choking benefited from risk assessments which identified the steps staff should take to prevent choking and staff understood how to respond appropriately.

People's diabetes and catheter care was managed well and staff knew how to support people with their individual needs. Management of health conditions such as epilepsy were well monitored and responded to.

Care plans were person centred and provided individualised information on how to care for and support people.

Staff said they had received more training and felt supported by the manager. The views of people and other individuals were sought so the service could improve.

We found a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service well-led?

Requires Improvement

The service was not consistently well-led

A new manager had been appointed in May 2017 and had made some improvements to the service. Further improvements were required to improve outcomes for people in relation to managing people's behaviour and the reporting of safeguarding incidents.

Action had been taken to respond to most areas of concern raised at the previous inspection, but there was continued failure by the provider to adequately identify, monitor and reduce risks to people as part of their quality assurance processes.

The manager sought feedback from people and other individuals to improve the delivery of the service.

Warren Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook a focused inspection of Warren Lodge Care Home on 20 July 2017. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection in February 2017 had been made. We inspected the service against one of the five questions we ask about services: is the service well-led. This is because the service was not meeting legal requirements in relation to that question.

The inspection was undertaken by two inspectors and two specialist nurse advisors, the specialist nurse advisors had experience of nursing older people.

Before our inspection we reviewed the information we held about the service, this included the provider's action plan, which set out the action they would take to meet legal requirements. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority, looked at any safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We spoke with eight people who lived at Warren Lodge. Not everyone was able to verbally share with us their experiences of life in the service; we therefore spent time observing their support and carried out a Short Observational Framework for Inspections (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with four visitors. We looked at the environment including the bathrooms and some people's bedrooms. We spoke with three nurses, two care workers, the chef, one hostess staff, the manager, the regional support manager, and the regional manager. We 'pathway tracked' 11 people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the service where possible and made observations of the support they were given. This allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed other records. These included records of care and treatment, risk assessments, training records and quality assurance information. We asked the provider to send us information after the inspection which they did in a timely manner.

Requires Improvement

Is the service well-led?

Our findings

A visitor said, "I think they look after (person) extremely well; I can't praise the carers enough. The nurses are excellent and very caring". A person said, "I can do what I want here", and another person said "The home is perfect and the staff are very polite".

At our last inspection, the provider's quality assurance processes had not been sufficiently robust to consistently identify and resolve shortfalls in the quality and safety of the service. Some people had been identified as at risk from choking but there were no individual assessments in place to show how the risk could be reduced. There was a risk that people who had been prescribed thickened drinks may drink un-thickened fluids resulting in them choking. People that required specialised equipment to drink did not always have equipment available to them. There was insufficient guidance for staff to refer to when supporting people with their diabetes and some people did not benefit from any foot care records. (People living with diabetes are susceptible to foot problems brought about by poor circulation). The management of people's epilepsy had not been effective and catheter care was not adequate. Safeguarding incidents and behaviour that may challenge had not been managed well, checks and audits of incidents had not been sufficient to highlight that safeguarding systems were not being consistently operated. Training needs in some areas, such as end of life care and diabetes management had not been recognised or addressed. Management oversight and supervision had not been robust enough to identify those training needs. Care plans were not always followed in practice and audit processes had been ineffective in drawing attention to areas which required improvement.

At this inspection we found that the provider had taken action to improve some of the issues raised in our last report and in the Warning Notice served. However, other areas had not been adequately addressed because management oversight and monitoring had been lacking.

Some people could display behaviour which was challenging to manage. Staff completed ABC (Antecedent, Behaviour, Consequences) charts to document people's behaviour. One person's records were incomplete and not very detailed and stated 'unknown' in the antecedent's (what had been the trigger or what happened before the behaviour) column of the record on the majority of entries. This made it difficult to assess what may have led to the behaviour and therefore reduce the impact of it or to prevent a behaviour from happening or escalating.

There was a lack of a clear process for gathering information about incidents , analysis of the data, discussion about any intervention used, reviewing of the intervention and looking at impact of any intervention on behaviour and whether it was successful or not. There was no proper auditing or trend analysis to monitor people's behaviour, look for patterns or trends and implement strategies to support them more effectively.

Staff said that they did not have training about completing ABC charts although they were filling them in regularly. This lack of appropriate training and the lack of detail in the records had not been picked up through management oversight and checks. As a result, there was insufficient meaningful information to

address why some people behaved in the manner they did. Staff lacked the information to gain further understanding of why people behaved in a particular way so they could respond more proactively to support the person positively.

Generally safeguarding incidents were reported to the appropriate individuals following the provider's agreed processes. However, we found one ABC record where a person was exhibiting inappropriate behaviours towards another person. Staff had also made a record in daily notes about this; which mentioned that a nurse had witnessed the incident. However, when we spoke to the nurse, their account of what happened differed to the information in the daily notes and on the ABC chart. The incident had not been reported to senior management. We brought this to the attention of the regional support manager who said they would have expected the matter to be recorded using the appropriate incident form and reported to the manager immediately for further investigation and discussion with the local safeguarding authority.

Following our inspection we heard from the local authority about a further incident which had been notified to them .This involved a different person showing inappropriate behaviour towards another person. However, when this was followed up by the local authority they were informed that the initial report was not accurate and that the behaviour had been less concerning. The lack of consistency between reports about incidents created the potential risk that they would not be appropriately referred or investigated. This had not been picked up through the provider's and registered manager's auditing and oversight of the service.

Some people had problems when drinking and were prescribed thickeners by the dietician to add to the fluids they drank. Although people received thickened fluids as required, two people did not have their own supply of thickener and had been using other people's stock specifically prescribed for that person. Although all people had received their fluids in the appropriate way there was a risk that stocks of thickener would run out earlier. The provider and regsisterd manager's checks had not picked this up. We raised this as a concern with the manager and more thickener was ordered during the inspection.

At our last inspection, people did not always have access to the mobility equipment they needed; which placed them at risk of falling. At this inspection we observed a different person almost falling on two occasions. Staff were able to prevent them falling by running to them and catching them at the last minute. The care plan for this person said that they needed a walking frame to be able to mobilise on their own. The walking frame was not with them during our observations. We asked staff about this and they said the frame must be in the person's bedroom, but when we checked, it was not. Staff found the person's Zimmer frame in another place and ensured they had it alongside them during the remainder of our inspection. Although similar situations had been highlighted in our last inspection, they had not been remedied by management monitoring and intervention.

The lack of robust and effective systems to assess, monitor and mitigate risks to people is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were at risk of choking benefited from risk assessments which identified the steps staff should take to prevent choking. People were referred in a timely manner to the Speech and Language Therapists (SALT). The recommendation of SALT were incorporated in the care plans and guidelines for staff to deal with choking were in the daily notes. Staff said that they had been trained in the management of choking although felt more practical training would be beneficial. Staff followed the guidelines outlined in people's care plans in practice and people were offered the appropriate equipment to drink and eat as recommended by SALT.

People's diabetes was managed well and care plans contained the necessary information to guide staff to monitor and respond to concerns. Staff demonstrated they understood how to care for people's diabetes safely. However, staff had not followed up on a prescription for Glycogel that one person's GP had been asked to supply in June 2017. (Glycol-gel is used to raise the blood sugar when it becomes low). The manager said action would be taken to resolve this. People received regular foot checks from the chiropodist and staff knew how to contact the diabetic nurse should there be a need. The GP was overseeing the care of people with diabetes.

Staff managed urinary catheter care according to the recommendations made in people's care plans. For example, catheter output was recorded in daily fluid charts, and staff noted when the output was abnormal (low amount or dark colour). Any concerns were managed accordingly, and referrals for further professional input was made in a timely manner if a urine infection was suspected.

Management of health conditions such as epilepsy were well monitored. For example, one person's care plan contained information which documented the typical presentation of their seizures, management and care of the person during the seizure, and after care including medication. There was also a seizure record chart included with the person's medication administration chart which was reviewed to maintain good oversight of the person's health.
Care plans were person centred and provided individualised information on how to care for and support people. There was specific information about the person's individual needs, their preferences, and likes and dislikes. Care plans contained an initial assessment of needs prior to admission, followed by a detailed care plan.
The new manager had been in post since May 2017 and was not yet registered with the CQC, but applying to become so. They were supported by a deputy manager, who was also new in post. The manager told us that they had been working hard to make the necessary improvements but accepted that there was still more work to do in some areas. A staff member told us they enjoyed working at the service and the new manager was very supportive and would come to the unit to talk to them. The staff member said there had been a lot of training recently. One person told us that they felt there had been " Too many changes, too soon" and that this had sometimes effected the atmosphere at the service because they said, staff felt under pressure. Communication between staff had improved although the regional manager said further work was needed, "We are 100% in a better place, there are still some areas to improve. Areas of communication and care planning need further work to improve". Nurses conducted weekly clinical risk meetings to maintain good oversight of people's individual needs and written handovers were completed during each shift so staff were aware of any important information to help them support people well.

Feedback had been sought from people, their relatives and staff about their experiences of the service through surveys. Analysis for the staff survey indicated morale in the staff team and attitude had improved. Regular staff meetings were held to share important information and obtain feedback from staff about the service and what could improve. The service had received a number of compliments since February 2017 including, 'The ducks add something very special and interesting to the residents home life', 'Phenomenal care home', pleasantly surprised that husband settled nicely down' and 'Everyone is so kind to (relative) this is his home and I love it here'.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Oversight of the service had not been sufficient to identify shortfalls in the quality and safety of the service.