Lycette Care Limited

# The Warren

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

The Warren is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Warren accommodates a maximum of 27 people in one adapted building. People were receiving either nursing or residential care. There were 25 people using the service at the time of this inspection.

Lycette Care Ltd took ownership of The Warren 8 December 2017 since when there have been two registered managers. 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. The current registered manager has left the service and is the process of deregistering. A new manager started at The Warren the week following this inspection. At the time of the inspection the provider was managing the service on a day to day basis. They assisted with this inspection.

This was the first inspection since Lycette Care Ltd. took ownership. This means there was no previous rating.

Quality monitoring arrangements had not ensured people received a safe service which met their individual needs. This included omitting to assess where there was a high risk to a person's health. Not all care plans provided staff with the information they required to provide person centred care. Some information was contradictory, some missing and some no longer used, as it was out of date. This had the potential to increase risk.

There were not always enough staff available to meet the needs and wishes of people using the service. Staffing was a concern mentioned by most staff, who said they were sometimes unable to provide care to the standard they themselves expected. People also spoke of having to wait for care but "didn't want to make a fuss".

Meaningful, individual activities were not always promoted. Some people had not continued following their interests, on a misinformed belief this would not be possible. The provider said they would follow this up robustly. Some people enjoyed group activities.

Medicines were managed in people's best interest but best practice was not always followed. Securing oxygen cylinders and not double checking hand written entries, for example. We have made a recommendation in relation to medicines.

Staff considered the standard of training to be satisfactory but said they could not always attend it, as they

were needed to provide care when it was taking place. The provider said this was now being addressed. There had been a trial of one to one supervision meetings, but this was not found to be satisfactory and so staff were not currently receiving this. There were plans to reintroduce supervision using a different approach. Staff received a yearly appraisal of their work.

People were protected through the recruitment arrangements.

Staff had a good understanding of the types of abuse and what steps to take if they believed a person was at risk. People were protected from discrimination.

The premises was kept in a safe state. Improvements had been made to better meet people's diverse needs and the provider had further improvements planned, once they had asked people's views about this.

The premises was very clean and fresh. Equipment to promote hygiene was properly maintained. Staff had the protective equipment they needed. Some had not yet received training in infection control, but his was being arranged.

People's legal rights were understood and protected. Where people lacked capacity to make informed decisions these were made in their best interest.

People's health was closely monitored. Where external advice and expertise were required, this was arranged. Letters of compliment indicated that end of life care had been delivered to a high standard, and promoted people's dignity.

Staff were proud of the work they did and spoke frequently of the high standards they aspired to. People and their family members said that staff were kind, caring and friendly. Privacy and dignity were promoted.

A complaints procedure provide a formal way for people to complain. The provider said they considered any complaint to be a way to improve the service. People's views were sought through day to day contact, two formal family meetings and an audit which was held to look at 'the dining experience'. The provider was aware of the requirement to make information available in accessible formats and had plans to progress this, using tablets, for example.

The provider was aware that they had not yet achieved the required standards, or the standards which they aspired to, and they were keen to improve.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

Some aspects of the service were not safe.

Individual risks relating to people's safety and wellbeing were not always assessed.

Staffing arrangements were a concern to people using the service and staff and affected the level of care some people received.

People said they felt the service was safe.

Peope received their medicines as prescribed and on time but best practice improvements could be made to protect people and staff. .

Recruitment arrangements were in place to protect people from staff unsuitable to work with vulnerable adults.

The premises was safe and there were arrangements in place should there be an emergency.

People were protected from abuse and discrimination. Staff had a good knowledge of how to identify and report any concerns.

The premises was clean and fresh.

### Is the service effective?

**Good**

The service was effective.

Suitable staff training was available and where there had been difficulties for staff to attend this was being addressed.

Staff were supported to do their job and how this was achieved was being reviewed.

People's legal rights were understood and upheld.

The standard of health care provided ensured people's health was promoted. External health expertise was sought appropriately.

People received a nutritious and varied menu according to their tastes and preferences. Dietary concerns were followed up and managed.

## Is the service caring?

Good

The service was caring.

People and their families praised the kindness, friendliness and caring attitude of staff.

People's privacy and dignity were upheld.

People were consulted and choices offered when receiving their care and support.

## Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care plans lacked information of importance; some information was contradictory and some no longer current. People were not always consulted when their care was reviewed.

Meaningful activities, based on people's abilities and wishes, had not always been made available to them. This was being addressed as a priority following our feedback.

Group activities were enjoyed by many and a programme of events kept them informed.

Information accessibility was understood and there were plans to take this further and meet people's individual needs as they arose.

End of life care was praised by people's family members and some staff had received specialist training.

## Is the service well-led?

Requires Improvement

The service was not well-led but the provider knew they had not yet achieved the quality of service to which they aspired and had plans to take this forward, with the newly recruited manager.

The need for improvements in safety and quality had not always been identified through the service quality monitoring arrangements.

Staff had been through a prolonged period of change which had

affected their morale. This was said to be improving and they felt the provider was now listening to their views.

There was a strong ethos of care and a desire to attain high standards.

# The Warren

**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 was the first inspection since the service was registered in December 2017 and so the first time it received a rating.

The inspection took place on 28 and 29 November 2018. The inspection was completed by one adult social care inspector and one 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, in this case, the care of family in residential and nursing homes. Their role was to ask people and their representatives their views about the service and observe staff interacting with people.

Some people living at the home were unable to share with us their views about The Warren and so we spent time in the dining room and lounge areas informally observing staff interactions with people. We used the principles of the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Before our inspection, we reviewed the information we held about the service. We reviewed notifications of incidents that the provider had sent us since their registration. A notification is information about important events, which the service is required to send us by law. We had not asked the provider to provide information specifically toward this inspection.

During our inspection, we spoke with eight people using the service, four in-depth, five people's family members, 11 staff members, and the provider. We looked at five records, which related to people's individual care needs and sampled several people's medicine records. We viewed three staff recruitment and training records, and records associated with the management of the service. We received feedback about the service from a health care professional with recent knowledge of the service.

Requires Improvement

# Is the service safe?

## Our findings

Some aspects of the service were not safe.

People using the service had conditions which posed a risk to their health and welfare. Each person's care plan included four set sections of risk assessment. These were: general risk assessment, including self neglect and risk of pressure sores, falls risk assessment, personal emergency evacuation plan (PEEPS) and a movement risk assessment. The provider showed us a movement assessment and explained that it did not lead onto a management plan. They had therefore implemented a detailed moving and handling plan. They explained that they had begun completing this for people. The provider said, " This was one of the many assessments that we undertake."

However, some people had risks which were not assessed. In one case, a person had a high risk of sepsis. There was no risk assessment, or care plan, specifically to protect the person from this risk. A senior staff member confirmed this was an omission and said that the risk management system needed to be expanded to include every individual risk.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

People did not always feel they got the support they needed on time. For one person this had led to a complaint. People's comments included, "Everyone is kind to me. I am in a safe place and if I need anything, I know I just need to ask. But the carers are really very busy, so I don't like to speak out or complain all the time. They have enough to do already" and "I have my call bell and can call for help if I need it, day or night. The staff are very busy at times, but I never have to wait long really, even at the weekend or in the middle of the night." One person said there were times when the staff were so busy that they became entirely focussed on just getting the basic daily tasks completed. Another said they did not want to 'make a fuss'. Another said staff answered their bell quickly but sometimes had to come back to them later, adding, "It happens mostly in the afternoon".

Comments about staffing levels from staff included, "Okay" and "We're well enough staffed more than average", "We struggle with that", "I've had enough. I'm tired out" (of there being insufficient staff), "Fluctuating. Recently new care staff have started. There are times when we are stretched" and "Not enough staff."

Staff said that the number of staff allocated to work in the afternoons sometimes left them unable to meet people's personal care needs, such as hair washing, bathing and showering. Two staff said people were left in bed if there were not enough staff to assist them back to bed in the afternoon. We confirmed that, of the 25 people resident, 20 required two staff working together to assist them with personal care. The first day of our inspection there were five care workers and two senior care workers in the afternoon. The rota showed the number of afternoon care workers varied. Care workers were supported by a nurse on each shift, domestics, kitchen staff, an activities worker, administration staff and maintenance workers.

The provider said there was a 14 day rota. Where they had previously needed to employ agency staff, this was no longer needed. They said they were continuing to look at staffing needs, saying, "We listen to the nurses and we have a tool that identifies care needs and calculates the required time for care". They added that the rota was to be reviewed when the new manager started, the following week. However, currently the staffing arrangements did not always ensure that people's needs were met in a timely way.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

People, their family members and staff considered the care provided to be safe, one saying, "I came here after a heavy fall when I hurt myself and ended up in hospital. I went home briefly afterwards but never felt entirely safe as I was alone all the time. If anything happens here, I won't be alone. I really feel very safe here."

People received their medicines as prescribed but additional safety measures would further improve medicine management.

Nursing staff were trained to administer medicines to people, as no people using the service were able to manage this themselves. We saw how medicines were delivered to people individually and people told us they received their medicines as and when they expected them.

Good practice in medicine management included the secure storage of medicines and clear medicines records. Codes were used, if a medicine was refused, for example. We saw that some people were prescribed medicines to be administered 'as required'. This included one, the use of which would be used to calm a person. We found there was no protocol to inform staff when the administration would be appropriate, without which staff might not be consistent in their decision making. That protocol was put in place straight away. Other areas where improvement could be made were free standing oxygen cylinders, posing a risk should they be knocked and fall. We also found hand written entries, were not double signed to help prevent the risk of being written incorrectly.

We recommend the service reviews their medicine administration policies to ensure they are in line with national guidelines.

Recruitment arrangements protected people. These included checks prior to staff working unsupervised, including references from previous employers and Disclosure and Barring Service (DBS) checks. A DBS check helps employers to make safer recruitment decisions by providing information about a potential staff member's criminal record and whether they are barred from working with certain groups of people.

People were protected from abuse and harm. Staff were very knowledgeable in how to recognise abuse and report it. This included reporting to management and externally, to the local authority safeguarding adults team, the Care Quality Commission or where necessary, the police. One safeguarding concern had been reported in the previous 12 months. However, this was found to have occurred prior to the person's admission to The Warren.

The provider had a good understanding of how to protect people from discrimination. Their plans for changes to the building layout and equipment will further ensure changes to the building layout and equipment, which would further ensure barriers to independence and care would be reduced. For example, changing the flooring, so as to be more user friendly to people living with dementia.

The premises was kept in a safe state and any maintenance was quickly provided. Two maintenance personnel worked at the service. Very well organised records showed that all servicing and safety checks were completed and there were contractual arrangements to ensure none were missed. Where a piece of flooring needed attention, this was immediately dealt with. The premises was checked regularly to ensure it remained safe and well kept.

Devon and Somerset Fire and Rescue service had confirmed in a letter dated June 2018 that a previous action plan had been fulfilled. Staff received fire safety training and regular checks of equipment protected people from the risk of fire.

People said they were happy with the cleanliness at The Warren. Their comments included, "Cleanliness is top notch. No smell. Clean sheets and towels and empty bins every day."
The premises was clean and fresh. Necessary maintenance to a washing machine was being completed during our inspection and plans were in place for one of the three sluices to be replaced as it was currently not working.

Each person had gloves and aprons in their room for staff to use while providing personal care.

The service had a low incidents of accidents and none were of a serious nature. Computerised data collection ensured that the provider could monitor accidents. This overview would identified increased risk, such as certain times of the day, for example.

There were plans in place should an emergency occur, a loss of key staff due to illness, or a fire, for example.

Good

# Is the service effective?

## Our findings

The service was effective.

Staff received an induction when new to the service. One described their induction training as "Satisfactory", although they added that they had worked in care before. They described being shown around, receiving moving and handling training, fire safety and spending a lot of time shadowing experienced staff. The provider said that all staff, unless they already had qualifications in care, received Care Certificate training regardless of their experience. The Care Certificate is an identified set of induction standards that health and social care workers should adhere to when performing their roles.

Other staff opinion of the training included, "(The provider) is really working on that. All the mandatory training is in place" and "The training is fine but there is no time set aside for it. Yesterday there was training in nutrition, but the new senior care workers couldn't attend because they were providing care." Other staff reiterated this concern. For example, a care worker told us they had not received training in infection control whilst at The Warren. In response to this the provider informed us, "The majority of staff attended (infection control) training in June this year provided by the care homes team". They added, "In terms of training staff, attending training will be off rota so there should be no further issue with them being needed on shift at that time."

There were arrangements to ensure staff competence. These included closely monitoring new staff, who were supervised for a period of time, depending on their experience, and questionnaires for staff to complete. For example, we saw that staff had completed a health and safety questionnaire.

We confirmed that nursing staff were able to maintain their professional training and told that, should staff wish to undertake further qualifications in care this would be encouraged. For example, a staff member who wished to undertake level 3 health and social care qualifications was being helped to do so.

A programme of supervision had been introduced but had not been found to be of value. Currently, a new system was being considered. Most staff felt they could take any concern or question to the provider or senior staff and so this provided them with support. Staff comments included, "(The provider) is a nice person and says I can come and chat at any time." The provider said that staff appraisals were planned for January 2019 and all had been completed in January 2018, this being a yearly arrangement.

People said the staff were knowledgeable and knew what they were doing. Comments included, "(The staff) know their jobs and are very professional, so there's no need for feedback or anything unless things go wrong; which they don't. If we need anything we just need to ask. Everything is fine, anyway, so…no need" and "Staff are very well trained and enjoy their jobs which means they look after us well." People's family members said, "It's so professional. I can't fault the place." A health care professional said, "The (nurses) and carers had adequate knowledge, knew the clients and were very caring."

Adaptation of the premises promoted people's independence. People had no difficulty using mobility aids

in the communal rooms and corridors. People who needed a wheelchair to access the dining room remained in their wheelchairs whilst eating but had no difficulty as a result of this. People had the use of a vertical lift and stair lifts between different levels of the premises. Where specialist equipment was needed, such as pressure relieving mattresses, these were provided in a timely manner. The provider said how they had already upgraded some areas of the premises, such as a bathroom, and would ask people their priorities for the next stage of upgrading and decoration. In particular, it was said there would be emphasis on a more dementia friendly environment.

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The provider understood the importance of seeking people's consent and offering them choice, preferring to have bedsides in place, for example. Where people lacked capacity to make some decisions, the staff were clear about their responsibilities to follow the principles of the MCA when making decisions for people in their best interests.

The provider understood that they must apply for authorisation to restrict people's liberty and had made applications for this where necessary.

People said they were either mostly happy or very happy with the quality, quantity and availability of food. They said the menu choices suited their individual needs and preferences. One person said, "I  love the food. They make excellent meals. I can't complain on that score. 8 out of 10". However, one person told us, "It often" arrived (at their room) cold". The provider said they would investigate why this had happened and correct it immediately. Most people had chosen to have their meals delivered to their room, rather than use the dining room.

The menu included a variety of options, such as fish, meat and vegetarian dishes. Each morning people were asked what menu choice they wanted that day. Where people had specialist needs, a risk of choking for example, there were records available to kitchen staff about this, and appropriate meals provided. Each person using the service had their weight monitored and we saw how any concerns were followed up. Drinks were available to people at all times and they were encouraged to maintain good hydration.

People's health was fully promoted. When we attended a staff hand over of information we found that people's health care needs were discussed at length, so that the next shift of staff were fully informed. This included people's physical, mental and emotional needs. Regular visits from local GPs showed that any concern was quickly followed up. Where specialist advise was needed, this was sought, examples being wound care and concerns around the risk of choking. Arrangements were in place to provide routine health care, such as eye tests. One person's family were worried that their relative was not getting the physiotherapy they required, but staff had tried hard, as yet unsuccessfully, to make that arrangement.

Good

# Is the service caring?

## Our findings

The service was caring.

We observed people in communal areas. Staff engaged with people in a cheerful manner, making sure everything ran smoothly but with their primary focus on people's needs. Staff appeared calm but purposeful in attending to their work. They often did more than just complete what was required of them, interacting with people and asking friendly questions, offering help or seeking assurances that people were comfortable and content. This showed staff had a caring attitude.

People and their family members spoke highly of the staff providing their care. Their comments included, "They take such good care of everything. They all know me and what I like. I can choose what I want and there is no pressure to be like everyone else", "I can't fault the place. All the carers are so kind and loving and its warm and welcoming", "(The staff) can't do enough for me. They're all just lovely people", "The staff are so good, fun and we have a laugh together. They're all really caring people" and "(My relative) sometimes needs time to understand things and they repeat themselves all the time. They are easily confused and often forgetful, but the staff don't mind. They are just so patient."

Staff protected people's privacy and promoted their personal dignity. Care staff were clear that the service they wanted to provide should be genuinely person-centred, free from unwarranted intrusion in people's personal lives and protective of them. One person said, "When I have a hospital appointment or something, the carers will arrange anything I need. My (family member) usually takes me in their car, but the carers are always ready to help if needed." Another person said, "My privacy is always protected, like when I'm going to the shower or bathroom, they always knock, and they use privacy screens like in hospital, so I can't be seen by other people."

The provider placed a lot of importance on people's feedback about the service, and listening to their views. Nursing and care staff consulted people regularly about their preferences and aimed to meet them. They showed commitment to the people in their care, through the way they spoke about people and the concern they demonstrated. The provider emphasised the importance of using language which was respectful and promoted people's dignity.

Toward receiving people's views there had been a 'Families meeting' in July 2018. This was to provide an update on the progress since the new ownership, including staffing and changes to the premises and ask people what they thought about it. There had been no resident meetings. The provider told us: 'Residents meetings will also be held monthly and documented in a service user friendly format. I will also be holding a relatives meeting early in the new year. If residents are reluctant to attend a group meeting then their opinions and views will be sought individually through one to one meetings and questionnaires.

Staff understood the importance of equality and diversity in that each person should be supported to have the same quality of life, despite people's differences and any barriers, such as disability. To that end, new equipment was being provided and people's views were to be sought about potential decorative and

practical environmental changes.

Requires Improvement

# Is the service responsive?

## Our findings

The service was not always responsive.

Limited recorded information, in particular, some care plans, had the potential to increase risk and reduce the quality of care people received.

A computerised system, which included care planning, was gradually introduced from February 2018. The provider said that when they purchased The Warren people's care plans were extremely minimal and so all plans needed to be completely reviewed.

Some electronic care records did not provide the information from which staff could provide safe and responsive care. Lists of medicines did not correspond to the person's current prescribed medicines, for example. The provider said staff had decided not to continue listing medicines on the electronic system. However, these had not been removed and could cause confusion. Some entries were contradictory. For one person there were two capacity assessment, with the same date, to decide if the person understood the risk from refusing personal care. One said they did have capacity to understand the risk and the other said they did not have capacity to understand the risk. The provide said this had been "A technical issue". In a section called, 'psychological/emotional' it was recorded that the person 'had no issues', whilst other information said they would 'cry and be upset', and 'hide any worries' which a registered nurse confirmed. Staff told us that the transition of records to the electronic system had not been easy, adding, "We have trouble finding things on it".

Not all people were adequately consulted about their care. One person, asked if they were consulted about the care they received, in particular their care plan, said they thought they were told after it was decided, rather than asked. Their care plan had contradictory information about their level of understanding, but nurses said that, although variable, they were able to give their views and make informed choices. When their care was last reviewed, in July 2018, it was recorded that neither they, or their family, closely involved in their care, had been asked to take part in the review.

In September 2018 the Care Quality Commission received a concern from a health care professional, who had reviewed three people's care at The Warren. They described "A huge lack of information" about people, having looked at both electronic and paper records. They said they had fed this back at the time to the registered manager. We found the standard of care planning had not improved because information was lacking and inaccurate. When we fed back our findings the provider told us: "We are currently in the process of rewriting and adding more detail and personalisation to the current care plans. Once these are complete each resident will be offered a copy in an appropriate format for their records. The new manager will be running an in-house report writing course and also a care planning course to support staff to be able to have input and ownership of the documentation and for it to be written in an appropriate manner and in an appropriate level of detail."

People and their family members told us people's needs and preferences were not always met. For example,

one said, "I like to go to bed quite early, around 3pm if I can. I need help to get ready and into bed, but often the staff will ask me to wait until they can get to me. Often I don't actually get to bed until 4pm or even 5pm." And, "I know a lot of people would say 3pm is early to go to bed and the staff are very busy in the afternoons, but it's what [my relative] wishes to do. Around 3pm they'll start to get very fidgety and nervous, checking their watch all the time, because they want to get to bed. Waiting every day until 4pm or even 5pm is, to them, really stressful. It's just that the staff simply can't get to them any sooner."

People were not always supported to follow their interests, and engage in activities which were meaningful to them. For example, one person said "Knitting is something I've always done all of the time…my fingers can still cope now, but we used to knit along when we chatted…I wish I could join a knitting circle or something." This showed that people did not always receive care which was centred on them as an individual.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Stimulating group activities were provided from Monday to Friday, but less so at weekends. A programme of events and planned activities was posted in a main corridor. In the morning many people were quietly passing their time in their own rooms, with a small number of people sitting in the lounge, television room or conservatory. People said they rarely or only very occasionally undertook activities outside the service, but they did use the large, light and airy conservatory for a variety of organised group activities and general relaxation. A visiting 'Old Time Music Hall' singer/musician attracted a large audience in the conservatory in the afternoon. Many members of the audience joined in the singing. Many people remained in their bedrooms all day. They received some one to one visits from the activities workers. People said they had the freedom to choose where they spend time and where they eat on a daily basis.

Two activities workers were employed. They had produced information folders which included information about people's histories, likes, dislikes, hobbies etc. Activities were being planned for the Christmas period. These included a visit from a primary school and plans to attend a pantomime. This showed that the importance of celebrating special events was understood.

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. People receiving support had varying communication abilities. Staff were able to communicate with, and understand each person's requests and moods, as they were aware of people's known communication preferences. Staff described how to interpret the body language of a person unable to speak due to a stroke, for example. A care worker said, "We need to give people time to respond, to not feel rushed." Where a person was profoundly deaf, staff described the importance of regularly checking their hearing aid was working. The provider said they were looking into the use of 'tablets' for people to get information and maintain relationships and some had already enjoyed 'face to face' on-line meetings.

Information on how to make a complaint was available to people. People said that they could definitely raise any concerns about anything that worried them with any member of staff, including the provider. Most said they would prefer to talk first to their family about any serious complaints but would feel entirely comfortable asking staff for help if necessary. There had been five complaints received by the service, which had been investigated and closed. The Care Quality Commission had received a concern about the service. This was looked at during this inspection and fed back to the provider. The provider said, "We want people to make a fuss so we know how we can improve the service for them."

People said how caring staff were and how much confidence they had in the care provided, which included end of life care. Some staff had undertaken specific training in end of life care. Compliments from people's family included, "Thank you for looking after (ther person) so well", "A huge thank you. The nursing care he received was awesome and I know he enjoyed his short time at The Warren" and "Thank you to your wonderful team…and for everyrhing you did to keep (the person) healthy and happy."

Nursing staff confirmed they were supported to maintain their nursing expertise and there were many examples of where nurses followed up on health care concerns, contacting external health care professionals appropriately, for example. One person told us how well their pain was controlled. People we visited who were being cared for in bed looked comfortable, had water and their call bell within reach. We were told that currently there were no care plans for end of life care as none were required at this time. However, where decisions had been made around response to any acute episode of ill health, (such as whether the person had chosen to be resuscitated), this information was available and easy for staff to find.

Requires Improvement

# Is the service well-led?

## Our findings

The service was not well led because monitoring of the service had not always identified where risk was not being managed and improvements to the quality of the service could be made.

There were systems in place to monitor the service, medicines, records and premises checks, for example. However, those checks had not always led to acceptable or safe standards. Some care plans lacked information and included out of date and contradictory information. They could not be relied upon to inform staff practice. Assessment of known risks to people's health and welfare were not always included in risk management or care planning. The effect of the staffing arrangements, the main concern raised by both people using the service and staff, was not fully understood by the provider, for example, affecting how often people could bathe. Staff training was not up to date. People had not been supported to follow activities of personal interest to them, with the potential to affect their emotional wellbeing. Information which could have improved people's lives, such as the use of a minibus, was not known to some people.

The provider said that a review of staffing had been their initial priority; there had been a lot of staff changes. Staff described how difficult those changes had been, and to some staff, they continued to be. One said, "I wish (the provider) had listened more to staff. The transition (of ownership) has been very difficult."

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

There has been two registered managers since the current provider took ownership of the service. A third manager started their employment at The Warren on 3 December 2018, the week following our visits. People said they were generally very happy with the way the service was organised and run. They had no strong opinions about the leadership methods or management style, or the service's future plans.

People and their family members praised the care staff. Their comments included, "This is an excellent home." A staff member said, "I think the owners are working very hard to improve the quality of the service." The majority staff opinion was that the provider was now listening to them. One said, "Morale is not too bad now." Another said, "The best place I've ever worked."

A senior member of staff said, "I could not praise the staff enough over the last two years" and "It's a very good staff team." Staff praised each other and spoke of a strong culture of professionalism and caring attitude; staff were dedicated to the wellbeing of people using the service.

The provider had a clear vision for the service and spoke of high standards and person centred care. They were enthusiastic and described a commitment to improvement. They told us, "I am aiming to have a nursing home which is completely person centred. I'm not there yet. Still a little way to go." To that end they had met with Devon County Council Quality Assurance and Improvement Team. Where we identified a need for improvement the provider responded immediately. This included initiating a full investigation where information of concern was raised by a staff member. This showed a strong desire to get things right. To that

end there had been staff and family meetings. All staff met in January 2018 and August 2018, night staff in July 2018 and nursing staff in August 2018. A family meeting was held in July 2018.

There had been no resident's meetings, but there were plans to increase meetings, going forward. However, there had been an audit of the 'mealtime experience' and there were plans to consult people about improvement to the premises. We saw where the quality of an audit had needed reviewing, and this had been done. The electronic care system used by the service was said to be able to 'interrogate' the data within, and so inform the provider where improvement was needed. For example, a 'care plan integrity check'. This showed, for example, where 'blanks' existed, meaning that information was missing. When functioning efficiently (currently staff were having problems recording on the system that they had arrived at work) and containing comprehensive information, the system should help inform the safety and quality of the service.

The importance of links within the community was understood and being progressed. For example, planning a visit to a pantomime and inviting local school children to visit over the Christmas period. A community library visited so people had reading material available to them.

The provider had ensured that they had notified the Care Quality Commission of important events, as they are required to do.

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<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>People's individual needs and wishes were not always provided for in that care planning was not comprehensive, people were not always involved in their care planning and activities which were important to them were not always made available, where this was possible.<br><br>Regulation 9 (1) (a)(b)(c) (3) (a) (b) (d) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Individual risks to people's welfare were not always assessed, or plans in place to mitigate such risk.<br><br>Regulation 12 (1) (2) (a) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Quality monitoring arrangements had not ensured people received a safe service which met their individual needs.<br><br>Regulation 17(1) (2) (a) (b) (c) |

| Regulated activity | Regulation |
|---|---|

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

Staffing arrangements did not always ensure staff could provide the care people needed.

Regulation 18 (1)