Shaw Healthcare Limited

Warmere Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 11 December 2017 and was unannounced. Warmere Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Warmere Court is situated in Yapton, Arundel in West Sussex and is one of a group of homes owned by a National provider, Shaw Healthcare Limited. Warmere Court is registered to accommodate 40 people. At the time of the inspection there were 36 people accommodated in one adapted building, over two floors which were divided into smaller units comprising of ten single bedrooms with en-suite shower rooms, a communal dining room and lounge. These units provided accommodation for older people, those living with dementia and people who required support with their nursing needs. There were gardens for people to access and a hairdressing room. The home also contained an unregulated day service facility where people could attend if they wished; however, this did not form part of our inspection.

The home had a registered manager. A registered manager is a '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 home is run. The management team consisted of the registered manager, a deputy manager and team leaders. An operations manager also regularly visited and supported the management team.

At the previous inspection on 4 and 5 August 2016 the home received a rating of 'Requires Improvement' and was found to be in breach of the Health and Social care Act (Regulated Activities) Regulations 2014. Following the last inspection, we asked the provider to complete an action plan to inform us of what they would do and by when to improve the key questions of safe and well-led to at least good. This was because there were concerns about the sufficiency and knowledge of staff. In addition, the provider had failed to submit notifications to CQC to inform us of incidents and events that had occurred to enable us to have oversight and ensure that the relevant actions were being taken. At this inspection improvements had been made and the provider had met the previous breach. However, this is the third consecutive time that the home has been rated as Requires Improvement. There were concerns with regards to the maintenance of records to ensure people received appropriate and consistent care. Records did not always contain sufficient detail and were not always completed in their entirety. This related to people's healthcare plans, as well as food and fluid intake and cream application charts. It was not evident if people had received appropriate care or if staff had just failed to update the records. The maintenance of records was an area of concern.

There was mixed feedback with regards to the staffing levels within the home. People who resided in the nursing units of the home felt that there were sufficient staff and that their needs were met promptly, whereas people who resided in the residential units within the home felt that there was insufficient staff and they sometimes had to wait for support. When this was fed back to the registered manager they explained

that the provider was in discussions with the local authority and was reviewing the staffing provision within the home. This is an area of practice in need of improvement.

People were able to take risks to maintain their independence and development. Most risks had been formally assessed to ensure that appropriate measures were in place to ensure that people were not exposed to harm. However, not all risks had been formally assessed and not all risks associated with one person's certain lifestyle choice had been considered. When this was fed back to the management team, immediate action was taken and a risk assessment identifying and minimising these risks was developed and implemented. This was an area of practice in need of improvement.

People, their relatives and visitors told us that people were asked their consent before staff supported them and our observations confirmed this. The management team and staff had an understanding about the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS), however, had not consistently implemented this in practice. Some people had their capacity assessed in relation to specific decisions where as others, who had health conditions that might affect their ability to make decisions, did not. Consent forms, providing written confirmation that people had given their consent to a decision, were not always signed by relevant people who had the legal right to make decisions on people's behalves. Applications had not always been made to the local authority to ensure that people were not being deprived of their liberty unlawfully. This is an area of practice in need of improvement.

People, relatives and visitors told us that staff were kind, caring and compassionate and our observations confirmed this. Comments from people included, "They will do anything for you, you only have to ask", and "They all do their very best". People's privacy and dignity were maintained and they were treated with respect. People were protected from abuse as they were supported by staff that knew the signs and symptoms to look for and who knew what to do if they had any concerns about people's safety. Staff learned from instances and changed practice to ensure that people's well-being was promoted and maintained.

The provider had a clear set of values that encompassed a person-centred approach. People were involved in their care and treated with compassion, dignity, equality and respect. These values were implemented in practice and were in the culture of the home. The provider and management team had good quality assurance processes and audits that monitored the practices of staff and the effectiveness of the systems and processes at the home. The provider, management team and staff, worked with external agencies and professionals and continually reflected on their practice and learned from incidents and occurrences to ensure that the service continually improved.

People received a service that was responsive and centred around their needs. People received support from external healthcare services when required and told us that they had faith in staffs' abilities to notice when they were unwell. Staff were trained and competent and supported people in accordance with their needs and preferences. People had access to medicines to support their health and there were safe systems in place with regards to medicines management. The home was clean and there were good systems in place to maintain infection control and minimise the occurrence of cross-contamination.

People had access to activities and meaningful occupation and told us that they were happy living at the home. One person told us, "I like the entertainers and singers". People were involved in the development and on-going review of care plans and were able to voice their wishes and contribute to a plan of care that was specific to their needs and preferences. People were involved in decisions that affected their lives at the home. Regular meetings ensured that people were able to express their wishes. The provider welcomed feedback and had worked in accordance with their policy when they had received complaints and concerns.

Different departments in the home worked together to ensure that people received an effective and coordinated approach to their care. People's hydration and nutritional needs were met and people told us that they enjoyed the food. People were able to plan for their end of life care and received dignified and appropriate care to ensure their comfort.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered manager 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

The home was not consistently safe.

People were protected from the spread of infection. Most risks were identified and monitored and there were assessments in place to ensure people's safety. However, not all risks, particularly in relation to people's lifestyles and social needs, had been considered.

There was mixed feedback with regards to staffing. People who had differing needs did not always have access to sufficient numbers of staff.

Staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety. The provider demonstrated a reflective approach and implemented changes when lessons had been learned from incidents.

People had access to medicines when they required them. There were safe systems in place to order, manage, store, administer and dispose of medicines.

Is the service effective?

Requires Improvement

The home was not consistently effective.

People were asked their consent before being supported. The provider was aware of the legislative requirements in relation to gaining consent for people who might lack capacity but had not consistently worked in accordance with them.

People were cared for by staff that had received training and had the skills to meet their needs. Staff worked with external healthcare professionals to ensure that people received appropriate and coordinated care.

People had access to healthcare services to maintain their health and well-being. People were happy with the food provided. They were able to choose what they had to eat and drink and had a positive dining experience.

Is the service caring?

Good

The home was caring.

People were supported by kind and caring staff who knew people's preferences and needs well and who could offer both practical and emotional support.

People were treated with dignity and respect. They were able to make their feelings and needs known and were involved and enabled to make decisions about their care and treatment.

People's privacy and dignity were maintained and their independence promoted.

Is the service responsive?

Good

The home was responsive.

People had access to a range of activities and entertainment. People were supported to engage in meaningful activities and were not at risk of social isolation.

People were involved in the development and on-going review of care plans. Care plans were detailed and provided staff with personalised information about people's care.

People and their relatives were made aware of their right to complain. People were encouraged to make comments and provide feedback to improve the service provided.

People were supported to have a pain-free and comfortable death.

Is the service well-led?

Requires Improvement

The home was not consistently well-led.

The home has been rated as Requires Improvement for a third consecutive time.

People, relatives and staff were complimentary about the leadership and management of the home and told us that this had improved. However, records to document the care that people received were not always completed. It was unclear if people had not received appropriate care or if staff had failed to record their actions.

There was a positive culture and staff morale was good.

Mechanisms were in place to involve people and their relatives in decisions that affected their lives.

Quality assurance processes ensured the delivery of care and drove improvement. The management team maintained links with other external organisations to share good practice and maintain their knowledge and skills.

Warmere Court

Detailed findings

Background to this inspection

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

This inspection took place on 11 December 2017 and was unannounced. The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case the expert-by-experience had experience of older people's services.

Prior to this inspection we looked at information we held, as well as feedback we had received about the home. We also looked at notifications that the provider had submitted. A notification is information about important events which the provider is required to tell us about by law. Prior to the inspection we asked the provider to complete a Provider Information Return (PIR). We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with twelve people, two relatives, two visitors, eight members of staff, the deputy manager and the operations manager. The registered manager was not at the home at the time of the inspection, however, was contacted following the inspection to enable them to have their input. Prior to the inspection we contacted the local authority and subsequent to the inspection a tissue viability nurse (TVN), avoidance admittance matron and two GPs were contacted for their feedback about the home. We reviewed a range of records about people's care and how the service was managed. These included the individual care records for seven people, medicine administration records (MAR), four staff records, quality assurance audits, incident reports and records relating to the management of the home. We observed care and support in the communal lounges and in people's own bedrooms. We also spent time observing the lunchtime experience people had and the administration of medicines.

The home was last inspected on 4 and 5 August 2016, the home was rated as 'Requires Improvement' and

we found the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection on 4 and 5 August 2016, the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns with regards to the sufficiency of staff to safely and effectively meet people's needs. Following the inspection, the provider wrote to us to inform us of how they were going to address the shortfalls and ensure improvements were made. At this inspection it was apparent that improvements had been made and the provider was no longer in breach of the regulation. However, further areas in need of improvement were found.

There was mixed feedback from people, relatives, visitors and staff about the sufficiency of staff. The provider used a dependency tool and people's needs were assessed on an on-going basis and this was used to ensure that the levels of staff aligned with people's assessed level of need. The home is divided into four units, each accommodating up to ten people. There were two nursing units, each accommodating up to 10 people, with four care staff, a team leader and a registered nurse providing support. Feedback in relation to staffing levels on these units indicated there were sufficient numbers of staff and our observations confirmed this. One relative told us, "There has been nothing to suggest there are not enough staff and my relative has not complained". There had been three occasions since the previous inspection when there was not a registered nurse available to cover the shifts. However, the provider and registered manager had taken appropriate action to ensure that people's needs were met and to ensure their safety. A risk assessment had been devised to assess the risk this posed and to identify actions that were required to ensure people's needs were met. This included having access to other registered nurses in the provider's other homes as well as having access to external healthcare services such as 111, community nurses and GPs. There had been no adverse incidents during these times and people's care needs were met. The provider was continuing to recruit, however in the interim period had ensured that there were sufficient staff to meet people's needs through the use of agency staff. Staff and the management team were positive about the changes in staffing since the previous inspection. There had been a decrease in the amount of agency nursing staff being used and those that were used came from two agencies so that staff had been to the home before and were familiar with people's needs. One member of staff told us, "The home feels safer now, we used to be dependent on agency but we have got a much more stable staff team. Stability of the staff has been the big positive change. We can now see the use of agency staff as a solution rather than a problem. The agency nurses are much more consistent now, not letting us down". At the previous inspection the provider was attempting to recruit a registered nurse to oversee and coordinate the nursing support that people received, at this inspection a lead registered nurse was in post. They had worked hard to ensure that there was sufficient oversight of people's nursing needs and to ensure that the registered nurses had the relevant skills to meet specific needs, such as catheter care, which was also an area identified as in need of improvement at the previous inspection.

There were two residential units, accommodating up to twenty people, however, as people who were residing in these units did not have nursing needs, staffing levels were lower than those on the nursing floor. There were three care staff and a team leader providing support. Feedback from people residing in the residential units was on the whole, positive. However, some people told us that they sometimes had to wait for support from staff. Comments included, "I have to wait to use the commode" and "They need more

carers. There are two to look after twenty". Feedback from some staff echoed this. One member of staff told us, "Management have said staffing is one to nine downstairs [in residential units], but the level of care has changed completely. People come in with high dependency and when two people need the same piece of equipment to go to the toilet we can't do it. So we answer the bell and tell people we will be back, but it can't be easy for them and we are always under pressure". Another member of staff told us, "The job is too heavy as we are short of staff. A lot of people downstairs need two staff, especially with the number who need a stand aid [A piece of equipment to assist people to mobilise]. So there is not enough to cover the floor". When the feedback was raised with the registered manager they acknowledged that people's needs in the residential units had increased and explained that the provider was in conversation with the local authority on the suitability of staffing levels. Although, improvements in relation to staffing had been implemented and the provider was no longer in breach of the regulation, further improvements were needed to ensure that the support people receive on the nursing and residential floors of the home meets everyone's needs.

People, their relatives and visitors, told us that people felt safe. Comments from people included, "I am very safe both in bed and when I get up. I am hoisted into my chair and taken to the dining room. I feel that the two carers that hoist me make me feel safe, secure and comfortable", "I feel safe because staff and nurses are brilliant, they work hard to keep us safe" and "I feel safe because there are friendly people around me". A visitor told us, "They take safety very seriously". A relative told us, "I feel reassured that my relative is safe".

Risk assessments for people's healthcare needs were in place and regularly reviewed. People were involved in the development and on-going review of care plans and risk assessments. Each person's care plan had a number of risk assessments which were specific to their healthcare needs; these identified the hazards, the risks these posed and the measures taken to reduce the risk to the person. One person's assessment identified that they had an increased risk of falls. Measures had been taken to ensure that the person was able to continue to be independent whilst minimising risk. The environment had been considered in relation to items that the person might trip on, as well as the footwear they wore, their sight and any aids they may need to ensure that they could see properly, were also considered. When people had fallen, appropriate measures had been taken such as ensuring the person received medical attention when necessary and identifying the cause of the fall to minimise the chances of this reoccurring. Staff were made aware of risks to people's safety through verbal handovers, handover records and meetings as well as having access to risk assessments. These documents were stored securely to maintain confidentiality; this meant that staff were aware of how to support people and were aware of the measures to take to assure people's safety.

Accidents and incidents that had occurred had been recorded and monitored to identify patterns and trends. Relevant action had been taken to reduce the risk of the accident occurring again. For example, risk assessments and care plans had been updated to reflect changes in people's needs or support requirements. Risks associated with the safety of the environment and equipment were identified and managed appropriately. Equipment was regularly checked and maintained to ensure that people were supported to use equipment that was safe. Regular checks to ensure fire safety had been undertaken and people had personal emergency evacuation plans which informed staff of how to support people to evacuate the building in the event of an emergency. A visitor told us, "I was here when they had a fire drill; I went to the assembly point. All the bedroom doors close automatically and they check everyone is alright".

Since the last inspection risk assessments in relation to people's healthcare had improved and people were receiving appropriate care for their health needs. In relation to people's social needs, one person chose to pursue a lifestyle choice. Staff respected the person's right to pursue this and some safety measures had been implemented to ensure the person's and others safety. However, in one case there was not a documented risk assessment identifying all the associated risks nor appropriate measures planned and

implemented to fully ensure the person's and others safety. When this was raised with the management team a risk assessment was devised and implemented.

People were cared for by staff that the provider had deemed safe to work with them. Prior to staffs' employment commencing, identity and security checks had been completed and their employment history gained, as well as their suitability to work in the health and social care sector. This had been checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people. There were further checks to ensure that agency staff, who sometimes worked at the home, were suitable to work with vulnerable groups of people. Documentation confirmed that nurses had current registrations with the Nursing and Midwifery Council (NMC).

People were protected from discrimination and harm. Observations showed that people appeared comfortable in the presence of staff. One person told us, "No one ever gets angry with me or shouts at me". A relative told us, "No one is unkind to my relative; they respect what they want and always treat them with courtesy and respect". Staff had a good understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they witnessed any incidents. There were safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding people's safety and well-being. Mechanisms were in place to raise people's awareness of their own personal safety and to enable them to raise concerns. Regular residents' and relatives' meetings as well as reviews of people's care provided an opportunity for people to raise issues and discuss any concerns they had. The provider and management team had worked with the local authority when they had undertaken safeguarding enquiries and the management team had demonstrated a reflective approach to ensure that they learned from the outcomes of the enquiries to ensure people's safety. Records showed that the provider had been proactive and had raised safeguarding alerts to the local authority when they were concerned about people's well-being.

People were protected by the prevention and control of infection. Staff had undertaken infection control training and infection control audits were carried out. There were safe systems in place to ensure that the environment was kept hygienically clean. Staff were observed undertaking safe infection control practices; they wore protective clothing and equipment, washed their hands and disposed of waste in appropriate clinical waste receptacles. People, when appropriate, were supported with their continence needs and had access to hand-washing facilities. Personal protective equipment was available for staff to use to ensure that infection control was maintained and cross-contamination was minimised. One person told us, "My room is spotless". A visitor told us, "They wear aprons and rubber gloves for infection control and rooms are kept clean. The laundry does a good job too".

People were assisted to take their medicines by registered nurses and trained staff that had their competence regularly assessed. The provider had implemented an electronic recording system for the management of medicines across all of their services. Staff accessed peoples' medicine administration records using a laptop computer and used this to record when they had given people their medicines. Staff told us that this helped them to know when medicines were required and also identified the amount of medicines that were in stock to ensure there were sufficient stocks of medicines when people required them. Medicine records showed that each person had a medicine administration record (MAR) which contained information on their medicines and appropriate guidance for staff. Records had been completed correctly and confirmed that medicines were administered appropriately and on time. Records for one person advised staff of the type of drinks that should be avoided so as to avoid altering the structure and efficiency of the medicine the person was prescribed.

Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines. People, who were able, were encouraged to self-administer their own medicines and risk assessments were in place to ensure that there were safe mechanisms in place to enable this. Regular medicines reviews ensured that medicines to support people to manage their behaviour were monitored and their excessive use minimised. Appropriate documentation was in place so that information about people's medicines could be passed to relevant external healthcare professionals if required, such as when people had to attend hospital. Observations showed that safe procedures were followed when medicines were being dispensed and administered and people's consent was gained before being supported. People confirmed that if they were experiencing pain that staff would offer them pain relief and records confirmed that this had been provided. People told us that they were happy with the support that was provided and that they received their medicines on time. One person told us, "They watch you swallow it and write it down". The registered manager had notified us of medication errors that had occurred and had also reported this to the local authority. There had been no adverse effects of these medicines errors to people's safety and the registered manager had worked with the local authority and had reviewed their own procedures to ensure that the chances of these errors reoccurring were minimised.

Requires Improvement

Is the service effective?

Our findings

People, their relatives and visitors told us that staff asked for people's consent before offering support and our observations confirmed this. People were provided with choice and able to make decisions with regards to their day-to-day care. However, staff did not always adhere to the legal requirements associated with assessing people's capacity to make decisions and to gain their consent and this is an area in need of improvement.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty 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 manager and staff had an understanding of MCA and DoLS. A majority of people had mental capacity assessments in place which had assessed people's capacity in relation to specific decisions. When people lacked mental capacity best interests decision meetings had taken place to involve relevant people in the decision making process. Some people had Lasting Powers of Attorneys (LPA) who were legally able to make decisions on people's behalves when they lacked capacity in specific areas. The provider had sometimes demonstrated good practice by obtaining copies of the documentation for this to assure themselves that people making decisions on people's behalves had the legal right to do so. Staff were aware of people's changing needs and as a result mental capacity assessments were reviewed or renewed if changes had occurred. Staff ensured that practices that restricted people's freedom were minimised, when people demonstrated signs of apparent anxiety or distress, staff supported them appropriately, using distraction techniques and engagement as opposed to physical restraint to manage potentially challenging situations.

However, the appropriate application of MCA and DoLS was not always consistent. A sample of people had a condition which might impair their judgement and decision-making ability, had not always had their mental capacity assessed and staff had sometimes involved their relatives in the decision-making process without assessing if the person themselves lacked the ability to make decisions about their care and treatment. Some relatives had signed consent forms on people's behalves. It was not evident however if they had an LPA and therefore had the legal right to make decisions on people's behalves.

DoLS applications had been submitted to the local authority when staff had recognised that people's freedom was being restricted. Some DoLS had been authorised and were subject to conditions. This meant that the provider needed to ensure that the conditions associated with people's DoLS authorisations were met. Records showed that these had been met. A large proportion of people were living with dementia-type symptoms or conditions that could potentially affect their ability to make certain decisions. Most people were not able to leave the home without being accompanied by staff, due to issues related to people's safety. However, there was a low number of DoLS applications made to ensure that people's liberty was not

being restricted unlawfully. When this was fed back to the management team they explained that they would liaise with the local authority and make the appropriate applications. Although the majority of people had their capacity assessed and staff had worked in accordance with the legislative requirements in relation to this, this was not always consistent and therefore is an area in need of improvement.

People's physical and mental health, as well as their social needs, were assessed prior to, as well as when they moved into the home. Assessments took into account people's abilities and skills as well as their needs and care was centred on these. People's risk of malnutrition was assessed, a Malnutrition Universal Screening Tool (MUST) was used to identify people who were at a significant risk, and these people were weighed regularly, to ensure that they were not unintentionally losing weight. Records for some people showed that they had been assessed as being at a higher risk of malnutrition and staff had ensured that changes were made to the frequency in which the person was weighed so that they were monitored more closely. In addition, people's food had been fortified to increase their calorie intake. Food and fluid intake was recorded if people's intake of food needed to be monitored. People's skin integrity and their risk of developing pressure wounds was assessed using a Waterlow Scoring Tool, this took into consideration the person's build, their weight, skin type, age, continence and mobility. These assessments were used to identify which people were at risk of developing pressure wounds. For people who had wounds, regular monitoring took place and appropriate treatment provided. There were mechanisms in place to ensure that people at risk of developing pressure wounds had appropriate equipment to relieve pressure to their skin, these included specialist cushions and air mattresses as well as regular support from staff to frequently reposition.

People's healthcare needs were met. People and their relatives were involved in explanations and decisions about their healthcare needs. People and relatives told us that they were confident in staffs' abilities to recognise when they were not well and to seek medical assistance when required and our observations and records confirmed that people received timely intervention from healthcare professionals when required. Comments from people included, "We are pleased with the GPs who come out when necessary because they are the ones we had at our own home" and "You can see a chiropodist, optician, dentist and hairdresser". People's healthcare needs were monitored and reviewed on an on-going basis to ensure that the care that was being provided was meeting their needs.

People, relatives and visitors told us that staff were competent and that they had faith in staffs' abilities and skills. Comments from people described staff as 'excellent' and a relative told us that they were 'brilliant staff'. When staff were asked about access to learning and development opportunities, they told us, "Training, is a strong point and supervision is very good, I have learned a lot" and "It's their approach, [provider's] you feel supported and I feel I am doing a more professional job. The manager even demonstrates things to new staff on induction". The registered manager told us, "I am big on making sure staff are well-trained and have a good knowledge".

Staff that were new to the home were supported to undertake an induction which consisted of shadowing existing staff and familiarising themselves with the provider's policies and procedures as well as an orientation of the home, an awareness of the expectations of their role and the completion of the Care Certificate. The Care Certificate is a set of standards that social care and health workers can work in accordance with. It is the minimum standards that can be covered as part of the induction training of new care workers. All staff, regardless of roles, had access to on-going learning and development to equip them with the necessary skills to support people effectively. In addition to completing the provider's core training, staff undertook courses that were specific to the needs and experiences of people that lived at the home and who used the services. For example, Parkinson's awareness training. Links with external healthcare professionals were maintained to provide additional learning and development for staff. Most care staff held

diplomas in Health and Social Care or were working towards them. Registered nurses were provided with appropriate courses to maintain their competence and to ensure their knowledge and skills were current so as to support people with their nursing needs. People were cared for by staff that had access to appropriate support and guidance within their roles. Regular supervision meetings and annual appraisals took place. These meetings provided an opportunity for staff to be given feedback on their practice and to identify any learning and development needs. Staff told us that they found supervisions helpful and supportive. The registered manager and provider recognised the importance of valuing and empowering staff. People, relatives and staff could nominate members of staff by putting their names in a box, each month a member of staff was declared a 'Warmere Winner'. In addition, to recognise staffs' contribution to the service, the provider had introduced the National STAR awards which recognised staff who demonstrated excellence.

People's diversity was respected and people were treated fairly and equally. Person-centred care was promoted throughout the staff team. People were supported by staff that knew them, their needs and wishes, well. One person told us, "It is better to be here, they know all about what you like and what you don't like". People were supported to independently mobilise around the home and technology, such as call bells, were available for people to use if they required assistance from staff. One person had access to other forms of technology to aid their independence and encourage stimulation as they had a computer, mobile phone, iPad, iPod and a Kindle. A visitor told us, "They have their own computer and with help can access internet banking, they are tracing their family tree and can keep in touch with friends on social media, and they also store their photographs". The person told us, "The Wi-Fi here is good and I am writing a book". There was good inter-departmental working and effective communication took place to ensure a holistic approach to meeting people's care and support needs. Regular meetings took place to share information on each person to ensure people were provided with appropriate care that was consistent. One member of staff, who worked in a role other than care, told us, "We get good information about people's needs and get told of any changes". The sharing of information extended to external services and records showed that there had been good communication with external services to ensure people received coordinated care.

Staff had encouraged links with the community. Some people could access the community independently or with their family and others were supported to visit local cafes and shops. The home was designed in such a way that provided adequate space for people to enjoy time with one another. People also had their own rooms that they could use if they wanted to have their own space. People could choose to socialise with other people, enjoy one of the activities or events, receive visitors and enjoy the communal gardens in warmer weather.

People told us that they enjoyed the food that was provided and had access to drinks and snacks throughout the day and our observations confirmed this. When people were asked about the food they told us that they were provided with choice and that there were alternatives available at short notice if they changed their mind about their original choice. When meals were being served one person was overheard saying, 'Oh jolly good today, very tasty". Observations showed that some people chose to eat their meals in the dining rooms whilst others preferred to eat in their rooms or at small tables in the communal lounges. People had a pleasant dining experience and were able to socialise with others. Staff were respectful and supported people appropriately when they required assistance to eat and drink. Observations demonstrated that when people disliked the menu option that their right to change their mind was respected and they were able to choose alternatives. Aids and adaptions were made available for people to use to enable them to remain independent and to take into consideration their cognitive and physical abilities. For example, there were beakers with lids and handles that people could use if required.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion from staff that knew them well. Warm and personable interactions were observed. Comments from people, relatives and visitors praised staffs' caring attitudes. When speaking about staff, comments from people included, "They will do anything for you, you only have to ask" and "They all do their very best". A relative told us, "They are brilliant staff. They have improved on the care I could give my relative but they still make space for me to share in the care". A comment on an online review website from a person living at the home stated, 'Just after a few weeks I felt that this was my home. Everyone made me feel so welcome and did everything that they could to help me settle in, it is like being part of a big family, including all the staff and management'.

The provider had a set of values, 'Wellness, happiness and kindness'. It was evident that the management team and staff were working hard to ensure that this was implemented in practice. The atmosphere was calm and people were cared for by staff that were understanding and patient. People were happy in the presence of staff and willingly accepted support from staff that were happy and able to offer assistance. One member of staff quoted the provider's values and told us, "It isn't just words, it is a reality, the company want people to have a good life". Feedback within a recent resident's survey contained comments such as, 'Staff are caring, they're good staff' and 'Staff are very caring and thoughtful'.

Outside of peak times, staff took time to listen and talk with people. At times, some people showed signs of apparent anxiety and distress. Staff were on hand and responded promptly, ensuring that people were reassured. Observations showed that when staff responded to people's needs this had a positive impact on the person's well-being and they were observed to be calm. When possible, staff had collated information about people's lives, backgrounds, interests, employment and preferences. These were regularly reviewed and added to, so that when staff became more familiar with people and relationships developed further, the records could be updated to further inform other staff and ultimately enrich the positive relationships between people and staff. These mechanisms provided staff with an insight into peoples' lives before they had moved into the home. One member of staff told us, "We generally build-up good relationships with families so we build-up good information about people". People were encouraged and able to keep in contact with their family and friends. Visitors were welcomed in the home and observations showed people enjoying meals with their relatives as well as being actively involved in their loved ones care. Some relatives had made plans to spend Christmas day with their loved ones in the home. Positive relationships had developed amongst people. Observations during lunch showed people engaging in conversations with one another. A visitor, when speaking about their friend, told us, "They suffer from anxiety but this place is brilliant for them, there are three of them that meet up at mealtimes and in the lounge and being in this group helps maintain their confidence".

People, and their relatives if appropriate, were involved in people's care, as well as matters relating to the running of the home. Regular residents' and relatives' meetings took place to enable people and their relatives to share their ideas and be kept informed of changes at the home. The provider acknowledged that people and relatives may prefer to share their views and concerns in a different way and regular questionnaires were sent to gain feedback. Additional support to enable people to share their views could

be provided through advocacy services or people's paid representatives which had been appointed as part of their DoLS authorisations. An advocate and paid representatives are people who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

People's independence was promoted and encouraged. People could choose how they spent their time, some spending time in the communal areas of the home, whilst others preferred their own space in their rooms or quieter areas of the home. Some people independently accessed the local community. A visitor for one person told us, "They have their bus pass and their chair insurance, everyone knows where they are going and they have their phone for contact. They are safe and the staff have considered all of the risks. They are happier than they have ever been".

People were treated with respect and dignity and afforded privacy by staff who took time to explain their actions and involve people in the care that was being provided. Staff were mindful of the impact receiving support, particularly with aspects of people's personal care needs, could have on a person's dignity. One person told us, "They always supervise my baths and treat me with dignity and respect". Observations showed staff knocking on people's doors and waiting for a reply before entering people's rooms and asking people's consent before supporting them with tasks. Staff attended to people's needs in a sensitive and discreet manner and people told us that staff always promoted their privacy and dignity. People's wishes, with regards to their preferences of male or female care staff, were ascertained and respected. Staffing allocation ensured that there were staff of different genders so that people's wishes could be respected and accommodated. One person told us, "I prefer a female carer for baths but I don't mind a man at other times. They are very good and discreet".

Information held about people was kept confidential. Records were stored in locked offices and handover meetings, where staff shared information about people, were held in private rooms to ensure confidentiality was maintained. People's diversity was respected and staff adapted their approach to meet people's needs and preferences. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. Guidance produced by Skills for Care advises on the importance of promoting equality, diversity and human rights within the care planning and decision making processes. Care plans considered people's religious and spiritual needs. Records for one person showed that the person's faith had been considered when devising and implementing their care plan. Discussions with the person and their family had taken place to ascertain how much involvement the person wanted to have with regards to the impact their religion had on their preferences and choices. The person's religious needs were also considered with regards to the impact their religion had on their dietary requirements and within their end of life care plan.

Good

Is the service responsive?

Our findings

People, relatives and visitors told us that people were happy and led fulfilled lives. A comment on an online review website from a person living at the home stated, 'Residents needs are always at the forefront of everything that they do, even at the end of a long-shift staff will go that extra mile to make sure that you are comfortable and there is always a friendly goodbye'.

People had detailed and person-centred care plans that reflected their needs, abilities and preferences. This ensured that staff were provided with relevant and up-to-date information to guide their practice and to ensure that people were supported according to their needs and preferences. Prior to moving into the home, as well as when people first arrived, their needs were assessed and numerous care plans were devised, dependent on their needs and these were included within their care records. These care plans contained specific information about people's abilities and needs in relation to their physical, mental, emotional and social well-being. People and their relatives were involved in the development and on-going review of care plans. Comments from people included, "They discuss changes with me" and "We are having a review next week to discuss how the plan is working". A relative told us, "We have been fully involved in the care plan". These reviews helped to ensure that care plans were person-centred and reflected people's wishes. Care plans provided staff with detailed information to guide their practice. For example, care plan records for a person who was diabetic informed staff of the signs and symptoms to look for if the person's blood glucose levels became too high or too low. The level of person-centred detail in people's records, in relation to their healthcare conditions as well as their social needs, meant that staff were provided with sufficient guidance to ensure that people were supported in accordance with their needs and in the way that they preferred.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify record, flag, share and meet people's information and communication needs. Although staff had not received AIS training they had ensured people's communication needs had been identified and met. Staff told us this was looked at as part of people's initial assessments and formed their plans of care. Care plans contained details of the best way to communicate with people. Information for people and their relatives, if required, was created in such a way so as to meet their needs and was in accessible formats to help them understand the care available to them.

People had access to both one-to-one interaction and group activities and entertainment. A relative told us, "They [staff] have improved my relative's communication abilities by helping them to develop confidence. They were isolated at home. Here they see them regularly; they check on them and go to them when my relative calls. My relative is not really interested in the activities because they aren't one to mix much, but they go to watch a film sometimes. Staff always ask them". People had access to a variety of activities, such as external entertainers, arts and crafts, PAT dogs, (Pets as Therapy), Zoo lab and musicians. In addition, staff had recognised the positive impact interacting with younger people could have on older people, particularly those living within care homes. They had contacted local schools and had arranged for children to visit the home to sing Christmas carols. The provider had implemented an initiative across some of their

homes and had introduced a 'wishing tree'. This had been made and people and their relatives had been encouraged to write down people's wishes and pin these to the tree. Each month a wish would be picked from the tree and granted. Plans were then made to support people to fulfil their wish. One person had wished to go on a safari. Although this was not something that could be accommodated in its entirety, the person had been supported to visit Marwell Zoo to see animals that would be seen on a safari. The registered manager told us, "The wishing tree gives someone the opportunity to do something that they used to do or always wanted to do".

People could choose where they spent their time, some spending time in the communal areas of the home, whilst others chose to spend their time in their own rooms. People were provided with a call bell so that they could call for assistance from staff and had timely access to assistance and told us that when they used their call bells staff responded promptly. For people who were unable to use a call bell, due to their capacity and understanding, pressure mats were used so that when people mobilised staff were alerted and could go to the person to offer assistance. One person told us, "I only need to ring my bell and they come to see what I need. They come quickly". Records showed that dedicated activities staff had spent time with people, undertaking one-to-one activities to meet their social and emotional needs. Observations showed that staff took time to interact and communicate with people when undertaking tasks or offering support. The registered manager had recognised that this was an area for further development and had arranged for care staff to undertake qualifications in activities provision. They explained that this would enable staff to develop skills in interacting and initiating activities with people and was something that they hoped to implement amongst the staff team. People, their relatives and visitors were complimentary about the activities and entertainment that was provided. One person told us, "I like the entertainers and singers". Another person told us, "Next week 35 children are coming to sing Carols". A visitor told us, "They organise good events, they raised money at a garden party and the fete was successful and well attended by the community".

People were informed of their right to make a complaint when they first moved into the home. Posters were displayed that informed people of the complaints procedure and comments boxes and questionnaires were available for people, relatives and visitors to use to make their comments and concerns known. People told us that they knew how to make a complaint and would feel comfortable doing so, without the worry of any repercussions to their care. Regular meetings as well as care plan review meetings provided additional forums for people to make their feelings known. People told us and records confirmed, that people were able to speak freely and air their views and concerns. Complaints that had been made had been dealt with in accordance with the provider's policy and demonstrated that the provider was transparent and open with people who used the service. A relative told us, "Staff and management are very open. I wouldn't see any problem making a complaint and would trust them to answer it". The management team and staff demonstrated a reflective approach to their practice and were constantly reviewing how they worked and learned from instances. For example, changes to practice had been implemented as a result of some medication errors that had occurred.

Some people were able to plan for their end of life care. Staff had respected that some people chose not to discuss their wishes, however, others had chosen their preferred place of care, who they would like with them at the end of their lives and their funeral arrangements. Staff received support and advice from external healthcare professionals to ensure people experienced a comfortable and pain-free death. The provider took precautions to ensure that they were prepared for people's conditions deteriorating. Advice had been sought from external healthcare professionals, equipment hired and anticipatory medicines had been prescribed and were stored at the home should people require them. Anticipatory medicines are medicines that have been prescribed prior to a person requiring their use. They are sometimes stored by care homes, for people, so that there are appropriate medicines available for the person to have should they

require them at the end of their life. Relatives were welcome and able to spend time with people at the end of their lives. Observations of people who were receiving end of life care showed that people were supported according to their wishes and staff attended to people's needs to ensure their comfort.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection on 4 and 5 August 2016, the provider was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This was because the provider had not notified us of two safeguarding enquiries that were being conducted by the local authority. Providers are required to inform CQC of these enquiries to enable us to have oversight to help ensure that appropriate actions are being taken. Following the inspection the provider wrote to us to inform us of what improvements they would make. At this inspection it was evident that improvements had been made and the provider was no longer in breach of the regulation. Notifications, to inform CQC of events and incidents that occurred at the home, had been sent. It was recognised that the registered manager had made significant improvements since being in post, however, there remains a concern regarding the overall ability to maintain standards and to continually improve the quality of care. This is the third consecutive time that the home has been rated as Requires Improvement.

Records, in relation to people's care and treatment, were not always consistently maintained. For example, some people, due to being at increased risk of developing infections, had their fluid levels monitored. However, records showed that these had not been completed consistently or in their entirety. Other records, to monitor the application of topical creams to support people's skin integrity, were also not completed in their entirety. These incomplete records did not provide staff with guidance as to the care a person had received and made it difficult to determine if people had received appropriate care or if staff had failed to complete the required records. Records of people's care needs were sometimes inconsistent. Some people had robust and detailed care plans to inform staff of their specific healthcare needs. However, one person who had a specific healthcare condition did not have documented guidance to inform staff's practice of the signs that might indicate changes in the person's condition that would require further attention.

The sufficiency and maintenance of records to ensure that people's care needs are consistently met and maintained is an area of concern. As the home has been rated as Requires Improvement for a third consecutive time. The registered manager had not sufficiently assessed, monitored or improved the quality and safety of the service provided. This related to the completion of records to document people's care, the assessment of risk and an inconsistent approach to assessing people's capacity and ensuring that people were not being deprived of their liberty unlawfully. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection, the registered manager had only just started in their role and had not yet registered with CQC. At this inspection, the manager was now the registered manager and it was evident that they and their team had worked hard to identify shortfalls and make improvements. A registered manager is a '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 home is run. The management team consisted of the registered manager, the deputy manager and team leaders. The management team was also supported by an operations manager who frequently visited the home. People, relatives, visitors and staff were complimentary about the leadership and management of the home. Feedback within a recent residents' survey simply stated, 'Well-run'. A visitor told us, "They are both

[registered manager and deputy manager] approachable and acknowledge and greet you in a friendly manner. You can speak to them at any time". One member of staff told us, "The manager is a good support".

Warmere Court is one of a group of services owned by a national provider, Shaw Healthcare Limited. It is a purpose built building with accommodation provided over two floors which are divided into four smaller units each comprising of ten single bedrooms with en-suite shower rooms, a communal dining room and lounge. The home also contains an unregulated day service facility where people can attend if they wish, as it is not regulated it therefore did not form part of our inspection.

The management team were competent and held appropriate management or nursing qualifications. They ensured that staff felt supported and equipped to support people effectively. Staff told us and observations showed, that management had a visible presence in the home to ensure that both people and staff knew who to approach if they had any queries or concerns. Staff told us that they were involved and kept informed of any changes within the organisation. Records demonstrated that the provider was open and transparent with staff, regardless of their roles, through a range of regular meetings. Staff had access to regular one-to-one meetings with the management team and told us that they could approach management at any time if they had any concerns or needed further support. Staff were provided with regular feedback on their practice to enable them to reflect on and develop their knowledge and skills to improve the support that people received.

There was a relaxed, friendly and welcoming atmosphere and people, relative and visitors consistently told us that the home was a nice place to live and that people were happy. A comment on an external care home review website, completed by a person living at the home, stated, 'I had never imagined that I would live in a nursing home, like most people I had seen television reports of ill-treatment and very bad care. I am so pleased that I decided to give Warmere Court a try and now it is my home and will be for a very long time, I hope'.

A quality management system was in place and both manual and electronic quality management systems ensured that regular audits of the service, which included quality of life audits, were conducted by the registered manager and other external senior managers and were monitored by the providers' quality team. Action plans as a result of the audits were implemented and monitored to ensure that any improvements that needed to be made were completed appropriately and in a timely manner. The local authority also undertook their own quality monitoring visits to ensure that the home was a safe and suitable place for people to live. There were good systems and processes in place to ensure that the home was able to operate effectively and to make sure that the practices of staff were meeting peoples' needs. There were good quality assurance processes in place. There were mechanisms to obtain feedback from people and relatives to enable the management team to have an oversight of the service people were receiving. This ensured that people were receiving the quality of service they had a right to expect.

People, relatives and visitors told us and records confirmed that the provider and registered manager demonstrated their awareness of the Duty of Candour CQC regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons'. The provider was aware of their responsibility to comply with the CQC registration requirements. They had notified us of certain events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. Staff were encouraged to identify areas that could be improved upon and discussions had taken place in regular staff meetings. A whistleblowing policy informed staff of their responsibilities to raise any concerns. A whistleblowing policy provides staff with guidance as to how to report issues of concern that are occurring within their workplace.

The provider and management team had developed good links with the local community such as local schools. Relationships with external healthcare professionals and local authorities had been developed to ensure that people received a coordinated approach and service and staff learned from other sources of expertise.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations 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 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014. Good governance. Regulation 17 (1) (2) (a) (b) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. The registered person had not ensured that systems and processes were established and operated effectively to: Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Maintain securely an accurate, complete and contemporaneous record in respect of each service user,

The enforcement action we took:

Warning notice has been issued.