Warwick Park House Limited

Warwick Park Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection was undertaken on 1, 6 and 28 September 2016. The first day of the inspection was unannounced. Warwick Park Care Home Care Home provides nursing and residential care for up to 50 older and younger adults, some of whom are living with dementia or who may have physical or sensory health needs.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

On the first two days of the inspection 45 people were living at the service. At the time of the inspection the provider was involved in a pilot project with the NHS and local hospital, to help facilitate faster hospital discharges. Thirteen of the 50 beds at the time of the inspection were contracted by commissioners for this purpose. During the inspection, due to our concerns, admission to these beds was stopped by the provider.

Accommodation and facilities at Warwick Park Care Home Care Home are over two floors, with access to the lower and upper floors via stairs or a passenger lift. There are some shared bathrooms, shower facilities and toilets. Communal areas include two lounges, a dining area, a conservatory, a patio seating area and a garden.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are "registered persons". Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act

2008 and associated Regulations about how the service is run. The manager was also the registered provider.

At the previous two inspections (December 2014 and March 2015) we asked the provider to take action and make improvements. This was because care was not always safe, personalised and consistent; there were not sufficient staff to meet people's needs in a timely way and, the systems in place to monitor the quality of the service were ineffective. People were not protected from risks associated with their care. People were also at risk of not receiving their medicines as prescribed. People's records were not completed accurately to reflect care given.

At the unannounced comprehensive inspection of this service on 22 and 23 March 2016, breaches of legal requirements were found. We served Warning Notices on the registered provider. Warning notices are part of our enforcement policy and tell the provider where they were not meeting their legal requirements. They had to have put this right by 18 June 2016. An action plan was submitted by the provider on May 2016.

This inspection was to confirm that the service now met legal requirements. Following the first two days of our inspection, we found although there had been some improvement, we had continued concerns about people's safety and medicine management, a lack of consistent and personalised care and the systems in place to monitor the quality of the service remained ineffective. We shared our concerns with the registered manager and the local authority. The registered manager took an immediate decision to stop admissions to the short term discharge beds. A further action plan was submitted on 14 September 2014 to address concerns raised on the 1 and 6 September 2016. On the third day of the inspection, 28 September we found systems and processes had been developed which would support people living at the service to be kept safe. However, these systems were very new and would require considerable time to be implemented and improve practice. Following the inspection on 11 October 2016 an updated action plan was submitted to CQC detailing the actions the provider planned to take following inspection feedback.

There were problems with medicine management. We were unable to tell whether people had received all their medicines. Antibiotics did not always match what was recorded on the medicine administration records (MARs) and one person had a medicine available for chest pain that was not written on the MAR. Staff told us they would not know when to give that medicine. Additionally, we found, body maps did not give staff clear direction about where and how skin creams should be applied, and MARs did not record these being administered.

Care plans and a new care planning system were in the process of being implemented. The care plans we reviewed on the first day of the inspection lacked sufficient detail and guidance for staff. Important information about how to meet people's needs in relation to their health was lacking, for example how to care for people who had epilepsy or were vulnerable to skin damage. End of life care plans were insufficient and lacked information about how people may wish to receive care at this stage of their life. On the second day of the inspection the new "business manager" showed us an example of a care plan they had developed. They intended to implement these new, more detailed and personalised care plans for all people. These would to help guide staff to deliver effective and responsive care.

Risk assessments were in place but were not always correctly completed and risks were not carried through to people's care plans and the care they received. For example, not all people who had skin damage and who required regular moving to maintain their skin integrity received the care they required. During the inspection process action was taken to address people's risks and risk management in a more robust way.

Care provided did not always match the identified needs in people's care records, for example exercises to

help with people's mobility or being moved to maintain their skin condition at the intervals their care records advised. Food and fluid charts were completed but we found the amounts recorded did not always match what people had consumed and the recording was not always an accurate reflection of what they may have had.

People's health needs were not always met because of inadequate care planning. Poor record keeping also made it difficult to establish if people had received the care they needed. Health and social care professionals we spoke with gave us mixed feedback about people's care and their confidence in the registered manager's ability to action and embed learning from safeguarding feedback. However, they told us they were more confident in the new business manager's ability to improve the quality of care at the service.

The systems and process introduced to monitor quality since the previous inspection were not well understood by staff. Staff did not always understand what they were auditing. Some completed audits had identified what we found during the inspection, but these areas had not been followed up. Other audits undertaken for example, on care plans had not identified the concerns we found.

Most people we spoke with told us they were happy, the food was good and they felt cared for. We observed kind interactions between people and staff throughout the inspection.

The registered manager attended forums where best practice was discussed and had completed a locally run leadership course. Leadership and governance of the service had been considered following the last inspection and new key roles had been appointed, for example, a head of care and a new business manager. The new business manager intended to go through the registered manager process and the current registered manager intended to take on a training and overview role. The provider had made these decisions in order to drive future improvements and the implementation of the service's action plan.

Following the inspection feedback from the first two days of the inspection, the registered manager made a decision to stop some of the admissions to the service to enable the service to reflect and consider the action they needed to take immediately to ensure people were safe. The service considered how they were going to improve care planning, risk assessment, medicine management and quality monitoring of the service. An action plan was submitted to CQC on 14 September 2016 which had been developed in collaboration with the local authority improvement team. This action plan updated at the end of the inspection and a new one covering all areas of concern submitted to CQC on 11 October 2016.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

We found that action had been taken to improve aspects of safety however; the service was not always safe.

People's medicines were not always managed safely.

People were not always protected from the risks associated with their care and health conditions.

People were not protected from abuse as the correct procedures for safeguarding reporting were not always followed.

Staffing levels met people's needs.

Is the service effective?

Inadequate

The service was not always effective.

People were cared for by staff who had received training to meet their needs; the programme of staff training was ongoing to develop staffs skills further. More robust supervision processes were implemented during our inspection to help support staff development.

People told us staff always asked for their consent and respected their response. However, there was a lack of understanding amongst staff regarding the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

People were positive about the food however, further improvements were needed particularly for vulnerable people and those at risk of poor nutrition.

Is the service caring?

Requires Improvement

Aspects of the service were caring.

People told us they felt cared for and supported in making decisions regarding their care and treatment but this was not always well evidenced in care records.

End of life discussions and planning were not evident to reflect how people might wish to spend their last days or reflect their wishes.

People's feedback was mixed but most people told us they felt cared for.

Is the service responsive?

Inadequate

The service was not responsive.

People did not have personalised care plans in place which reflected their current needs, however these were beginning to be improved, developed and embedded.

People's care plans lacked the guidance and direction staff might require to meet people's care needs.

Activities at the home were limited but people told us they enjoyed the external musicians when they visited and staff were already looking at how they could make improvements.

People knew who to talk to if they had a complaint. There was a process for investigating complaints.

Is the service well-led?

Inadequate

The service was not always well-led.

There was a new management structure in place to help develop the leadership of the service.

Systems in place to monitor the quality of care were not effective. Systems were being developed, but these required implementation and the action plan required close monitoring.

The registered manager was receptive to inspection feedback and to working collaboratively with external agencies to improve people's care and the quality of the service.

Warwick Park Care Home

Detailed findings

Background to this inspection

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

We undertook a comprehensive inspection of Warwick Park Care Home on 1, 6 and 28 September 2016. The first day of the inspection was unannounced. This inspection was completed to check improvements to meet the legal requirements after our comprehensive inspection on 22 and 23 March 2015.

The inspection team consisted of one adult social care inspector, a specialist nurse advisor of older people's care, a pharmacy inspector, and an expert by experience – this is a person who has experience of using or caring for someone who uses this type of service.

Prior to the inspection we reviewed the information held by us about the service. This included notifications we had received. Notifications are reports on specific events registered people are required to tell us about by law. Before the inspection we also sought feedback from professionals involved with the service. This included three health and social care professionals from the local authority.

During the inspection we spoke with 13 people who lived at the service and three relatives. We asked them their views about the service and their care. We looked at the care of six people in detail to check they were receiving their care as planned. We spoke with them where this was possible. We discussed the care needs of all people in general with the head of care, the registered manager and the new business manager. We attended a staff handover. We looked at the systems in place for managing medicines.

We spoke to staff involved in the administration of medicines and observed medicine administration. We spoke and met with 17 staff during the inspection period. We observed how staff looked after people in the lounges and observed lunch. We also spoke with four visiting professionals during the inspection about people's care.

We spoke with the registered manager, head of care and the new business manager about improvements

made since the previous inspection. The business manager had started on the first day of the inspection. During the inspection period, the registered manager submitted a new action plan. We reviewed this with the registered manager and business manager on the third day of the inspection and reviewed the new care planning documentation and checklists which had been developed. We reviewed the records the provider kept to monitor the quality of the service, audits, training records, supervision records and maintenance records.

Inadequate

Is the service safe?

Our findings

At the last inspection in March 2016 we found there were not always enough staff present to care for people safely, medicine management was not safe, and infection control practices were not robust. We also found risk assessments were not always reflective of people's identified needs, updated accurately and followed. We told the provider they had until the 18 June 2016 to put this right. At this inspection we found improvements had been made in relation to staffing and infection control practices however, further improvements relating to the management of medicines and risk assessment was required. Although the registered manager and staff were making changes to the way medicines were managed, at the time of inspection people's medicines were not always managed safely.

During our inspection we looked at the systems in place for managing medicines. Although managers and staff were making changes to the way medicines were managed, at the time of inspection people's medicines were not always managed safely.

At our last inspection, it was not always possible to check that people were getting their medicines as prescribed. During this inspection, we saw that staff recorded people's medicines administration on medicine administration records (MARs), but that some people's MARs were not completed accurately and contained gaps. Staff were recording a stock balance of all medicines administered, but the number of tablets recorded as being given and signed as given on the MAR did not always tally with the number of tablets in stock. One person had been prescribed a course of antibiotics. The number of signatures of the MAR showed they had three doses still to take, however we found there were four doses left. We saw that one person had a medicine in the trolley to be given when needed for chest pain, but this did not appear on their MAR. Staff administering medicines told us that they would not know when to give this particular medicine. This meant it was not possible to check that people were getting their medicines in a safe and effective manner, as prescribed.

Staff wrote MARs by hand for people who had did not have a printed MAR supplied by the pharmacy. We saw that most hand-written MARs contained no signature to show which staff member had written them or whether they had been checked for accuracy. We saw one hand-written medicine contained no information about the dose to be given, although this information was available on the pharmacy dispensing label. The National Institute for Health and Care Excellence (NICE) recommend that handwritten MARs should be checked for accuracy and signed by trained staff to reduce the risk of errors.

Although information about people's allergies to medicines was recorded on medicine profiles or allergy warning cards, staff did not record this information on MARs. Information about people's allergies to medicines should be identified on the MAR to ensure staff have knowledge of it at the point of administration.

Creams and other external preparations were applied by care staff that were not always trained to give medicines. Guidance and direction on where and how to apply these preparations was not always available to staff. We saw that one person had a body map in their room showing where staff should apply different

creams. Another person, who had moisturising creams and steroid creams on their MAR, had no body map and staff recorded application in the daily notes. Moisturising creams should be applied liberally but steroid creams should be applied thinly to avoid skin damage. This information was not available to care staff applying the creams in people's rooms. This could mean that people were not having creams applied as prescribed by their doctors or in a way that kept them safe from skin damage.

Medicines were stored in locked cupboards, medicines trollies or in the medicines fridge. Staff recorded the maximum, minimum and actual temperature of the fridge. Although records showed that the fridge was in the correct range for storing medicines (2-8°C) during July and August 2016, we saw that a maximum temperature of 26.8°C was recorded for a period covering five days in June. The record did not show what action staff had taken and when asked, the staff member who had recorded the temperatures could not explain what they had done to make sure medicines in the fridge were safe to use or what they would do in the future.

While guidance was available for staff to give non-prescribed medicines if needed, we saw that one copy of the 'homely remedies' list was out of date and the other in date copy, had not been signed for use in the home.

Staff obtained medicines from a community pharmacy. We saw that some people had missed doses of their medicines as they had run out. Staff explained that sometimes people had to register with a new doctor when they moved to the home and this can cause a delay in obtaining medicines. One person, who had run out of a tablet to treat a mental health condition, had missed two doses. During the inspection, staff arranged with the doctor and pharmacy for the medicine to be delivered, so the person could take their medicine that evening.

People did not always receive their medicines safely. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff gave people their medicines in a safe and caring way. Staff asked people if they needed any medicines that were prescribed to be taken when required. People told us that they could call staff if they needed medicines outside of the set medicines round times.

Staff with responsibility for giving medicines had received appropriate training. Managers showed us records of staff competency checks to give medicines, which were ongoing. A relatively new staff member told us, although they had worked with medicines before, they had attended an external medicines training course since starting working in the home and was supervised by managers when they started to give medicines.

We saw that managers were auditing medicines processes and staff told us they reported medicines errors.

By the third day of the inspection, considerable progress had been made in the management of medicines. A medicine audit had been undertaken, stock control issues actioned, a new topical MAR had been developed and staff training was in progress. We saw issues identified from audits between the 6 and 28 September 2016 had been discussed in a supportive way with staff to help embed learning and development.

Risk assessments were in place which addressed people's risks of falls, malnutrition and risk damage. However, we found these were not always completed and reviewed accurately. For example, staff had not followed the scoring system of the risk assessment tools to achieve the correct level of risk which meant they may not be receiving the correct level of care.

We found one person had two risk assessments in place for falls, one which stated they were high risk, the other saying medium. This person had a mobility care plan to maintain their safety which included walking with two staff however; we saw them walking alone with different equipment. Staff told us the person wanted to be independent but their risk assessment and care plan did not reflect how staff should try to minimise the risk of falls. We spoke with the registered manager about the discrepancies we found with the risk assessments and they agreed further training was required so all staff understood how these should be completed.

Another person we met had three pressure ulcers. The information the home had received prior to their admission, indicated they were at very high risk of skin damage, required regular repositioning and their feet elevated. Staff we spoke to said they did not know this and the person told us they were not repositioned frequently and their feet were not elevated at night. We fed back our concerns to the registered manager.

A further person we met was also at high risk of skin damage. Their risk assessment identified this, but the information in their room, their care plan and staff we spoke with, gave three different pieces of information regarding how frequently they should be moved (one, two and four hourly). Staff told us the person was checked hourly and repositioned two hourly, however the person's records did not indicate this, for example on 31 August 2016 we found they had not been moved for four hours and then six hours. This meant, the person's risk assessment, care plan and staff's understanding of the care they needed, and documented care given, did not evidence they were receiving the care they required to maintain their skin condition.

Body maps were in place which recorded some of the injuries sustained from accidents or areas of skin damage. However, we found these were inconsistently completed, bruises were not always noted on the body maps and we found external agencies had not always been informed of injuries which may warrant investigation.

People did not always receive safe care because there was not clear guidance in place which all staff had read so they would know how to reduce risks. For example, one person had very contracted limbs, epilepsy and advanced dementia. Their care plan gave no guidance to staff about how to provide their personal care so they were not injured and no guidance was in place regarding management of their epilepsy. We asked the registered manager to update this person's care plan as a matter of urgency and this was actioned by the second day of the inspection.

New "intentional rounding sheets" had been developed since the previous inspection to record the checks staff undertook. These were in place but did not always match people's risk assessments and care plans. A new staff handover system was in place so changes were documented and shared more frequently as the staff team changed shifts however, we found these were not always completed.

The management of risk related to poor nutrition and hydration was not always followed according to the provider's policy. The amounts recorded did not always match what people had consumed and although these were totalled at the end of the day, the action staff were to take according to the new reporting policy was not always followed. This meant people may not get the prompt help they needed to manage risks related to their nutritional needs.

People's risk assessments were not always in place as necessary, followed, updated accurately and reviewed effectively. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

By the third day of the inspection the service had reviewed the way they were monitoring people's risks and

documenting the care given. New paperwork and checks were in place to monitor those who had skin wounds, catheters, diabetes and other health needs. Staff shared information about people's risks at their handovers and staff were allocated to follow up specific requests. We observed this new way of working on the 28 September 2016. These changes required further time to embed.

We spoke to the registered manager and business manager about their understanding of safeguarding and when to report incidents which might occur. They agreed refresher training was required to improve their understanding and told us "The threshold is much lower than I was doing." The registered manager had been internally investigating concerns or bruises but had not realised when they might need to let CQC or the local safeguarding team know of alleged abuse.

An incident occurred during the inspection period, we were informed of this by the registered manager on day three. After a discussion, they understood they needed to make a safeguarding alert as the incident had put people at risk of neglect. On the 28 September 2016, the registered manager advised us staff had a new computer so they would be able to raise safeguarding alerts themselves.

Systems and processes in place were not robust to identify potential abuse and report allegations of abuse of service users. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had a safeguarding action plan following previous alerts which had been raised. The recent recommendations from the local authority safeguarding team replicated our findings during this inspection. The service and registered manager had begun work with the local authority to address issues raised from alerts made and the previous two inspections. This plan detailed issues which had been raised and the action required to address any areas. The new checks and systems in place needed further time to embed into practice to keep people safe.

All the people we spoke with told us they felt safe at the home and felt confident talking to staff if they were worried about anything. Clear guidance was available to staff and displayed on the staff noticeboard so all staff knew procedures for reporting safeguarding when identified.

At the previous inspection there were concerns regarding infection control practices and the safety of the environment. The registered manager had taken action to ensure door guards had been removed, areas which were not safe were locked and the water was regulated so people were not scalded.

Regular cleaning checks occurred and we found the service was clean and free of odour during our inspection however, we noted a lack of storage space within the service for medicines and equipment so the clutter in some areas made it difficult to clean. The registered manager told us they would find storage space so bathrooms were not used for equipment.

At the previous inspection there was not sufficient staff on duty to meet people's needs in a timely way. The registered manager had taken action to address these concerns and introduced a new call bell response system. A daily dependency tool was completed to ensure there were sufficient staff to meet people's needs safely. Staff were recruited safely and underwent the required checks to ensure they were safe to work with vulnerable adults.

Inadequate

Is the service effective?

Our findings

At the last inspection in March 2016 we found people's mental capacity was not always being assessed which meant care may not be given in line with people's wishes. We also found care records did not clearly record people's health needs for example, those who might need their food and fluid intake monitoring or their weight. Additionally, we found staff did not always receive appropriate training, professional development and supervision to enable them to carry out the duties they were required to perform. The provider had submitted an action plan. This advised training in mental capacity would be accessed, there would be clearer recording of people's capacity to consent to their care, and advice would be sought from professionals in relation to Deprivation of Liberty (DoL) applications. We were told care plans and records would be updated to reflect people's health needs and staff action. The action plan told us staff training would be accessed to develop staff skill. We did not find significant improvements in this area.

During this inspection we checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. We found these laws were inconsistently understood by staff.

The 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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found some staff had a better understanding of the Mental Capacity Act and we observed consent was always obtained prior to care being given.

However, there was still confusion amongst staff in their understanding of the Mental Capacity Act and people's mental capacity assessments were incomplete and inaccurate. For example, some people had capacity but their assessment said they did not. Staff told us they discussed people's care with a range of professionals and the family where appropriate. This process ensures any decisions were made in the person's best interests and these were now recorded. However, staff also told us they were making best interest decisions where people had capacity. This is not in line with the Mental Capacity Act (2005) code of practice.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had applied for DoLS on behalf of all people who might require one and those people who would not because they had capacity. We spoke to the registered manager and business manager during feedback about further training and education to help staff grasp these complex laws.

The legislative framework of the Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards (DoLS) were not being followed correctly. The principles and codes of conduct associated with these laws were not followed. This is a breach of Regulation 11 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

By the third day of the inspection, the business manager had introduced new consent tools which were related to individual decisions. These would support staff to assess people's capacity. Following the inspection, the business manager told us "In terms of MCA and safeguarding we have spoken with QAIT and they are coming in to carry out a training session about rights and risk taking. We have also identified an MCA champion and are currently looking for additional training for both her and the wider staff group. All consent documentation and accompanying MCA assessments and best interest checklists have been reviewed and replaced on a new decision specific and more detailed tool."

People's health needs or conditions were not clearly recorded; advice sought from professionals was not always recorded and care plans were not reflective of people's needs or updated as people's needs changed. This meant it was difficult to know whether people were receiving the support they required to maintain their health.

New communication and handover processes were in place by the third day of the inspection. We attended staff handover to observe how the new handover and communication systems were working. We spoke to staff who told us "There is better delegation and sharing of information"; "Staff are allocated areas now which is better"; "It's a bit early to know; we're working on care plans and have a prototype of how they should be"; "The information and documentation in people's rooms is simplified – three recording sheets in to one, much better"; "The DTAs (these are short term, discharge from hospital beds) not being here has lifted the pressure; but everything's so new, it's been so rapid"; and "We need more time." The head of care told us "We desperately want to get this right; we feel positive about the changes." During this handover we observed a team working hard to communicate well, a less rushed atmosphere and more organisation.

Nutritional screening tools were in place, but these were not understood and not always completed correctly. Food and fluid monitoring charts recorded people's intake and output when there were concerns, but these were not accurate. For example, one person who had a full water bottle had been recorded to have drunk far more than the amount they had sipped from the bottle. Staff were not sure the quantity of fluid different containers held. We found the rationale for having people on food and fluid charts was not clear. For example, on some days people's forms were competed whereas on other days they were not. The provider's guidance for referring concerns to the GP were not always followed. For example, there were instructions for staff to call the GP if people's fluid intake was under 1000 mls. However, one person we met with advanced dementia rarely had over 550 mls but we were unable to see a record that the GP had been informed although staff told us they were aware. The person's health conditions meant they were totally dependent on staff to care for them.

We also found that people's weight was recorded when there were concerns but staff did not always think about what they were recording and did not always identify errors. For example, when a person's weight had dropped by 10kgs in a short space of time. This was clearly an error as the extremely low weight recorded (20kgs) was outside of parameters for an adult.

We spoke to the registered manager and business manager about our concerns related to people's weight records and food and fluid intake recording. When we returned on the third day of the inspection, picture charts had been developed so staff knew the amount of fluid a cup held. The registered manager also advised she would teach all staff how to complete the assessment tools and they showed us the competency check they intended to use.

The kitchen staff were positive and passionate about the meals they cooked. Food was homemade and

nutritious. A survey had been carried out by the chef asking people what they might like on the menu. We were told the chef went out of their way offering a variety of dishes such as octopus, haggis for a Scottish gentleman and fresh fish dishes. The kitchen staff had the information they required about people who required a special diet. People told us "I choose to have breakfast in my room, staff bring it to me on a tray, there is usually the choice of four dishes, and I would say the food is very good."

Staff had received training since the last inspection in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS), dementia, dignity and respect and tissue viability. We spoke to the business manager and registered manager about supporting staff to understand the training they had received through supervision and competency checks.

We reviewed supervision records on the first day of the inspection and the third day of the inspection. On the first day we were concerned about the quality of supervision records and discussions held. The new staff supervision sheets we saw on the third day were more comprehensive and supportive of the discussions held. The new competency assessment tools would be used to further enhance staff learning. Staff told us these new competency tools would be "a continuous process – formal training, observation of understanding and verification through checking." The new system scored staff competency from novice to expert so the management team would know the support each staff member required.

We spoke to the registered provider about the design and environment at Warwick Park Care Home. There were two lounges (the red and blue lounge), a dining area, a small conservatory and outdoor terrace space. There were not enough seats if people at the home wished to sit in these areas and not in their room. The red lounge over lunch was chaotic with people, staff and equipment; people were queuing to try and get in and out. There were not enough tables and chairs for people to sit at if they wished to eat their lunch at a table. The blue lounge had the nursing station and was used for staff handovers. This meant three times a day the people's lounge was filled with staff and not an area where people could relax. The layout of this room in particular was more like a ward environment rather than a lounge. As we looked around the home, we saw bathrooms cluttered with equipment and used for storage. The registered manager listened to our feedback and was going to think about how they could make changes.

Requires Improvement

Is the service caring?

Our findings

At the previous two inspections (December 2015 and March 2016) we found people were not always respected and involved in their care, treated with kindness and people's privacy and dignity were not always supported. Additionally we found care records were poor, end of life care was not planned and people were not involved in their care planning. We found some improvements had been made but action was still required.

People's feedback was mixed. People shared with us, "On the whole, staff are wonderful, we have a lot of choice here"; "Staff are wonderful, friendly and caring; some sit and talk to me. There is a mixture of personalities, some treat me with respect, some don't"; and "Staff are polite, respectful and joke with me. They listen and spend time with me."

People's care records lacked detail to enable staff to provide personalised care and because staff had not read everyone's care records, they did not know the people they were caring for well, particularly those unable to verbally communicate with staff. For example, one staff member we spoke with knew very little about the person they were about to provide personal care too. They didn't know how to communicate with them through touch because they couldn't hear. Other care plans we reviewed suggested staff talked to people to ascertain their pain; however these people were unable to talk. Most care plans detailed information about people's needs but they were disorganised. For example, information wasn't in the right place; information was inconsistent and sometimes inaccurate.

People's end of life care wishes were not recorded; so staff may not know how people wished to be cared for at the end of their lives. We visited one person who was at the end of their like, there was very little recorded for staff to know how they or their family might want their last days to be.

People's care was not always reflective or appropriate to their needs. This is a breach of Regulation 9 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

There were four double rooms at Warwick Park Care Home. These rooms were allocated to the DTA beds (short term discharge from hospital). Staff tried to maintain people's privacy and dignity in these rooms by a curtain divider. People had no choice of room when they came as a DTA client. The staff at the home and registered manager were aware of the limitations of these rooms and told us it was like a "hospital system." They explained, if people disliked sharing and a single room was available, they were offered one.

The staff we met throughout the inspection spoke in a caring way about people. Some staff we spoke with knew little about people's background, but realised why this was important and explained it helped to enable positive relationships to be formed with people. However, the interactions we observed were warm and genuine, gentle and staff were patient with people.

Staff told us of the things they did to make people feel they mattered. For example, the chef had made a haggis meal for one person who came to live at the home; they were Scottish and missing their home.

One staff member told us they had noticed one person was low in mood. When they asked why the person explained, it had been because they did not have any toiletries. So staff went out and bought the person what they needed. Another member of staff had bought a detangling hair product with their own money, knowing that it would be useful when combing one person's hair. Staff told us they had bought prune juice out of their own money, for a person who liked this and it was now on the menu for residents to have.

A member of staff stated that a resident had 'nick names' (complementary) for all the members of staff, this seemed to be a sign of friendliness by the staff towards them. We spoke to the registered manager and business manager during feedback about checking with people the names staff used to describe people; this was because one person told us they had overheard staff calling her a "miserable person", which had upset her.

Special occasions were celebrated, for example birthday cakes were made for each person on their particular day. People's cultural needs were met and people were supported to go to church if they wished.

Inadequate

Is the service responsive?

Our findings

At the previous inspection (March 2016), we found the recording of people's care was not always personalised or consistent across all records. Care records had significant gaps and staff were not always able to tell us about the care people needed or how they preferred care given. Care records were disorganised and information not recorded. We also had concerns about the lack of activities and stimulation for people. The action plan the provider sent us following the March 2016 inspection, addressed the action they were taking. However, we found improvements had not been made.

People's needs were assessed prior to coming to live at Warwick Park Care Home. Where possible people, and those who mattered to the person, and health professionals were involved in identifying their needs prior to admission. New people were encouraged to visit the service to ensure it was the right place for them. They also sought as much information of people's needs to ensure any initial care plan was able to respond to their needs. However, we found some people's assessment records particularly those admitted at very short notice had not been developed into comprehensive care plans. For example, we read in people's care records and information, conditions such as epilepsy, poor pain management, skin care needs and nutritional needs were detailed. However, care plans did not reflect people's needs or give adequate guidance to staff. The lack of information could impact on staff providing personalised care to meet people's needs for example not knowing how to communicate with people with advanced dementia.

Staff were unable to tell us how people preferred their care delivered. Staff told us they had not read people's care plans. Some care plans did have information about people but staff providing care had not read these so knew little about people, particularly those unable to speak. Staff's description of people's needs conflicted with information we read for example staff told us one person could move themselves but we read that they were paralysed from the waist down. Not all staff knew people's backgrounds and histories; this personal information about people's lives help staff have meaningful conversations with people.

Care plans and people's records were disorganised and not up to date which meant it was hard to evidence personalised care being given. For example, some people's records gave conflicting information about how often they should be checked or repositioned to maintain their skin condition. Other people's records had significant gaps so it was impossible to evidence whether care had been given as required. For example, some day's people had their food and fluid recorded, other days they did not.

Care records were not accurate, complete and contemporaneous in respect of people. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the end of our inspection, the registered manager showed us a copy of a new care plan which was going to be introduced. The care plan was more person centred and comprehensive.
Staff gave us some examples of where personalised care was delivered, for example one person had their room decorated in the pink they wanted and another person was supported to enjoy their love of football and attend football matches locally.

Relatives and visitors we spoke with told us they felt involved in discussions about their loved ones care and they felt able to contribute their views but care plans did not reflect this in all cases.

Staff told us they participated in handovers which gave them current information about people's needs or they asked one of the senior staff if they were unsure. Handovers had improved since the last inspection and staff had sheets with essential information, such as previous medical history and nutritional needs.

People were provided with some opportunities to remain cognitively, physically and socially stimulated. There was no longer an activities co-ordinator in post as they now worked as a member of care staff. There were long periods of people sitting in the lounge with the television on with no one watching the programme. People told us they enjoyed the external musicians who visited and we observed people enjoying a singer during the inspection. Staff told us this was an area they wished to improve further. We saw that people who were able, were enjoying passing the time on the terrace chatting. Staff told us they tried to make time to read to people, do their nails and sit and chat.

The registered provider told us there had been challenges with the DTA beds and the transitions between hospital, the care home and accessible, timely community support. We were given feedback by the registered manager regarding some of the issues the service have experienced and have shared these with the local authority commissioners. The registered manager told us they had raised their concerns with commissioners.

People were not quite sure how to raise a complaint but told us they felt comfortable speaking to the registered manager and other staff. The service had a complaints policy in place. This was made available to people and relatives on enquiring. The registered manager was available and talked to people about their care frequently enabling concerns to be picked up and resolved promptly.

Inadequate

Is the service well-led?

Our findings

At the last two inspections (December 2015 and March 2016), we found the quality monitoring systems were not effective in identifying areas that required improvement. The provider sent us an action plan detailing the improvements they would make by the end of May 2016. These included changes to care plans, risk assessments, staffing numbers and reviewing medicine systems. In addition, new sheets would be introduced to check people had the care they needed, nutritional monitoring would be improved and end of life care reflective of people's needs and wishes. We found the changes made had not been sufficient and audits and processes in place remained ineffective at driving change. For example, we reviewed one care plan that had recently been audited. The care plan was not fit for purpose. We showed the business manager and staff the issues we found in two care plans.

Other audits, such as the medicine audits had identified errors we found during the inspection but action had not been taken to make improvements. The auditing system was not followed through to make changes which would enhance care and reduce further errors.

Daily, weekly and monthly checks were in place but in all cases those completing the checks did not appear to understand what they were checking for or how to remedy the identified actions. For example, the issues with food and fluid intake charts had not been identified nor that care being delivered was not in line with people's care plans. The changes made and audits undertaken were not joined up; there was no oversight of audits undertaken to ensure areas of concerns identified were followed up. The action plan was not monitored effectively to ensure its proper implementation.

Systems were not in place to identify the shortfall in staff competence that we found during this inspection for example the incorrect completion of essential assessment tools.

Systems and processes in place were not established and operated effectively to ensure good governance. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the previous inspection the management structure had been changed. The registered manager informed us they wished to take on more of a training role and had appointed a new business manager. The new business manager started on the first day of the inspection, and a new head of care had also been appointed. Their role was to support and guide the nursing and care team. Although, both members of staff had not been in their new roles long they gave us confidence in their ability to facilitate change. They told us they were committed to displaying good leadership skills, staff were motivated and quality care was provided.

Following our feedback after our first two days of inspection, the senior management team had been proactive. The registered manager stopped admissions to the short term discharge (DTA) beds in order to reduce the pressure on the service and enable rapid, more robust processes to be considered.

The new business manager sent us an updated action plan following the inspection (on 11 October 2016) clearly identifying what action they were going to take, how they intended to do this, and the timescales. We saw on day three this action plan had started to be implemented although it was very early to say whether these would be effective in driving change. However, what we observed on the third day was positive. The new business manager and registered manager showed us new style care plans which were more comprehensive. We saw examples of conversations held with staff where improvement was required and the competency tool they planned to implement. We were shown improved handover documentation and improved systems to manage those people with complex health needs. A new 28 day rolling auditing system had also been developed with clearer accountability.

The action plan had been shared with staff during the inspection and we found staff were keen to deliver and were committed. The atmosphere in the home was calmer, more organised and less rushed. Staff were clearer on their purpose and roles.

The new business manager and head of care told us weekly tasks were being allocated to staff dependent upon their skills. For example, one staff member interested in wound care had been tasked with updating people's care plans where skin integrity was compromised. The administrator was completing new, up to date information sheets for people with their essential information. We were told the development of activities had been allocated to a senior care worker. Care plans were being moved from the nursing station to a private place in people's room so they were easily accessible to all staff. Staff had also been asked to read the new care plans as they were being re written and sign to indicate their understanding. Staff told us "We are working as a team, it feels good, it's empowering and there's more autonomy."

The registered manager advised that the new business manager had started the process of checks required to become the registered manager of the service.

At the last inspection we found all significant events had not been notified to the Care Quality Commission (CQC) in line with legal requirements. The registered manager knew how to notify the Care Quality Commission (CQC) of any significant events which occurred in line with their legal obligations and we had received notifications since the previous inspection.

The registered manager had systems in place to ensure the building and equipment was safely maintained. The utilities were checked regularly to ensure they were safe. Health and safety checks such as that for fire safety equipment took place regularly.

People and staff spoke positively about the registered manager and the head of care and felt comfortable approaching her. They felt any issues would be heard and acted on.

Staff confirmed they were able to raise concerns and said these were dealt with properly by the registered manager. Staff had a better understanding of their roles and responsibilities on the third day of the inspection and said they were supported by the registered manager, head of care and business manager. Staff told us the registered manager worked alongside them. Staff said there was good communication within the staff team and they were working better together.

The registered manager and provider took an active role within the running of the home. The lines of responsibility and accountability within the management structure were now clear.

The registered provider promoted the ethos of honesty, was willing to learn from mistakes and admitted when things had gone wrong. This was apparent during the three feedback sessions. This reflected the

requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment. We found the registered manager responsive to inspection feedback, reflective and keen to improve the quality of the service and care provided.

There was a whistleblowing policy in place to protect and support staff, and staff felt confident reporting concerns to the registered manager. However, an external person had also been identified that staff could speak with in confidence. The registered manager had put this in place as family members worked at the service and they wanted to ensure this would not hinder staff disclosing any information of concern.

The local authority was working closely with the service at the time of the inspection and staff and the registered manager had found the advice and support helpful. The registered manager was attending local forums where good practice was discussed and shared, and had they had also registered for a leadership course which was run locally by the local authority.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 (1) (a) (b) (c) (2) (3) (b) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care plans were not in place and did not always reflect personalised care being delivered. Documentation relating to people's nutrition and hydration were inaccurate which might lead to people's needs not being met. End of life care planning did not reflect people's needs and wishes.

The enforcement action we took:

We took enforcement action and imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11(1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff were not acting in accordance with the requirements of the Mental Capacity Act (2005) and associated code of practice.

The enforcement action we took:

We took enforcement action and imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) (c) (g) Health and Social Care Act 2008 (Regulated Activities)

Treatment of disease, disorder or injury	Regulations 2014. Care and treatment was not always provided in a safe way. The management of medicines was not always proper and safe. Risks were not assessed and mitigated to ensure the health and safety of service users.

The enforcement action we took:

We took enforcement action and imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13(1) (2) (6) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems and processes in place were not robust to identify potential abuse and report allegations of abuse of service users.

The enforcement action we took:

We took enforcement action and imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) (f) of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014. People's care records were not always complete, contemporaneous, or an accurate reflection of decision made regarding their care. Systems and processes were not in place to assess, monitor and improve the quality and safety of the service. There were not adequate systems in place to assess, monitor and mitigate risks relating to the health and welfare of service users.

The enforcement action we took:

We took enforcement action and imposed conditions on the provider's registration.