Warwick Park Care Home Limited

Warwick Park Nursing Home

Inspection report

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Tel: 01892541434

Date of inspection visit:
25 August 2017

Date of publication:
19 September 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was carried out on 25 August and was unannounced. Warwick Park Nursing Home provides care and accommodation for up to 25 older people. There were 19 people living in Warwick Park at the time of our inspection, 60% of whom lived with dementia or memory loss.

There was a registered manager in post. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection, we found the provider was in breach of the Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's mental capacity in regard to specific decisions had not been accurately assessed; Meetings to make decisions on people's behalf and in their best interests had not been held when appropriate; Staff had not received effective training in mental capacity to enable them to follow the processes required by the Mental Capacity Act 2005. At this inspection, we found that compliance with the regulation has been achieved.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options had been considered.

Staff sought and obtained people's consent before they helped them. Staff knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm. Accidents and incidents were recorded and monitored to identify how the risks of recurrence could be reduced.

There was a sufficient number of staff deployed to meet people's needs. Thorough recruitment procedures were in place which included the checking of references. Staff received regular one to one supervision sessions and all essential training for their role. Staff knew each person well and understood how to meet their support and communication needs. Staff communicated effectively with people and treated them with kindness and respect.

A new electronic system ensured that medicines were stored, administered, recorded and disposed of safely and correctly. Staff were trained in the safe administration of medicines and kept relevant records that were accurate.

The staff provided meals that were in sufficient quantity and met people's needs and choices. Staff knew about and provided for people's dietary preferences and restrictions.

People were promptly referred to health care professionals when needed. Personal records included

people's individual plans of care, life history, likes and dislikes and preferred activities. People's individual assessments and care plans were reviewed monthly or when their needs changed. The staff promoted people's independence and encouraged people to do as much as possible for themselves.

Activities were provided that were suitable for people living with dementia or memory loss. People's feedback was actively sought at relatives and residents meetings.

Staff told us they felt valued by the registered manager and they had confidence in her leadership. The manager was open and transparent in their approach. They placed emphasis on continuous improvement of the service.

There was a system of monitoring checks and audits to identify any improvements that needed to be made. A new electronic system provided the registered manager with a clear oversight of the service. The management team acted on the results of checks and audits to improve the quality of the service and care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. There was a sufficient number of staff deployed to ensure that people's needs were consistently met to keep them safe. Safe recruitment procedures were followed in practice.

Medicines were administered safely. There was an appropriate system in place for the monitoring and management of accidents and incidents.

Staff knew how to refer to the local authority if they had any concerns.

Risk assessments were centred on individual needs and there were effective measures in place to reduce risks to people.

Is the service effective?

Good

The service was effective.

Staff were appropriately trained to carry out their role. They had improved their knowledge of the principles of the Mental Capacity Act 2005 and about the Deprivation of Liberty Safeguards (DoLS). The documentation in regard to MCA processes was appropriate and demonstrated staff's understanding about the processes to follow, in line with legal requirements.

The registered manager had submitted appropriate DoLS applications and had considered the least restrictive options to keep people safe.

People were provided with a choice of suitable food and drink.

People were referred to healthcare professionals promptly when needed.

Is the service caring?

Good

The service was caring.

Staff communicated effectively with people and treated them

with kindness, compassion and respect.

Staff promoted people's independence and encouraged them to do as much for themselves as they were able to.

People's privacy and dignity was respected by staff.

Appropriate information about the service was provided to people and visitors.

Is the service responsive?

Good

The service was responsive to people's individual needs. Staff had a good knowledge of how to meet people's individual needs.

People or their legal representatives were invited to be involved with the review of people's care plans. People's care was personalised to reflect their wishes and what was important to them.

The delivery of care was in line with people's care plans and risk assessments. A daily activities programme was being provided.

The service sought feedback from people and their representatives about the overall quality of the service. People's views were listened to and acted on.

Is the service well-led?

Good

The service was well-led.

There was an open and positive culture which focussed on people. People and staff were complimentary about the manager and their style of leadership.

The manager placed emphasis on the continuous improvement of the service.

There was a robust system of quality assurance in place and as a result, action was taken to implement improvements.

Warwick Park Nursing 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 carried out to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was carried out on 25 August 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.

The provider had completed a Provider Information Return (PIR) prior to our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We considered the PIR and looked at notifications that were sent to us by the registered manager and the local authority to inform us of significant changes and events.

We looked at the care and treatment records for 12 people. We looked at people's assessments of needs and care plans and observed to check that their care and treatment was delivered consistently with these records. We reviewed documentation that related to staff management and five staff recruitment files. We looked at records concerning the monitoring, safety and quality of the service, menus and the activities programme. We sampled the services' policies and procedures.

We spoke with seven people who lived in the service and eight relatives to gather their feedback. Although most people were able to converse with us, others were unable to, or did not wish to communicate. Therefore we also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the provider, the registered manager, two nurses, four care workers, an activities organiser,

one catering assistant, and the person responsible for the maintenance of the premises. We contacted three local authority case managers who oversaw people's wellbeing in the home to gather their feedback.

Good

Is the service safe?

Our findings

People told us they felt safe in the service. They told us, "I feel absolutely safe here", "I always have my room door open day or night, I always feel safe, staff are very kind and always around" and, "Staff always come quickly if I press the buzzer; I always see the night staff walking pass and looking in to check I am okay." Relatives told us, "Mum wanted to get up this morning, she buzzed and someone came within a minute. It is easy to find staff, and the carer took time to answer our questions about Mum, we feel she is very safe here", "Staff are always in the lounge, they make sure [X] is safe when he is sitting in the chair" and, "There is always a lot of staff about, this is very reassuring, they make everyone here feel safe and looked after if they have any problems."

There was a sufficient number of staff to meet people's needs in a safe way. We looked at staffing rotas that indicated that enough care and nursing staff were deployed during the day, at nigh time and at weekends. The registered manager reviewed staffing levels regularly, using a scoring tool that took account of people's specific needs to ensure a sufficient number of staff were deployed. Additional staff were deployed when necessary, for example; when a person needed one to one support when they were unwell, and to support a person at the end of their life. Agency staff were seldom used to cover staff absences and when they were used, the same staff were requested as they were familiar with the service, the service's policies and people's needs. People's requests for help were responded to without delay.

Staff who worked in the service understood the procedures for reporting any concerns. All of the staff we spoke with were able to identify different types of abuse and were clear about their responsibility to report suspected abuse. They were aware of the whistleblowing procedure in the service and expressed confidence that any concerns would be followed up. Staff were up to date in their training in the safeguarding of vulnerable adults. The safeguarding policy reflected local authority guidance.

The home's fittings and equipment were regularly checked and serviced. Safety checks had been carried out throughout the home and these were planned and monitored effectively. These checks were comprehensive, appropriately completed and updated. They addressed the environment, water temperature, appliances, and fire protection equipment. A new lift had been installed that had been checked for safety in August 2017. Equipment that was used by staff to help people move around was checked and serviced annually, and replaced when necessary. Portable electrical appliances were checked regularly to ensure they were safe to use.

Each person's environment had been assessed for possible hazards. Building works were in progress to extend the premises and attention was paid to environmental safety when new areas and corridors were re-designed and built. Precautions had been taken to separate the building work from the rest of the home with partitions that blocked any dust and noise. All radiators were being replaced by low surface temperature ones. People's bedrooms and communal areas were free of clutter. The premises were well maintained and systems were in place to ensure the service was secure. There was a system in place to identify and log any repairs needed and action was taken to complete these in a reasonable timescale. The business continuity plan had been updated to include building works and the risk of the lift becoming out of

order. The provider told us all environmental assessments will be reviewed and updated to reflect the new environment as building works finished.

Regular checks on fire equipment were carried out and a detailed fire risk assessment was in place. There was a detailed risk assessment produced with the involvement of the building contractors to ensure environmental risks created by the building works, particularly in relation to fire precautions, were identified and controlled. Staff were familiar with the process for evacuating the service in case of a fire. Fire drills were completed in accordance with the home's policy, and staff had attended a fire drill in July 2017 using new routes while building works were in progress. All visitors were instructed of the location of the assembly point upon arrival to the home. There was appropriate signage about exits and fire protection equipment throughout the service. People had individual personal emergency evacuation plans in place which detailed the level of assistance they would require if it was necessary to evacuate the service. These were included in a 'grab bag' that was located in the entrance for easy access. There were detailed plans in place concerning how the service would manage an emergency such as flooding, failures of heating system and severe weather.

Accidents and incidents were monitored to identify any areas of concern and any steps that could be taken to prevent accidents from recurring. Appropriate logs were completed, recorded in a computerised system, analysed and audited by the manager to identify any trends or patterns. As a result of an audit, visual checks of three people had been increased during the day and at night time.

Medicines were administered safely. Appropriate arrangements were in place in relation to the storage, and recording of administration of medicines. Medicines were ordered and administered through an electronic system which went live in June 2017. This contained a medicines record for each person in the home, which displayed their photograph, medical diagnoses and any allergies. Individual prescriptions were colour-coded according to whether they were regularly given, prescribed for use 'as needed' or self-administered. The system reduced the risk of staff giving a second dose of medicines in error. For medicines to be given 'as needed', the system required the nurse to show the reason why it was given, and showed the time that must elapse before a further dose could be permitted. For controlled drugs, a second member of staff counter-signed in the electronic system and in a conventional register. The supplying pharmacist had a direct link to the electronic system and could enter new prescriptions. This method provided live monitoring of stock of medicines held in the home and alerted when re-ordering was indicated.

Nurses and senior care assistants who had received relevant training were assessed by the registered manager to check their competency. The application of topical creams was recorded on charts that were kept in people's rooms. Staff gave people time and support to take their medicines without rushing. A relative told us, "[X] never wanted to take any meds but with the staff [X] is very happy to take them."

Risk assessments were centred on the needs of the individual and were reviewed monthly, or sooner when people needs changed. Staff were aware of the risks that related to each person. There were individual risk assessments for people who had difficulties swallowing, when people were at risk of skin damage, of malnutrition, and of falls. Assessments in regard to falls took account of people's previous falls history, their medicines, their medical condition, their balance and abilities. Control measures to reduce the risks of falls included specialist equipment such as pressure pads to alert staff when a person got out of bed, and the help of two care workers. In addition, each person in the home had been provided with new beds that could be lowered to the ground to minimise risks of falls. People who were at risk of weight loss due to reduced appetite had been referred to a dietician and were closely monitored; people who were at risk of skin damage were provided with specialised mattresses.These mattresses were regularly checked to ensure they were suitable for people's individual weight.

Thorough recruitment procedures were followed to ensure staff were of suitable character to carry out their roles. Criminal checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. Staff members had provided proof of their identity and right to reside and to work in the United Kingdom prior to starting to work at the service. References had been sought before staff were appointed and references were obtained from the most recent employer where possible. There was a system in place for checking and monitoring that nurses employed at the home had appropriate professional registration with the Nursing and Midwifery Council (NMC). Disciplinary procedures were followed and action was taken appropriately when any staff behaved outside their code of conduct.

Good

Is the service effective?

Our findings

People said the staff gave them the care they needed. They told us, "The nurses always check if I need more help with my care, they call a GP if I am poorly" and, "All the staff are very professional, they mean business, they are confident.", Relatives told us, "Staff appear very efficient", "The doctor is always called when needed, and I always get a call when the doctor is visiting so I can talk with the doctor" and, "Staff know what they are doing. Before [X] came back from hospital, the staff and the hospital staff talked together to make sure that all [X]'s needs are known and met."

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 take 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).

At our last inspection, we found the provider was in breach of the Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. This was because people's mental capacity in regard to specific decisions had not been accurately assessed; Procedures had not always been followed when making a decision on people's behalf and in their best interests; Staff had not received effective training in mental capacity to enable them to follow the processes required by the MCA.

At this inspection, we found that compliance with the regulation has been achieved. A more effective training had been sourced and provided to the management and staff team. Processes in regard to mental capacity assessments and best interest meetings were understood and followed in practice. Staff we spoke with were knowledgeable and able to describe the main principles of the MCA and how these impacted on people's rights. Assessments of people's mental capacity had been carried out to check they were able to consent to remaining in the home, and to their care and treatment. People's mental capacity to consent was assessed appropriately before people were provided with wheelchairs and lap belts, reclining chairs and lifting apparatus, and when their wishes for resuscitation were discussed. Appropriate DoLS applications had been submitted for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied. The registered manager had considered the least restrictive options for each individual to keep them safe. When appropriate, Independent Mental Capacity Advocates (IMCAs) were enlisted to help represent people's views when families were not available. Staff sought consent from people before they helped them move around or before they helped them with eating or with personal care. A person told us, "The [staff] are very polite, they always ask me if it's okay before they help me, and if I say not right now they come back later."

New care and nursing staff underwent a thorough induction when they started work. This included shadowing senior care workers for two weeks or longer until they could demonstrate their competence before working on their own. The competency of all staff administering medicines had been assessed and

documented. New staff studied to complete the Care Certificate as part of their twelve month induction. This certificate was launched in April 2015 and is designed for new and existing staff, setting out the learning outcomes, competencies and standard of care that care homes are expected to uphold. Staff completed workbooks to evidence their knowledge that were reviewed at three intervals over a period of twelve weeks. Observations of practice were carried out by the deputy manager and head of care. As a result of an observation, a staff meeting had been held to discuss the storage of wheelchairs so they would not obstruct fire exits. This had been remedied. Care and nursing staff received one to one supervision sessions every three months and were scheduled for annual appraisal of their performance.

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. The training that was provided included health and safety, first aid, dementia care, manual handling, safeguarding and infection control. Additional training included dignity in care, end of life care, care planning, and care specific to people's health conditions such as catheter care, stroke, Parkinson's disease and diabetes. The service participated in a local hospice scheme where staff could access specialist training, such as advanced end of life care for people who lived with dementia and the use of syringe drivers (portable pumps that are used to provide a continuous dose of medicine through a syringe). An electronic system flagged when staff needed to attend refresher courses, and this monitoring system ensured that staff were up to date with their training.

There was an effective system of communication between staff. Staff handed over information about people's care to the staff on the next shift and the registered manager twice a day, or more often when necessary. Information about new admissions, accidents and incidents, referrals to healthcare professionals, people's outings and appointments, medicines reviews, people's changes in mood, behaviour and appetite was shared by staff appropriately. An electronic calendar listed people's scheduled appointments and transport. The electronic system flagged how often people needed to be checked or repositioned; when their blood needed to be taken; and when their food and fluid intake needed to be monitored. A person who was on dialysis (a treatment to remove waste products and excess fluid from the blood when the kidneys stop working properly) needed to drink a precise amount of fluids in a 24 hour period. Staff were aware of this requirement and the person's ingestion of fluids was closely monitored to ensure the appropriate level of hydration was attained. This monitoring system ensured effective continuity of care.

People gave us positive feedback about the food. They told us, "We have a choice of two things for main and pudding; If I want it chopped they will cut it for me if I ask" and, " The food is fine; not amazing but good and fresh and we have choice; it is always hot and there is plenty of it." Relatives told us, "The food looks good and smells nice; good size portions" and, "If [X] doesn't like it they offer something else." While building works were in progress, the kitchen was used only to prepare cooked breakfasts, light meals and snacks. The service used a sister home's kitchen to prepare the food, and meals were brought over in specialised containers. Staff checked the temperature and served the meals onto individual plates after having checked people's dietary requirements, preferences and special requests. One person had their soup served into a mug, another had their meal served on a smaller plate as they preferred. Several people had their breakfast late in the morning as they preferred, and cooked breakfasts were available when requested. The registered manager told us, "When the building works have finished we will be able to use a state of the art on-site kitchen and take the food to a higher level; we can't wait."

We observed lunch being served in the dining areas and in people's bedrooms. People were offered a choice of two main courses and of alternatives. While they ate, they commented, "That's lovely", "really nice" and, "looks nice." One person had mashed potatoes instead of chips; another was given yoghurt instead of the main pudding. People were offered a choice of drinks that included wine, and staff offered a sample of wine

if people were unsure about the taste. A person preferred cold milk and this was provided. Staff helped people who may have swallowing difficulties, and aids were provided so people could better manage eating independently.

People were weighed monthly or weekly when there were concerns about their health or unplanned weight loss. Fluctuations of weight were noted in a dedicated care plan. We path-tracked a person's nutritional care plan as they had experienced weight loss due a reduced appetite. The person had been referred to a dietician who had made specific recommendations about frequent high calories snacks and fortified milk shakes throughout the day. This was implemented in practice as staff were aware of these recommendations. Sandwiches were offered when the person declined a hot meal, and they were offered second helpings when they were consenting to this. Staff told us, "We make sure it is a manageable portion, and we encourage [X] to eat it a little at a time."

People had been referred to health care professionals when necessary. People had been referred to the GP, a community psychiatric nurse, a speech and language therapist (SALT) and mental health services when necessary. Staff responded effectively when people's health needs changed and ensured health care professionals' recommendations were noted in people's care records and followed in practice. People were able to retain their own GP or were registered with local GP surgeries. People's wellbeing was promoted by routine visits from health care professionals. A podiatrist visited every six to eight weeks to provide treatment for people who wished it. A visiting optician and dentist service was available. People were offered routine vaccination against influenza.

There was temporary pictorial signage throughout the home to help people find their way around as building works were in progress. The food menus, activities programme, service user guide and complaint procedures contained pictorial elements that may help people living with dementia understand. The provider told us a re-decoration programme was to be implemented once the building works were completed.

Good

Is the service caring?

Our findings

People told us they were satisfied with how the staff cared for them. They said, "The staff are all lovely people, always smiling and jolly, and not pretending to be nice, they are genuine" and, "Can't fault the staff, nice people." Relatives told us, "The staff are very attentive; they always ask what [their relative] would like to be done, and before they do anything they make sure [X] is comfortable" and, "Staff are very attentive to [X]'s needs, always make sure [X] is comfortable; [X] likes to talking with staff and enjoys the teasing and bantering." One relative described staff as, "Always very nice; some are delightful."

The staff approach was kind and compassionate. We spent time in the communal areas and observed how people and staff interacted. There was a homely feel to the service and there were frequent friendly and appropriately humorous interactions between staff and people whom staff addressed respectfully by their preferred names. Staff knew how to communicate with each person. Staff were bending down so people who were seated could see them at eye level. Some members of staff sat and conversed with people with genuine interest. They waited for people's response and interacted positively with them.

People could spend time in private areas when they chose to, such as in a newly built lounge or in the garden which had been terraced and furnished with tables and chairs. Building works were in progress to include a coffee lounge in the dining room area and a therapy room in the new extension. Visitors were complimentary about the new layout of the building, saying, "The new lounge is a vast improvement, cleaner, lighter and brighter, and mum can sit with other people or out in the garden when we visit, there is so much more space."

People were assisted discreetly with their personal care in a way that respected their dignity. People's records were kept securely to maintain confidentiality. People's privacy was respected by staff who knocked gently on bedroom doors to announce themselves before entering. Staff used a privacy screen when people needed to be helped with moving using apparatus while in the lounge. Two people told us, "Staff always knock and ask if they can come in" and, "Even if my door is open, the staff always knock before they come in." Some members of staff had had additional training to become the leads in dignity in care, and were available to give advice to their colleagues when needed.

Specific communication methods were used by staff when necessary. People had communication care plans that clearly outlined any challenges people may face and how staff could overcome this. A person had visual impairment and anxieties about falling. Their communication plan explained to staff how to reassure and lead the person to ensure their safety; how to describe the food on their plate; and how to ensure their eyes were free of infection. This was implemented in practice. We observed staff gently leading that person when they walked and describing their surroundings to them. Another person had hearing difficulties had requested staff to talk to them in their right ear, clearly, slowly and without shouting. Staff were communicating with the person following these recommendations.

Staff encouraged people to do as much as possible for themselves. Staff checked that people were appropriately dressed and all people were well presented with comfortable clothing and footwear. People

washed, dressed and undressed themselves when they were able to do so. A person was given cream to apply on their arms; another was encouraged to brush their teeth autonomously. Staff presented options to people so they could make informed decisions, such as what they liked to eat, to wear or to do, to promote their independence.

Attention was paid to equality and diversity. People's spiritual needs were met with the provision of a monthly religious service held for people of all faith denominations. Staff who came to work in Warwick Park from abroad were supported by the management team to familiarise themselves with English culture and perfect their command of English language. Two members of staff had become fluent in English while working in the service and told us, "We learn English with the residents, we often laugh together about how to say things, we learn every day, we learn the language about care first because it matters the most." A relative told us, "About 18 months ago we had a meeting with the manager, concerned that staff were not able to communicate with mum. Now it has totally changed, staff very helpful, all of them very friendly and their English has come in leaps and bounds."

Clear information about the service and its facilities was provided to people and their relatives in a service user guide, a brochure, an updated website and through social media. The complaint procedure was displayed in the entrance. The registered manager used emails and video chat software to communicate with people's families who lived abroad and were not able to visit frequently.

People were involved in their day to day care and in the reviews of their care plans when they were able to and when they wished to be. The registered manager told us, "We try to make the reviews informal and relaxed, the head of care or the deputy manager sits with each person and talk about the care to find out what they like or how their experience of living here could be improved." Care plans were updated following events such as an illness or a period of hospitalisation.

People or their legal representatives were consulted about how they wished the service to manage their care and treatment when they approached the end of their lives. When appropriate, people were invited to take part in 'advance care plans' (ACP) titled 'Thinking ahead' and were supported by staff during the process. These plans give people the opportunity to let their family, friends and professionals know what is important for them for a time in the future where they may be unable to do so. When people approached the end of their life, pain management was in place to ensure people were comfortable. The home was supported by the local hospice and hospice clinical specialist nurses visited the home to give advice and support to staff when necessary. Therefore people could be confident that best practice would be maintained for their end of life care.

Good

Is the service responsive?

Our findings

People gave us positive feedback about how staff responded to their individual needs and wishes. They told us, "The staff do everything I need them to do and more when I ask", "I let the carers know when I want to get up or go to bed, I like to lie down in the afternoon and they help me with that" and, "I am able to tell staff if I want to stay upstairs, they never put pressure on me, they know what I'm like." Relatives told us, "Our mum can get as many showers as she wants" and, "The staff take their cues from the residents."

People's needs had been assessed before they moved into the home to check whether the service could accommodate these needs. These assessments included an outline of people's likes, dislikes and preferences over their care and lifestyle. There were clear accounts of people's needs in relation to their medicines, communication, nutrition, skin integrity, mental state and social interests.

Staff followed care plans that reflected people's individual needs and wishes. There were risk assessments that were carried out before people came into the service, such as risks of choking or falling. This information was included in an initial care plan that was in place when people moved into the service. Care plans included people's life history and what was important to them, so staff could understand people. They included a 'This is me' section about their life story and memories that were significant for people. Individualised care plans about each aspect of people's care were developed further as staff became more acquainted with people, their particular needs and their choices. These included care plans for breathing, enablement, pain, sleeping, social interactions and sexuality.

All care plans were routinely reviewed and updated by the deputy manager and nurses on a monthly basis or sooner when needed, such as when people had experienced a fall, an illness or a period of hospitalisation. The registered manager told us, "Any changes, big or small, lead to a review of the person's care." These reviews were titled 'evaluations' and took account of a dependency tool that was used to check how much care each person needed. An electronic system flagged when reviews were due to be carried out. Care and nursing staff were made aware of any changes and updates at daily handovers and at weekly heads of department meetings. People's families or their legal representatives were invited to be involved with the reviews of their care.

Staff took into account people's preferences, likes and dislikes about people's routine, activities and food. These were noted in their care plans and members of staff we spoke with were aware of what people liked to do, which routine they preferred and what they favoured to eat. Staff we spoke with were able to tell us about people's previous occupations, interests, and about specific requirements. For example some people had expressed the wish to have their favoured brand of toiletries; to have a comforting sheepskin blanket, to have their bedroom door left open at night with their light turned off; to have nails cut short; and to have a hairdresser come twice a week. These requirements were facilitated.

People were able to express their wishes or comment on the way staff delivered their care at monthly residents meetings. These meetings were recorded and indicated that people who remained in their bedrooms had also been consulted by the activities coordinator to gather their feedback. People were

invited to comment on their care, the catering, laundry, activities and the environment. We noted that the minutes of these meetings were not identifying each person when they offered their comments, and referred to them solely as 'People said…' This meant that any action that may need to be followed up with individuals may be difficult to implement. We discussed this with the provider and registered manager who assured us that feedback would be better recorded in future. Minutes of the last meetings held indicated that people were satisfied and had no complaints. People were invited to comment on how the service was run. Satisfaction surveys took place annually and people and relatives were provided with a questionnaire to complete that was analysed by the provider. A current satisfaction survey was in progress.

People we spoke with were aware of how to make a complaint. They told us, "No cause to complain apart from the noise because of the building works sometimes but it won't be for much longer and it can't be helped so we understand" and, "I would not hesitate to complain but everything is fine as it is." A relative told us, "[Their relative] used to be a nursing sister and she would soon put the staff in their place if they were doing something wrong, but staff appear very efficient." Detailed information on how to complain was provided for people in the service user guide and displayed in the entrance.

A range of daily activities that were suitable for people who lived with dementia was available. The provider employed two activities coordinators who shared their time between the home and another sister home. One activities coordinator was absent therefore care staff supported the second activities coordinator in providing activities to each person in the home. The activities coordinator spoke to us about the activities provided. These included art and crafts, reminiscence games, karaoke, reading, music and sing along, quizzes and discussions about news events. One to one activities were provided for people who remained in their room, and sensory equipment was used appropriately. Themed days included a Chinese new year, an Ascot day with champagne and racing games through video games, a 'Rock around the clock' party to which families were invited. External performers visited the home, such as singers, a zoo lab with exotic animals, performing cats, a pantomime cast, a guitarist, and a team of costumed gladiators to talk about Roman times. Regular outings were taking place to the coast, the local river, local cafés, castles, farms and garden centres. A person told us how they had enjoyed a trip on the river. The registered manager told us, "We hire a minibus for outings, and make several trips to make sure everyone who wants to take part is included."

Good

Is the service well-led?

Our findings

People, relatives and staff told us the service was well led by the provider and the management team. People we spoke with were aware of who the registered manager was and told us they felt able to talk with them and discuss any concerns. They told us, "The manager always pops her head in to chat. She is easy to chat to and always check if everything is okay for me" and, "The manager is so nice, she talks with us every day; she understands us." Relatives told us, "The manager is approachable, she is good and always polite, both she and her deputy are ever so helpful. The manager seems to know my mum very well, she is able to tell me how she is coping", "The manager is very nice; she explained clearly what help we can have". Relatives described the home as, "very well run" and, "well managed."

The registered manager had been in post since December 2015 and was also managing a sister home. She divided her time between the sister home and Warwick Park and was well supported by the two directors (the provider), a deputy manager and a head of care. The provider was recruiting for one additional head of care and was planning to recruit more nurses once the building works had ceased and more people could be admitted in the home.

Staff were positive about the support they received from the provider and the management team. They told us, "We feel valued, they do listen to us, we work well together as a team" and, "The support is very good, we get lots of training and one to one meetings" and, "There is an open door policy, we can approach the manager any time and the director is very present, he comes just about every day and we can also talk to him. "

The provider had conducted a recent confidential staff survey and staff suggestions for improvement had been included in a monitored action plan. As a result, the provider had provided stress management training to five staff who expressed an interest. When staff had expressed concerns about communication across the building, they had been provided with 'walky-talkies'; a monitoring system had been installed on the top floor, and the front door bell now rang on all floors so staff could hear it and respond without delay.

There was a thorough system in place to monitor the quality of service provided for people. The registered manager regularly walked around the premises to get an overview of the day to day running of the service, checked documentation and observed the environment people lived in. This included talking with people, relatives and visitors and staff, gathering their feedback about the environment, the cleanliness, the care, the food and activities. When any concerns were raised, action was taken on the day or as soon as possible. When people had made suggestions for improving the activities, the activities programme had been extended to include external performers and more outings.

The provider had installed a new electronic system that included an audit tool. This tool flagged when any audit needed to be done, and enabled the registered manager to check at a glance and monitor all aspects of the service. Audits and checks included care plans, accidents and incidents, nurses' reports, activities, medicines, and infection control. A, mattress audit had indicated one mattress had sagged. As a result,

mattress audits been increased to be done monthly instead of twice yearly. As a result of an audit in accidents and incidents, low profile beds (which could be lowered to the ground had been purchased, as well as fall alarms and crash mats. Audits of infection control had been split quarterly to provide the registered manager with more oversight. Staff were observed twice a year in regard to their practice with hand washing, PEG feed (a PEG is a feeding tube inserted into the stomach to provide nutrition and fluids to people who cannot eat or drink orally) and catheter care. An audit had identified a shortfall with a disinfection practice. This had been remedied. An audit of call bells on the timeliness of response had indicated the busiest times to be at 5am. This had helped inform a recruitment plan. The provider told us, "The plan is to increase the night care workers; we have 19 residents at present, and when we exceed 22 residents we shall increase the staff accordingly."

A system of weekly meetings was in place to discuss any concerns relating to people's care, equipment, staffing or about how the service was run. These were attended by the registered manager, deputy manager, head of care and senior care workers. Further weekly meetings were attended by one of the directors, the registered manager and heads of departments to discuss issues concerning cleaning, maintenance, the kitchen and activities. All staff meetings were documented and set up action plans that designated responsibilities for any follow up action. Actions were reviewed at the next meeting to check they had been followed up. A need to improve the medicines system so as to reduce the risk of issues and errors had been discussed. As a result, a new electronic system had been implemented in June 2017.

The manager was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. They were fully aware of updates in legislation that affected the service. Following our last inspection, they had implemented improvement in the training of staff in mental capacity awareness and had ensured the correct processes were followed. They were aware of the duty of candour. It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had conspicuously displayed their rating in the reception area and on their website. The registered manager promoted links with the community and welcomed a 'young citizen group' which consisted of teenage volunteers who worked on a project within the home, providing activities and entertainment. The provider had scheduled an open day when building works had finished, to which families and people from other homes and in the community were invited.

The service's policies were appropriate for the type of service and clearly summarised, to help staff when they needed to refer to them. Policies were reviewed on an on-going basis, were up to date with legislation and fully accessible to staff for guidance. Records were clear and well organised; they were kept securely and confidentially. Records were archived and disposed according to legal requirements.