Barchester Healthcare Homes Limited

The Warren

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 22 and 23 February 2017 and was unannounced.

The Warren provides residential care for up to 44 older people, some of whom may be living with dementia. The home is purpose built and accommodation is on one floor. Communal areas include a number of lounges, a dining room, a conservatory and a hairdressing salon. The home has access to garden areas. At the time of our inspection there were 41 people living within the home.

There was 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.

At our previous inspection carried out in January 2016, the home had been rated as good. At this inspection, completed in February 2017, we identified a number of issues that resulted in three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to staffing levels, the management of risks and medicines and the governance of the home. You can see what action we told the provider to take at the back of the full version of this report.

We have also made a recommendation to the service in relation to their compliance with the MCA.

There were not enough staff to meet people's needs in a timely and individual manner. People told us that they did not consistently receive support in an appropriate time and were sometimes left waiting. Staff agreed there were not enough staff to meet people's needs.

Whilst staff knew people's needs, they did not have time to meet these in a person centred way. People's preferences were not always met. Care plans lacked guidance for staff to meet people's needs in a safe and individual manner. They did not always contain accurate and up to date information or reflect people's current needs. Care plans did not demonstrate that people had been involved in the planning or regular review of their care needs. People's dignity was not consistently maintained and their privacy was compromised at times.

The risks to people had not always been managed in a way that fully protected them. Where risks had been identified, appropriate control measures had not been consistently applied. The risk to the environment and those associated with adverse events had been identified but required review. Regular maintenance and serving of the building and equipment had taken place.

The service had a comprehensive quality monitoring system in place but this had been ineffective at driving timely improvement. Whilst most of the issues highlighted in this report had been identified by the service, actions had failed to rectify them in good time and were still evident. The registered manager did not have a

full overview of the service and the needs of the people who used the service.

Staff morale was low and staff told us that they did not feel supported or appreciated by the manager or provider. They told us this was due to being short staffed and that they felt their concerns were not listened to.

Most people told us that they had confidence that any concerns they may have would be addressed by the service. However, one relative had had a negative experience in relation to the concerns they had raised and the service had taken some months to respond.

The service was in the process of recruiting additional staff to fill vacancies. Recruitment processes were in place to help reduce the risk of employing staff not suitable to work in the home. New staff received an induction and ongoing training and did not begin work till appropriate checks had been carried out.

Processes were in place to help reduce the risk of people experiencing abuse. Staff had received training in how to prevent, protect, identify and report potential abuse and knew where to go to report any concerns they may have. Accidents and incidents were recorded and a clinical governance system ensured that an overview and analysis of these was in place to help mitigate future risk.

The CQC is required to monitor the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and report on what we find. People's human rights had not been compromised but the service had not consistently worked within the principles of the Act. Staff were able to demonstrate that they assisted people to make choices and that they gained consent before providing support. However, documentation around the recording of people's capacity did not demonstrate adherence to the MCA.

People's nutritional and healthcare needs were met. People received enough to eat and drink and had a choice. They told us they enjoyed the food provided. The service had assisted people to access a wide variety of healthcare professionals to aid health and wellbeing.

Independence was encouraged and people told us that the service was good at promoting this. Confidentiality was maintained and people told us that most staff demonstrated a kind and respectful approach. People enjoyed and appreciated the varied and regular activities the service assisted them with.

The service regularly and actively encouraged people's views on the service. People thought the service strived for improvement and would recommend the service. However, they told us that some improvements were required in relation to staffing levels, staff retention and call bell response times.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not enough staff to meet the individual needs of those that used the service. People had to wait inappropriate amounts of time for assistance.

The risks to people who used the service had not been adequately managed putting people's health, wellbeing and safety at risk.

People did not consistently receive their medicines as the prescriber intended.

Is the service effective?

Good

The service was effective.

The service did not fully adhere to the Mental Capacity Act 2005 (MCA).

People were supported by staff who had received an induction and ongoing training to meet the needs of those that lived at The Warren.

People's nutritional needs were met. People had enough to eat and drink and they were provided with a choice. Access to a wide variety of healthcare professionals was available.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity and privacy was not always considered or maintained.

People told us that they had been involved in the planning of the care and support they received.

Independence was encouraged and the people who used the service were positive around this aspect of the service.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care and support that was personal to them. Care plans did not consistently record people's individual needs or preferences and the support they needed in relation to them.

Most people felt confident that any concerns they may have would be dealt with appropriately.

People enjoyed the activities the service provided and felt there were enough of them and that they met their needs.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The quality monitoring system the service had in place had not been effective at rectifying issues in a timely manner.

Staff morale was low and staff told us that they did not feel valued or supported by the service or provider.

The service regularly and actively sought the views of those that used the service and those important to them.

The Warren

Detailed findings

Background to this inspection

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

The inspection was in response to a number of concerns raised directly to the Care Quality Commission. These concerns included low staffing levels and the negative impact this was having on the care and support people received. Concerns were also raised regarding the management of people's medicines and the responsiveness of the management team.

This inspection took place on 22 and 23 February 2017 and was unannounced. One inspector, an inspection manager and an expert-by-experience carried out the first day of the inspection. 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 second day of inspection was carried out by one inspector.

Before we carried out the inspection we reviewed the information we held about the service. This included statutory notifications that the provider had sent us in the last year. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law. We had also liaised with the local authority safeguarding team and the local authority quality assurance team leading up to the inspection.

During our inspection we spoke with six people who used the service, five relatives and one healthcare professional. We also spoke with the regional director, quality improvement specialist, registered manager, acting deputy manager, one cook, three senior care assistants, one agency worker and one care assistant. We observed care and support being provided to the people who used the service on both days. Following our inspection visits, the service submitted further records within the stated timescale.

We viewed the care records for 12 people who used the service. We also case tracked the care and support two people received and viewed the medicine administration records and associated documents for 11 people. We also looked at records in relation to the management of the home. These included staff

personnel files, minutes from meetings held, staff training records, quality monitoring information and maintenance records.

Requires Improvement

Is the service safe?

Our findings

There were not enough staff to meet people's care and support needs in an appropriate and prompt manner.

One person who used the service told us, "Call bells don't get answered of a night for an hour." Another person said, "When I do ring my bell it's usually 15 minutes before they [staff] answer it." This person went on to tell us how frustrating they found this. One relative we spoke with said, "Staff don't come quick enough. It's not surprising is it? They've got over 40 people in here and so few staff". Another relative said they thought there were enough staff but went on to say that if their relative rang their call bell, it took staff ten minutes to answer it.

Staff agreed that there were not enough of them to provide the care and support that people required. One told us that recently a person's call bell was ringing for one hour before staff could answer it and provide support. They went on to say that staff were still assisting people to rise from bed near to lunch time and that this happened every day. Three other staff members told us that the home ran short of staff on a regular basis. An agency staff member told us that they thought one more staff member was required in the morning to meet people's needs. They told us this was because many people required the assistance of two staff members to provide care and support.

During our inspection visits we saw that call bells were ringing for inappropriate amounts of time. On one of our visits we saw that four people required the assistance of two staff members at the same time, however there were only six care staff on duty. These associated call bells were observed as ringing for assistance for between 10 and 33 minutes. We alerted a staff member to the person who had been requesting assistance for 33 minutes. We saw that when the staff member arrived to offer assistance, the person was angry and distressed at having to wait; they had needed assistance to use the toilet. The senior care assistant had had to interrupt the administration of people's medicines in order to help this person.

On another occasion we saw that a staff member turned a person's ringing bell off whilst telling them that they would be back to offer support. We saw that the person again rang for assistance a short while later and that the staff member had not returned as promised. By the time we had alerted the registered manager to this, the person had been waiting for 27 minutes.

The staff rotas for the three week's prior to our inspection visits showed that shifts were not always staffed to the numbers the provider had stated. Senior care staff had been included in the staffing levels. No consideration had been given to the impact on people when the senior care staff were unavailable to provide support due to performing their accountable tasks such as medicines administration, dealing with healthcare professionals and the completion of records. For some shifts, we saw that the deputy manager had also been included in the care staff numbers.

These concerns constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people had not always been identified or managed sufficiently. For example, the service had assessed one person as being at high risk of malnutrition. The associated risk assessment had instructed staff to monitor the person's weight on a weekly basis in order to mitigate the risk. However, the service could not demonstrate that this had occurred and could not produce records to evidence this. In addition, records showed that this risk had not been assessed since 11 December 2016 even though recorded monthly weights showed a decrease in weight.

Another person who used the service had sustained injuries following a fall that had required hospital treatment. The service had failed to reassess the risk following this incident and care plans had not been updated to reflect any changes to the care and support the person may have required as a result. The service had not considered that the methods they were using to assist the person to transfer and mobilise may be causing the person distress due to their injuries.

A third person had experienced eight falls within one month before the service had recorded this risk. A care plan had been implemented prior to this however it gave staff little guidance in how to manage the risk. The service had ensured that the person had seen the GP in regards to their repeated falls however the risk assessment had not been updated to show the GP's recommendations. This meant the person was at risk of not receiving the support as recommended by the GP.

These concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how information in medication administration record (MAR) charts and care notes supported the safe handling of people's medicines.

Records did not demonstrate that the people who used the service had received their medicines in a way that promoted their health and wellbeing. In order to remain well, one person required regular blood tests, the results of which indicated the amount of a prescribed medicine to be administered. Records showed that a blood test was required on 24 January 2017 however staff were not aware if this had taken place and whether any changes were required to the prescribed amount of medicine. A number of senior staff had administered this medicine in the interim. All had failed to identify that the blood test had either not been actioned or, if it had, that the results had not been received by the home and the relevant records updated. Whilst the person had come to no harm as a result, it had put their health and wellbeing at risk.

Prior to identifying this omission, a senior staff member had told us that the office where faxes were received into the home, was locked after the administration team had left for the day and that seniors had no access. They told us that this resulted in faxes either not being received in a timely manner or going missing. They told us that faxing was the manner in which they received blood test results in relation to the medicine described above. On investigation, the senior staff member confirmed that the GP surgery had completed the blood test as required and faxed the results to the home but that they could not be found.

Where people had been prescribed medicines on an 'as required' basis, there was no guidance in place to ensure staff administered these safely and appropriately. The service told us that these had been in place but they could not be located at the time of our inspection nor were they submitted following our inspection visits.

Two people administered their own medicines. For one person who administered one of their prescribed medicines, a risk assessment had not been completed in order to ensure that the person was able to administer this safely or whether they required any assistance. For the second person, a risk assessment

document had been completed. However, this was a generic document and gave no indication of how the risk had been assessed or how the outcome had been reached.

We observed a senior staff member administer medicines to two people who used the service. For one person, we saw that they received their morning medicines at 10:45am when they had been prescribed for administration at 8am. This did not follow good practice guidelines and meant the person received their medicines over two hours later than had been prescribed.

Two of the four people we spoke with about their medicines told us that there had been occasions when their medicines had not been available to them. One person said, "There have been two occasions when [the service] has run out and it's taken three or four days before they're replenished. I can't understand how this happens when the staff tell me [the service] has reordering systems." Another person told us, "I needed eye drops and had to wait for two or three days before staff got them."

These concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The risks to the building and working practices had been identified assessed and recorded although these had required reviewing in January 2017. At the time of our inspection visits these reviews had not taken place. A business contingency plan was in place to help ensure the continuity of the service in the event of adverse events such as loss of utilities. However, this was dated April 2016 and did not contain up to date information. Regular maintenance and servicing of the building and equipment had taken place.

Any accidents or incidents experienced by the people who used the service, or others, had been recorded and analysed. These had been inputted into the organisation's clinical governance system which gave an overview of incidents. This system was available to both the registered manager and more senior management team at any time. However, this system had not been fully effective at identifying the actions required after people had experienced falls. For example, care records showed that care plans and risk assessments had not always been reviewed and updated as required after people had experienced falls.

The service had processes in place to help protect people from the risk of abuse. Staff told us that they had received training in safeguarding people and the records we viewed confirmed this. Staff knew how to report any concerns they may have both within the organisation and externally. Any potential safeguarding incidents were inputted onto the organisation's clinical governance system which ensured an overview was available for analysis. Staff recruitment processes were also in place to help safeguard people against being supported by staff who were not suitable to work in the service.

Good

Is the service effective?

Our findings

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 so that they can 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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff understood the need to gain people's consent before providing care and support. Staff told us that they supported people in a way which was led by the person themselves and our observations confirmed this. People also told us that staff asked their permission before assisting them and that they weren't restricted in their day to day lives. One person told us, "I choose how I spend my days." Another said, "I please myself."

Staff had received training in MCA and DoLS. However, implementation and documentation in regards to the MCA and DoLS was not consistently in line with the legislation and associated code of practice. The organisation had assessed the capacity of all the people who used the service in regards to whether they were able to make the decision to live there, when this was not always required. Where the service had assessed people's capacity to make a decision, this was not always fully compliant with the MCA.

The service had made some DoLS applications but none had yet been processed or authorised by the local authority. We saw that these applications contained basic information and did not clearly set out the restriction to be considered.

We concluded that although we saw no negative impact for people in regards to their human rights and the service's non-compliance with the MCA, records needed to be more robust in relation to this.

We recommend that the service seek support and further training on the MCA and take action to update their practice accordingly.

People told us that the staff had the skills and attributes to effectively provide care and support. One person who used the service said, "The staff are very good and well trained." When we asked another person if they had confidence in the staff, they said, "Oh, most definitely. The staff are very nice." The relatives we spoke with agreed.

New staff received an induction to introduce them to their role. The registered manager told us this included

shadowing more experienced members of staff and that it was flexible to meet individual needs. Staff told us that they had received training, that it was up to date and relevant. The training records we viewed confirmed this and showed that staff had received training in areas including food safety, manual handling, customer care and infection prevention and control.

People told us that they were happy with the quality of food and drink served, that they had plenty of choice and enough to eat and drink. One person who used the service told us, "Breakfast is between 8am and 10am and you can have anything really. It can be cooked or porridge or cereal or toast or whatever you fancy. Lunch is at 12pm and tea at 5pm with coffee around 1pm and 3pm. There's biscuits if you want them. Yes, I get enough to eat. If you fancy a sandwich, the staff will fetch one for you." Another person said, "At breakfast you can have what you fancy, hot or cold. The choice of main meals is very good. We absolutely get enough to eat, oh yes." A third person told us, "I had the beef cobbler today. The choice is fine. Staff bring round tea and coffee and biscuits in the mornings and afternoons. I have a milky drink before bed." One person did state that their food wasn't as hot as they would like but told us they would discuss this with the service themselves.

People's nutritional needs were met and where people required specialist diets, this was provided. The service regularly spoke with people to gain their feedback and input into the menu selections. The cook we spoke with told us all feedback and views were taken into account when new menus were designed. Through discussion, we could see that the cook knew people's needs well and was effective in their role. They were able to give us good information on how they met people's specialist diets and were knowledgeable in the preparation of these in order to maintain people's health.

During our inspection we observed lunch and tea being served in the dining room. We saw that this was a pleasant and social experience for those living at The Warren. Care had been taken to make the environment welcoming with spacious design and fresh flowers on the tables. Menus were available on each table and offered a selection of meals. A choice of cold drinks including sherry and wine was offered to people. We saw that there were plenty of staff available in the dining room to assist people as they needed it. For one person who required assistance, we saw that this was dedicated, kind and encouraging.

We did, however, note a variable level of support for those who chose to eat in their rooms. Whilst we saw one person receiving assistance in a patient and paced manner, another person appeared to be rushed and hurried by the staff member assisting them.

The people who used the service told us that their healthcare needs were met in a timely manner. One person said, "The GP comes Tuesdays. I had a hospital appointment recently and my family couldn't take me so staff ordered me a taxi and a carer came with me. You never go to appointments on your own." Other people told us that they saw the chiropodist and optician as they needed to. People's relatives had no concerns in relation to them accessing healthcare professionals and receiving the intervention they required.

Requires Improvement

Is the service caring?

Our findings

People were not always assisted in a way that maintained their dignity. Whilst we saw that some staff demonstrated a respectful, warm and polite approach, we saw some examples where people's dignity was compromised.

During our inspection we saw that a staff member assisted one person to rearrange their undergarments in the doorway between the communal corridor and their bedroom. There was no indication that the person was demanding the assistance at that time and in that place and this showed a lack of privacy for the person. On another occasion, we heard a staff member shout down the corridor to ask a colleague for assistance because a person had become incontinent. This showed a lack of dignity for the person involved.

Whilst observing lunch we heard a staff member tell a person who used the service that they were 'hard work' when they couldn't decide what to order or if they wished for anything at all. We saw no humour in this exchange. On another occasion, although staff asked the person's permission first, we saw that they assisted a person from the table in the communal dining room onto mobile weighing scales in order to take their weight. This showed a disregard for the person's dignity and consideration should have been shown for the need for this to be completed in private. Another staff member was heard to be encouraging a person to eat in an infantile manner with comments such as, "Just two more mouthfuls" and "Good girl."

However, we saw other examples where staff demonstrated a kind and considerate approach. For example, we saw one staff member softly touch the cheek of a sleeping person in order to rouse them gently for their lunch. On another occasion we saw that a staff member reassured and comforted a person as they assisted them to mobilise, showing concern for their wellbeing. The people we spoke with told us that staff treated them with kindness and consideration whilst one relative told us some staff were better than others in this respect.

Whilst people and their relatives told us that they were involved in the planning of their care and support, the care records we viewed did not demonstrate this. People told us that they were consulted and their relatives told us communication was good. However, for those people who had family members legally appointed to make decisions on their behalf, there was no indication that they had been consulted on the care and support their relatives received.

The people who used the service told us that the home was good at providing them with information in order for them to make decisions. For example, we saw that people had service user guides in their rooms as well as information on the activities taking place within the service. A wide variety of information was available throughout the home to assist people and included information on meeting dates, providing feedback and menu options.

People's independence was encouraged and they told us they appreciated this aspect of the service. One person who used the service said, "I am used to being independent and feel encouraged to remain so by staff." Another person told us, "I am very independent." People's relatives agreed that the service was good

at maintaining and encouraging their family member's chosen level of independence.

There were no restrictions on visiting times and people's friends and family could visit anytime.

Requires Improvement

Is the service responsive?

Our findings

Some people we spoke with told us that their needs weren't always met in a person-centred and individual manner. One person who used the service told us it depended on which staff member assisted them. They said, "Some staff help me better than others. Some are very good and others aren't so good." The relative of a person who used the service told us how staff continued to bring their family member a particular food type that they did not like. They told us this kept being returned and that sometimes an alternative wasn't offered.

All the care staff we spoke with told us that they did not have time to meet people's needs in an individual manner. One staff member described the care they provided to people as 'task-orientated' and a 'production line.' They told us they only had time to provide 'basic' care and no time to sit and talk with people. Another staff member said they completed care tasks only and that they were aware that they did not always meet people's personal preferences. They told us this was particularly the case in the time people preferred to rise in the mornings. They gave us an example and told us that on the day of our first inspection visit, a person had been assisted to rise sometime after their preferred time of 9.30am.

We looked at the care plans and associated records for 12 people who used the service. This was to see whether the service had identified, assessed and reviewed people's needs in a person centred manner. We saw that the quality of care plan completion was variable but that most did not contain enough person centred information for staff to support people in a safe, individual and preferred manner. Some did not contain accurate and up to date information. Whilst we saw that monthly reviews had taken place for most of the care plans we viewed, the service had failed to consider the impact of any changes to people's needs as they occurred.

For two people who lived with diabetes, there were no dedicated care plans in place to guide staff on how to assist these people with their medical condition. This meant that there was a risk these people may not receive the care and support they required in order to keep them well. For another person who had experienced a decline in health, care plans had not been fully updated to reflect the person's changing and current needs. For example, a care plan designed to manage the person's pain had not been updated to show that a new pain relief medicine had been required and prescribed. There was no information available to staff to show how they could support this person in relation to these changes and their pain. In addition, little information was available to staff on how this person preferred to have their personal care delivered.

For another person, the service had not considered the impact their diagnosis of dementia may have on the care and support they required. No dedicated care plan was in place for their diagnosis and their cognition care plan gave staff no guidance on how to meet their mental health needs. This person had also had a recent stay in hospital where they had undergone treatment for an illness. Their care plans had not been updated upon their return to the home to reflect the changes to their health and associated care and support needs. This meant staff did not have all the information they needed to provide person centred and appropriate care and support to this person.

Whilst staff demonstrated that they knew the needs and preferences of those they supported, the service was using a number of agency staff that may not have worked in the home previously or know the needs of those living there. Agency staff are temporary workers that cover shifts in the absence of permanent staff and may only work one shift at any one service. Whilst the agency staff member we spoke to at our inspection visit told us that they sat in on staff handover meetings, they told us that they did not always know the needs of those living in the home. Under these circumstances, it is important that care plan's accurately record people's needs in order for them to receive safe and appropriate care.

These concerns constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had conflicting views on whether concerns and complaints were managed appropriately and to people's satisfaction. Most people told us that they had had no cause to complain and that they felt able to speak to staff should they have any worries. One person said, "I would just speak with the [registered] manager or the senior staff. They would take things seriously." One relative said, "We have had no reason to complain." Another said, "I've not complained. I just wish there were more staff and that they answered [relative's] bell quicker." A third relative gave us examples of where they had raised concerns that had not been rectified to their satisfaction or in an appropriate timescale. We raised this with the registered manager and the regional director. For one of these concerns that had been raised in early December 2016, the service was still in the process of investigating the issues and, at the time of the inspection, had not yet reported its findings.

For other complaints received by the service, we saw that these had been logged and responded to appropriately.

The people who used the service told us that they enjoyed the activities provided by the service and that they had enough to do to keep them occupied. One person told us, "I never feel bored. The days just go. I join in with what I want to join in. I go to knit and natter or I can just pick up my knitting when I like." Another person said, "At Christmas the activities person bought me a sailing boat kit as they had spotted the model I brought in with me. They quickly knew I liked to make things. I think that's quite special." A third person said, "I really enjoy the quizzes."

During our inspection visits, we saw that activities were available to people and that these were varied to suit differing needs. We saw that the activities staff encouraged people to join in and offered assistance on an individual basis as needed. The home had a number of areas available to people to partake in activities and we saw that objects, books, games, crafts and music was accessible to those living at The Warren. A hairdressing salon was available and we saw that people having their hair done saw it as a social activity and an opportunity to engage with others. At the time of our inspection, people were setting seeds in preparation for the summer garden.

Requires Improvement

Is the service well-led?

Our findings

The provider had a comprehensive auditing system in place and although the issues recorded in this report had been identified via this system, the issues had not been fully rectified and were still present. This meant the system wasn't fully effective at assessing, monitoring and driving improvements within the service.

The regional manager completed regular quality monitoring visits and subsequent reports with action plans as required. We looked at the reports following the visits completed in September and November 2016 and January 2017. These looked at all aspects of the service and reported on the five questions highlighted in this report. In addition, the clinical development nurse for the provider had completed a comprehensive audit on medicines management within the home in January 2017. A member of the provider's regulation team had also completed a detailed audit of the service in January 2017. All of these audits highlighted issues with the service and their ability to meet the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The regional manager's quality monitoring audit for September 2016 showed that no guidance was in place for staff in the administration of medicines that are prescribed on an 'as required' basis. The audit completed in November 2016 showed that this was not checked at this visit. In January 2017, provider audits showed that guidance was still not in place. At this inspection, carried out in February 2017, guidance for staff was still outstanding.

The provider had identified further issues with the service's management of medicines, as highlighted in this report, at their internal comprehensive audit visit carried out in January 2017. The associated report showed concerns with receiving instructions for variable dose medicines, lack of risk assessments for people who self-medicated and anomalies with the times medicines were administered to people. These issues were still present at this inspection.

Provider audits had also identified some issues with staff meeting people's needs in a timely manner. The November 2016 audit identified that there were some delays in staff answering call bells during the visit. In January 2017, the provider's audit stated that staff appeared to have little time to engage in conversation and social interaction with the people who used the service. It reported that two staff stated they felt 'rushed' when providing care and support. This audit also identified that the senior staff member on shift had not been able to provide direct care support to people due to engaging in other accountable tasks. At the time of this inspection, these issues were still evident.

The provider had noted concerns with the service managing risk in January 2017. The regional manager's audit showed that the risk assessments for the building required reviewing. The regulation team's audit, dated 26 January 2017, showed that people's individual risk assessments were not subject to review where changes to needs had occurred. It also reported a lack of monitoring where people were at risk of malnutrition.

Issues with care plans had also been identified by the provider in September and November 2016 and

January 2017 in all audits undertaken. Concerns were still present at this inspection. Provider audits showed a lack of involvement and reviews of care plans with the regulation team describing the mental health care plans as 'generally poor'. This audit also identified that 'care plans lacked evidence of the assessment, planning, delivery and review of people's care needs and did not reflect the current support people required.' It acknowledged that previous audits had also identified these concerns.

We concluded that the provider did not have systems in place to effectively improve the quality and safety of the service and mitigate the risks relating to the health and wellbeing of the people living at The Warren. Timely action had not been taken to rectify the identified issues.

These concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a central action plan where all of the above audit findings had been inputted. This was emailed to us on 27 February 2017 following our inspection visits. One of the above actions showed as completed whilst all other actions were outstanding with no timescale given for completion.

Staff told us that they did not feel listened to, or supported by, the registered manager, senior management team or provider. They told us that they had raised concerns with the levels of staffing but felt these concerns had not been listened to. Minutes from a staff meeting held on 20 October 2016 confirmed these concerns had been raised and that no extra staffing would be provided by the organisation.

Staff told us that morale was low amongst them. One staff member told us that they felt this was because shifts were running short of staff and that they didn't feel supported in their role. They said, "We're not trusted or valued." Another staff member said staff were not as happy as they were and that this had gotten worse recently. They couldn't explain why this was. A third staff member told us that they didn't feel the service treated all staff equally and fairly and that this negatively impacted on how they felt.

There was a registered manager in post who had started in the role in September 2016. They had been registered with CQC in January 2017. From the information we hold about the service, we know that past events had been reported to us as required by law. The registered manager told us that they felt supported by the provider and saw senior managers on a regular basis. They told us that they kept their knowledge up to date by means of training, online research and by receiving appropriate alerts via email.

However, the registered manager did not consistently demonstrate that they had an overview of the service. They were not able to fully explain people's needs. For example, they were unaware of who had had applications submitted in relation to DoLS. They were also unable to tell us which people who used the service were living with dementia. When we asked the registered manager for information on those people at risk of losing weight, they were unable to tell us which people were at risk or where we could find information on weight monitoring.

The people who used the service told us that the registered manager was visible and approachable. One person told us, "[Registered manager] is approachable and from time to time has a meal with us. They are accessible, yes, very much so." Another person said, "Yes, approachable and accessible. [Registered manager] comes in for a chat about once a month." A third person told us, "I see the [registered] manager occasionally." Most of the relatives we spoke with agreed.

Meetings had taken place on a regular basis where the people who used the service, and their relatives, could feedback on the quality of the service and receive information in return. People told us that they

appreciated these opportunities to discuss the service. One person said, "They do monthly meetings and I'm pleased about this." The service also requested written feedback on an annual basis.

We asked people what they thought the service did well and what, if any, improvements were required. People told us that the staff were the best aspect of the service. One person said, "The staff are very good." Another person told us, "I have no complaints. The staff, the food and the 24/7 support – all this is appreciated." We asked people if they thought any improvements were required and, if so, what was needed. One person said, "Trouble is staff are always leaving. In the time I've been here there's been a lot of staff changes, there are too many new recruits." Another person told us, "I do wish the staff would come quicker when I ring my bell, particularly at night. Staff do take a long time to follow anything up." A relative also cited poor call bell response times as an area for improvement."

Following our inspection in January 2016, the service had been rated as good. We carried this inspection out in February 2017 in response to a number of concerns being raised directly with us. As a result of this inspection, the service has been rated as requires improvement.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The service had not done everything reasonably practicable to ensure people who used the service received person centred care and treatment that was appropriate, met their needs and reflected their preferences. Regulation 9(1)(2)(3)(a)(b)(d) and (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had failed to assess and do all that was reasonably practicable to mitigate the risks to the health and safety of the people who used the service. The service had failed to manage medicines in a proper and safe manner. Regulation 12 (1) (2)(a)(b) and (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service had failed to implement effective systems to assess, monitor and improve the quality of the service. The service had failed to maintain an accurate, complete and contemporaneous record in

respect of each person who used the service.

Regulation 17(1)(2)(a)(b) and (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of staff had not been deployed to meet people's care and treatment needs. Regulation 18 (1)