

J Lysaght

Warren Park Nursing Home

Inspection report

66 Warren Road
Blundellsands
Liverpool
Merseyside
L23 6UG

Tel: 01519320286

Website: www.warrenpark.co.uk






Date of inspection visit:
21 June 2018

Date of publication:
19 July 2018

Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

Warren Park Nursing Home is registered to provide nursing care for up to 40 people. It is situated in the Blundellsands area of Liverpool. The home has four floors with lift access to three floors and stair access to the administrative office on the fourth floor. The home is accessible to people who use a wheelchair. At the time of our inspection, there were 37 people living in the home.

At the last inspection on the 9 February 2016, the service was rated Good however we identified a breach of Regulation 12 (Safe care and treatment) due to concerns regarding the safety and storage of medication. Following the last inspection, the registered provider completed an action plan dated 15 April 2016 to tell us what they would do and by when to improve the safety of medicines. At this inspection, we found that registered provider remained in breach of Regulation 12 because medicines were not managed safely at the service and we identified a breach of Regulation 17 (Good Governance).

A registered manager was in post at the service, however, they were not present on the day of our unannounced inspection. 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. During our inspection, we were assisted by a nurse and two directors at the service. We discussed how the contingency arrangements in the registered manager's absence could be developed to ensure records were more easily accessible by other members of the management team because we found that some records were not available during our inspection site visit.

At the last inspection on 9 February 2016, we found that the registered provider was in breach of Regulation because medicines were not stored safely and securely at all times. The registered provider assured us they would audit the storage of medication and introduce regular spot checks during the medicine rounds to ensure that they were compliant with policies and procedures. At this inspection, we found that medication was still not stored securely and the recording of medication was not always accurate. Furthermore, we identified that audit processes were not sufficiently robust to identify errors and quality assurance procedures had not picked up on the issues we identified during our inspection. The registered provider remained in breach of the Regulations.

People told us they felt safe and secure living at the service. We received positive feedback from people and their relatives regarding the atmosphere in the home. Comments included; "There's a feeling of security. There's a feeling of contentment and a lot of fun" and said "It's always nice and clean and visitors are always made welcome."

Staff were recruited safely and pre-employment checks were carried out before they started work at the organisation to ensure they were suitable to work with vulnerable people. Staff were aware of how to protect people from avoidable harm and were aware of local safeguarding procedures to ensure that any allegations of abuse were reported and referred to the appropriate authority.

Our review of staff rotas showed there were appropriate numbers of staff employed to meet people's needs in accordance with the registered manager's dependency tool. Nevertheless, we received some mixed feedback from people and their relatives regarding the staffing levels at the service. We raised this with the registered provider's representatives at the time of our inspection who agreed to review the deployment of staff within the home.

Risks to people's health, safety and well-being were assessed and information was available to guide staff on how to mitigate risks. Support plans had been completed for everyone who was receiving care to help ensure their needs were met and to protect them from the risk of harm. Accidents, incidents and 'near misses' events were documented and the registered manager maintained oversight of these for future learning and prevention.

People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service supported this practice. Consent was sought in line with the principles of the Mental Capacity Act 2005 and applications for authorisations to deprive people of their liberty had been made appropriately. A registered mental health nurse was employed by the service and undertook assessments of people's capacity.

Staff told us they felt well supported. The registered provider's records showed staff had received adequate training to ensure they had the skills and knowledge to support people effectively.

Most people told us they enjoyed the food served at the home. One person commented, "It's quite good, there's a variety. We all get a newsletter and it has the weekly menu in it". We sampled the food available and found it to be of good quality. Staff knew, and catered to, people's individual dietary needs and preferences. People were supported with their nutrition and hydration intake when required and a coloured cup system was in place to facilitate this.

People's overall health and well-being needs were being safely and effectively supported. Staff monitored people's health and welfare needs and acted on any concerns promptly. The service maintained good links with community health partners to ensure people's outcomes were met. One visiting health professional told us, "The care is great."

People were complimentary about the staff and the service in general. Comments included; "Everyone gets treated very well here" and "They're [staff are] all very nice and kind." We observed good quality interactions from staff towards people living in the home. Everyone we spoke with told us their privacy and dignity was maintained.

People had access to a range of activities to promote their social inclusion and stimulation. The activities co-ordinator employed by the service organised a range of events, including trips out in the local community.

People and their relatives had access to a complaints procedure and they were aware of how raise a concern. The service had not received any recent formal complaints but people's 'niggles' and low-level concerns were documented and responded to.

Opportunities were provided for people and their relatives to comment on their experiences and the quality of service provided through the circulation of surveys and resident meetings. People told us that residents meetings were effective because they received feedback and issues raised were acted upon. People were kept informed about any changes at the service through weekly newsletters.

A variety of quality assurance procedures were in place to monitor and assess standards within the home and included regular audits in respect of care plans, weights, infection control and falls. However, we found the governance processes in respect of medication to be ineffective.

The registered manager had notified the Care Quality Commission (CQC) of events and incidents that occurred in the home in accordance with our statutory requirements. This meant that CQC could monitor risks and information regarding Warren Park.

The ratings awarded at the last inspection were displayed in the communal area of the home.

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 safe.

Medicines were not stored safely or recorded accurately and audit processes were not robust to identify errors.

There was mixed feedback regarding staffing levels at the service but the majority of people were satisfied with staff response times.

The necessary recruitment checks were completed to ensure staff appointed were suitable to work with vulnerable people. Staff understood how to recognise abuse and how to report safeguarding concerns.

Is the service effective?

Good 

The service was effective.

People told us that staff were effective in meeting their needs. Staff received regular training to support them in their role.

Staff adhered to the principles of the Mental Capacity Act (2005) for people who lacked capacity to make their own decisions. A registered mental health nurse was employed at the service to guide staff on best practice.

People were supported to achieve their health and well-being outcomes through regular liaison with health professionals.

Is the service caring?

Good 

The service was caring.

People spoke fondly about staff and told us there was a relaxed, jovial atmosphere in the home.

Staff knew how to protect and promote people's dignity and privacy and people confirmed this was maintained when providing care.

There were no restrictions in visiting, encouraging relationships

to be maintained.

Is the service responsive?

Good ●

The service was responsive.

People and where appropriate, their relatives, were involved in the assessment and planning of their care and support.

People had access to a complaints policy and a process was in place for documenting minor gripes.

People enjoyed a range of activities offered at the service which included trips out in the local community and visits from local schools.

Is the service well-led?

Requires Improvement ●

The service was not consistently well-led.

Medication was still not managed safely at the service and the quality assurance systems were ineffective in identifying this.

Resident meetings were held regularly and people told us that responsive action was taken to any issues raised.

Staff enjoyed working at the service and spoke positively about the support offered by the registered manager.

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

This inspection took place on 21 June 2018 and was unannounced.

The inspection team consisted of an adult social care inspector, a medicines inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case, caring for a person living with dementia.

Prior to the inspection we contacted the local authority quality monitoring team to seek their views about the service. They raised no concerns about the care and support people received. We also considered information we held about the service, such as notification of events and incidents which occurred at the service which the registered provider is required by law to send to CQC. Before the inspection, we asked the registered provider to complete a Provider Information Return (PIR). This is a form that we require providers to send us at least annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan how the inspection should be conducted.

As part of the inspection, we spoke with nine people who used the service and six of their friends and relatives. We spoke to two directors of the service, three registered nurses, a senior carer and 3 members of care staff. We also spoke to the activities co-ordinator, the catering manager and one visiting health professional. We reviewed care plans for four people who used the service, three staff personnel files, Medicines Administration Records (MAR) for 11 people, staff training and development records as well as information about the quality assurance and management of the service. We observed two nurses completing their morning medication round and the administration of medication to three people across all three floors of the home. We received some follow-up records from the registered manager upon their return, following our inspection site visit.

We observed the lunchtime service and staff interaction with people who lived at the home at various points during the inspection. We carried out a Short Observational Framework for Inspection (SOFI). SOFI is a methodology we use to support us in understanding the experiences of people who are unable to provide feedback due to their cognitive or communication impairments.

Is the service safe?

Our findings

At the last inspection on 9 February 2016, we identified concerns in relation to the safety of the medicines. This was because we observed that medication and the medicine trolley were left unattended with the keys in the lock for at least 10 minutes. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. During this inspection, we found continuing concerns in respect of how medication was stored which posed a risk to people's safety. In addition, we identified many anomalies with the recording of medication.

A specialist medicines inspector reviewed how medicines were managed at the service. We identified that the medication room was not secured during our visit because the door did not close properly. We observed a nurse leaving the door unlocked because the frame was split and the lock did not engage. From our discussions with the registered nurses on duty, this was not an isolated occurrence. We brought this to the attention of the directors of the service and a maintenance person immediately fitted an additional handle to enable staff to pull the door shut. However, during the later course of our inspection, we visited the store room to find it unlocked again with medicines unsecured and accessible to anyone who visited the home.

We noted two storage cupboards within the medication room which contained medication for two people who had passed away. This medication had been retained on the request of the coroner. This medication was noted to be unsecured during our inspection and one of the medication was held past its retention period.

We identified that some medication did not have the expiry date documented on the bottle. One such medication was an oral solution designed to last 10 days with guidance as to the destruction of 50ml after each 10 days. The records did not evidence that destruction was occurring in accordance with the manufacturer's guidance. The lack of an expiry date on this liquid medication was unsafe practice.

Controlled drugs (CD's) are prescription medicines that have controls in place under the Misuse of Drugs legislation. We reviewed the controlled drugs register and checked seven entries and cross checked a selection against the actual and Electronic Medication Administration Record (EMAR) stock figure. We saw these were generally recorded clearly each day however there was no record that an audit of the stock had taken place except for a 'tick box' form contained within the fridge temperature records. Some entries stated, "Received from Pharmacy" written in the wrong column and this did not provide sufficient information in accordance with the relevant legislation and good practice guidance. We identified that there was excessive stock of the controlled drug 'Oxycodone' and that medication was not being used in the order that it was received from the pharmacy because older stock was not being used first.

We checked a sample of medication and identified further anomalies with the recording of medication. For example, one person's records showed they had received antibiotics prior to a hospital admission in May 2018 but had nothing since that date. We reviewed the person's care plan records which did not reference any antibiotics in use, however, we identified that two capsules had been removed from the current stock. This reflects unsafe practice because this medication could not be accounted for.

We checked the stock of medication for a further three people who lived in the home and identified continued errors with the stock balances for all three people because they did not correspond with what was recorded within the MAR.

The non-administration of medication was not recorded in an accurate manner and this contributed to the errors we identified during our inspection. This was because recording "Resident refused" or "Clinical Decision" did not deduct the stock from the running total on the EMARS. There was a lack of consistency in respect of the use of these 'reason codes' because non-administration had been recorded in a variety of ways even by the same members of staff.

The audit system and processes in place were not robust enough to identify errors. For example, we noted that the medication self-assessment in place had scored the service 100% in respect of ordering/storage and answered in the affirmative to the question, 'Treatment room locked' and 'Any non-administration of medication is recorded correctly?'.

This is a continued breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

People told us they received their medication on time and were happy with how this was administered. Each person's record had their photograph on the front to ensure medication was given to the correct person. Special green medication beakers were in use to ensure people, who were left with liquids to consume, were identified. Some medicines need to be stored under certain temperatures to ensure their quality is maintained. We saw that fridge temperatures were recorded daily and were within range.

People told us they felt safe living at the home and visitors also agreed their loved one was safe. People described what made them feel safe. Comments included; "The kindness and nobody's rushing about. You don't give safety a thought", "I can't think of any dangers, the staff are well-trained", "There's always someone around. You've only got to press your buzzer and they're there." One person's relative told us, "I'm here every day. Any changes are monitored and emergencies are dealt with immediately."

People offered a range of responses when asked about staffing levels. Comments included, "They're very busy, but calm, I don't have to wait", "Sometimes they do [have enough staff], sometimes they don't. If staff leave and they're not replaced", "Sometimes they're in a rush" and "That varies, they have a lot to do". Visitor comments echoed this range of responses. Comments included; "A lot depends on what's going on", "All the staff are good, I just think they need more staff at mealtimes" and "Sometimes they're really busy." Another relative told us they felt the standard of care deteriorated at weekends.

The service monitored and assessed staffing levels to ensure sufficient numbers of staff were deployed to meet people's needs. Staff rotas confirmed that staffing levels were maintained at seven carers in the morning and five carers in the afternoon alongside two registered nurses to meet the needs of the 37 people living in the home. We raised some of the mixed feedback we received regarding staffing levels with the directors during our inspection who agreed to review the deployment of staff across the home.

Safe recruitment procedures were in place to ensure that staff appointed were suitable to work with vulnerable people. We reviewed three personnel files and saw evidence of application forms, photographic identification, appropriate references and Disclosure and Barring Service (DBS) checks. DBS checks consist of a check on people's criminal record and a check ensure they are suitable to work with vulnerable adults. The training matrix showed staff had received training in safeguarding and staff understood what course of action to take if they felt someone at the service was being abused or neglected.

Risks to people's health and wellbeing were assessed in a variety of areas such as falls, skin integrity and hydration. These assessments were reviewed regularly and preventative measures were put in place to minimise any identified risks. For example, people assessed as being at risk of developing pressure ulcers, had associated care plans to advise staff of what support the person required, such as reposition changes and specialist equipment.

The registered manager maintained oversight of incidents, accidents and near miss events. Appropriate action was taken in response. For example, for incidents of falls, staff followed guidance and ensured that 24 hours' post falls observation was completed. The accident records showed each fall was recorded with details of where it occurred, injuries caused and any contributing factors. Action was taken following this, for example, the update of relevant risk assessments. Near miss events had 'corrective action' documented to record the preventative measures in place to prevent re-occurrence.

People were supported to live in a safe environment that was free from hazards. Regular checks were completed of the environment and equipment to ensure they did not pose a risk to people's safety. We spot checked some safety certificates such as gas safety, electric and PAT testing and these were all up to date. Fire evacuation points were clearly marked out and records showed that had received the relevant training.

The building, bedrooms and communal areas were clean and well-maintained. Staff had received training in infection control and used Personal Protective Equipment (PPE) when providing care. Warren Park care home had achieved a 'Good' rating from the local food standards authority on 24 October 2017. This demonstrated hygienic food handling practices. The housekeeper showed us cleaning schedules which demonstrated that a series of daily cleaning tasks were completed alongside monthly 'deep cleans' to promote good cleanliness within the home.

Is the service effective?

Our findings

People told us that staff were competent and had the necessary skills and knowledge to support them. Comments included; "I would say they're very good", "Most of them. There's always someone there who seems to know what they're doing", "Yes, the two young ones are doing very well". Visitors agreed, with one commenting, "They have regular training. The new staff shadow experienced ones for quite a bit."

Staff reported feeling well supported in their role and that they had the skills and knowledge they needed to equip them. Records showed that staff received training in a variety of topics including; moving and handling, nutrition, 'react to red' pressure area care and dementia awareness. One staff member told us they had been on Parkinson's training which enabled them to understand more about the condition and the importance of time specific medication. Another staff member told us the service had supported them to receive 'Train the trainer' in moving and handling.

Whilst there were some gaps in the registered provider's supervision schedule, staff were happy with the frequency of supervision and felt able to raise any support needs informally. Records showed that all staff had received a supervision or appraisal in the last six months which enabled any development or training needs to be identified.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff adhered to the principles of the Act and sought consent before providing care. A registered mental health nurse was employed by the service and completed a variety of cognitive reasoning assessments and capacity assessments for people in the home.

Care plans were signed by people themselves where appropriate and consent documents were contained within care files in respect of specific decisions such as information sharing, use of bed rails and for photographs to be taken. The best interest process was used where people were assessed as not having capacity to make specific decisions.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Our review of records showed that the registered manager made applications to the local supervisory body as appropriate and a copy was retained within people's individual care files. Lasting power of attorneys were also documented within care records.

People were supported with their nutrition and hydration intake and we spoke to the catering manager who was aware of people's individual requirements including pureed diets and those with diabetes. People's dietary needs were assessed on admission and any allergies or special dietary requirements were

documented within the care files and in the kitchen. The service had introduced coloured cups to alert staff to any specific hydration support requirements.

Most people enjoyed the food available at the home. Comments included; "First class I enjoy it", "Very good I enjoy it, there's plenty to eat" and "The food's very good." People told us that the service had responded to their requests to have their main meal at teatime with a light option at lunchtime. Some people thought aspects of the meal delivery could be improved such as timeliness. We observed the lunchtime service and sampled the lunchtime meal of quiche and salad and found it to be of good quality. We discussed with the directors how the mealtime service could be developed to make this more of an enjoyable event with the introduction of music and table dressings.

Records showed that people were supported to access health care professionals such as GPs, podiatrists, opticians and dieticians. Everyone we spoke with told us they could see a doctor if they were unwell and visitors told us they were always kept informed. Staff escorts were provided to accompany people to routine health appointments if needed. Staff worked closely with other professionals and records of multi-disciplinary visits were documented within people's care plans so staff were aware of any treatment required or advice given. We identified that one person at risk of weight loss was not weighed weekly in accordance with professional advice and brought this to the attention of the directors during our inspection. A visiting health professional was present during our inspection and spoke positively about the care provided at Warren Park stating, "The care is great."

A key information document was kept in each person's file with pre-formatted information containing personal information and GP. A nurse told us that at the point of admission, staff completed additional information in respect of people's current medication, mobility needs and up-to-date health information. This information was useful when transferring between services or in the event of emergency or urgent hospital admittance.

The environment of the home was clutter free and accessible for those with mobility problems. There was a passenger lift to allow access to different floors within the home and people could access the garden. The home had adapted bathrooms and specialist equipment such as ceiling hoists to assist those with mobility difficulties.

Is the service caring?

Our findings

People provided positive feedback regarding staff in the home and told us they were treated with respect. Comments included; "[Staff treat me] absolutely wonderfully. They treat me as the person I am and they're so friendly", "They're very friendly, I get treated with dignity and respect", "[I am treated] very well. They're friendly and good. They notice things", "They're kind, they look after me well" and "Very well, they've always called me by my Christian name, they're nice girls." People's visitors agreed and told us, "They're lovely. I've not met one that's not pleasant", "The ones who have been here all the time know [relative] quite well. If he's having an off day they can spot it right away" and "They're lovely."

Not everyone could recall being involved in making decisions about their care but records showed they, and their families, had been consulted where appropriate. This was evident through consent documents contained within care files which were signed by people themselves, or their family members. Support plans were in place to guide staff on how to provide appropriate care to those with dementia who may struggle to make some decisions. One plan documented that the person was able to make their own choices regarding what clothes to wear if shown what is available by staff. This ensured that staff had sufficient knowledge to assist people to remain involved in making decisions about their care. Another care plan recorded that the person could make simple day-to-day choices but outlined what areas of support they required such as reminders regarding mealtimes and help to identify family members.

The registered provider's records showed they were aware of their obligations in respect of the Accessible Information Standard. The Accessible Information Standard aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need from health and care services. Information was recorded within files regarding people's communication needs to ensure people who might need additional support were identified. For example, staff were advised to communicate in simple language and use short sentences for one person who was living with dementia. Another care record instructed staff to ensure a person's hearing aids were used and that the batteries were charged to enable them to engage in conversation.

The provider information return outlined that people could access information using an electronic tablet, with the text size adjusted to suit and documentation was available in alternative formats. One person who used the service had sight problems. This person told us that staff assisted them to engage with reading materials in alternative formats such as 'talking books'. Additionally, we noted that another people's whose first language was not English had support tools in place, such as commonly used phrases in their preferred language, displayed in their bedroom so that staff could engage with them.

People spoke positively about the atmosphere within the home. Comments included; "[The atmosphere is] calm but very positive", "Friendly, I'm very close to the staff", "I think it's very happy. Everyone talks to each other", "It's really good" and "People will come in and talk to me, I'm not stuck on my own. Everybody seems to know everybody else."

During the inspection we observed relatives visiting at various times throughout the day. We saw that

visitors were welcomed by staff and there was no restriction as to when people could visit, which encouraged relationships to be maintained. Some friends and relatives had become 'volunteers' at the home as part of the service's volunteer programme and accompanied people on trips out in the community. People's relatives also commented on the positive atmosphere in the home. Visitors told us "[The atmosphere is] good, there's nearly always something on" and "Very friendly, everybody talks to everybody else."

Staff demonstrated a good understanding of how to protect and promote people's dignity and people confirmed that staff maintained this in practice by closing doors and curtains during any personal care. Reminders were contained within care records such as, 'Staff to close the door when attending to person's continence needs to maintain privacy.' We observed staff asking for consent before providing support to people. Staff had received training in Equality and Diversity and understood how to apply this in their everyday practice. Care records also demonstrated a consideration of people's individual diversity and cultural needs, for example, religious beliefs. Regular church visits were offered at the home including a Catholic mass every month and communion every week.

Is the service responsive?

Our findings

Care files contained a pre-admission assessment which ensured the service was aware of people's needs and that they could be met effectively from the point of admission to the home. Care plans were in place to guide staff on how to support people effectively. These covered a variety of aspects of care delivery such as eating and drinking, nutrition, elimination and mobility. These plans were evaluated monthly and any changes to people's support needs were documented to ensure the service remained responsive to the person's needs. For example, one person's care plan was updated to reflect new advice from the dietetic service in order to promote weight gain.

Care records were person centred and contained information about people's likes, dislikes, routines and backgrounds. This information enabled staff to provide care based on people's preferences. An 'All About Me' document contained information on the person's background and social history such as their previous occupation, hobbies and important relationships. This information ensured new staff could familiarise themselves with a person's life story which promotes conversation and rapport building.

People had access to call bells in their rooms to enable them to call for staff support when required. Assistive technology was also used such as sensor mats and fall alarms. This enabled staff to respond in a timely way and provide support to people when they needed it. We identified one person whose call bell was not positioned within their reach and brought this to the attention of the directors during our inspection. The majority of people told us they were generally satisfied by staff response times and by how quickly their needs were met. Comments included, "[Staff answer call bells] quickly", "A reasonable length of time, I'm satisfied", "It depends on the time of day. They're slower at mealtimes, on the whole it's pretty quick." A visitor told us, "If the buzzer goes off, they are here like a shot."

An activities co-ordinator was employed by the service to offer people a range of activities to promote social inclusion and stimulation. The activity coordinator told us they had a gardening club; and offered activities such as arts and crafts, baking, reminiscence and a series of workshops. Organised trips out in the local community were arranged and on the morning of our inspection, four people had been taken to see the 'Terracotta Warriors' exhibition at a nearby museum. People told us they spent their time watching television, reading, listening to the entertainment and enjoyed visits from local schools. Comments included, "I join in the activities, I like to get out of my room" and "I read, watch television and do activities most afternoons." People's visitors appreciated the variety of activities on offer, "They have a lot of activities, e.g. chair aerobics. They all enjoy themselves", "I like the way they do so much with them. It's nice there's so much going on" and "They push the boundaries, they take people out."

People had access to a complaints procedure which was circulated to all people who used the service within the service user guide. Most people told us they would complain to either the staff on the floor or go to the office. The nurse assisting us with the inspection told us there has been no recent formal complaints. We looked at a 'food compliments and complaints book' which documented people's feedback regarding the food and saw that people's suggestions were then discussed within catering meetings. A suggestion box was also available in the communal area of the home to enable people to express dissatisfaction or make

suggestions.

The staff training matrix showed that care staff had received training in 'end of life care' in accordance with the six steps programme relating to the provision of quality care for people at the end of their lives. This meant that people could be supported to remain in the home if that was their preference. Some people's end of life wishes were recorded within their care files in respect of their funeral choices. Care records contained information in respect of whether people had completed 'Do Not Attempt Resuscitation' (DNAR) forms.

Is the service well-led?

Our findings

Overall people were happy with the service provision and our feedback and observations confirmed that staff were caring, effective and responsive. Nevertheless, we identified areas of practice which could pose a risk for people's safety, namely in respect of medication storage and recording. This was a recurrent theme from our last inspection in 2016 whereby the registered provider was in breach of Regulation 12 (Safe care and treatment).

The registered provider had not taken sufficient action since our last inspection to improve the safety of medicines and the required improvements had not been made to the quality assurance systems and processes. Audits in place to check the safety of medicines were not robust because they had not identified the issues we found during the inspection. In addition, medication self-assessments were not sufficiently self-critical because they consistently scored the service highly in respect of the storage and recording of medication. This meant that governance systems in place to monitor the quality and safety of the service were not always effective.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A registered manager was in post at the service however they were unavailable at the time of our unannounced inspection. 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. We were assisted during our inspection by two directors of the service and a nurse. We found some information was not easily accessible in the absence of the registered manager. We raised this with the directors at the time of our inspection and discussed how the organisation of records could be strengthened to facilitate ease of reference by other members of staff in the registered manager's absence.

People knew the registered manager and told us they, and the directors were visible throughout the service. Staff spoke positively about the support provided by the registered manager. Comments included; "[Registered Manager] is fair and approachable" and "Any problems, I would go to the registered manager, they are very good and would do their best to sort it out." Staff also felt comfortable in approaching the directors of the organisation for support. One staff member told us, "I've been to [director] for things a few times." Staff told us communication amongst the team was effective and they enjoyed working for the organisation. Comments included, "It's the best home I've ever worked in."

We saw evidence of managerial oversight in respect of areas such as falls, weights, infection control and care plans. We found that this information was used to improve the delivery of care and the service. For example, the infection control audit scored each area accordingly and made recommendations such as a targeted deep clean of specific bedrooms and these were marked off once completed. Similarly falls audits looked at the occurrence of incidents, the time of day, type of falls and the area in which they occurred.

We noted that the registered provider also attended a series of management meetings to offer another tier of oversight. Minutes of these meetings showed that discussion was held regarding incidents at the service, falls and any safeguarding issues.

People were encouraged to provide feedback on the quality of care being delivered through the circulation of resident and relative questionnaires. People were kept informed about changes and events such as activities, menu changes and current affairs through the weekly newsletter.

Regular resident and relative meetings were also held to enable people to contribute towards the improvement of the service. Minutes showed discussion was held regarding food, activities, the environment and overall care. Actions were developed following meetings and timescales allocated and we saw evidence that these had been completed, for example, suggestions for trips out in the community. People told us their feedback was listened to and used to develop the service. Comments included, "They're [resident meetings are held] about once a month. I would say they respond", 'Things change, they listen to you' and "They respond to issues." People's visitors also told us the service was responsive to suggestions for change. Visitor comments included; "We hear about things in the newsletter, sometimes things change", 'Absolutely things change' and "Yes, they listen to what they [people who live in the home] are saying."

The registered manager had notified the Care Quality Commission (CQC) of events and incidents that occurred at the service in accordance with our statutory requirements. This meant that CQC could monitor risks and information regarding Warren Park care home.

From April 2015 it became a legal requirement for providers to display their CQC (Care Quality Commission) rating. The rating from the previous inspection was displayed for people to see at the entrance to the home.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	Medicines were not stored safely or recorded accurately and audit processes were not robust to identify errors.
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	Medication was still not managed safely at the service and the quality assurance systems were ineffective in identifying this.
Treatment of disease, disorder or injury	