The Warren Residential Lodge Limited

The Warren Residential Lodge

Inspection report

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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

The inspection took place on 21 and 24 August 2018 and was unannounced.

The Warren Residential Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Warren Residential Lodge is registered to provide accommodation for up to 31 people, including people living with dementia care needs. At the time of our inspection, there were 29 people living at the service. The service was arranged over one level, which was divided into different 'zones'. Five bedrooms had en-suite facilities and there were four communal bathrooms in addition to three toilets. There were two lounges, one dining room and a garden area that people could easily access.

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The home was last inspected in July 2017 when it was rated as 'Requires Improvement' overall with a breach of Regulation 17 of the Health and Social Care Act 2008 relating to Good Governance. At this inspection we found that appropriate actions had been taken and therefore the service was no longer in breach of this regulation.

People felt safe living at The Warren Residential Lodge. Staff knew how to keep people safe and how to identify, prevent and report abuse. They engaged appropriately with the local safeguarding authority.

Individual and environmental risks to people were managed effectively. Risk assessments identified risks to people and provided clear guidance to staff on how risks should be managed and mitigated.

There were appropriate arrangements in place for the safe handling, storage and disposal of medicines.

Recruitment procedures were in place to ensure that suitable staff were employed by the service.

People received care and support from staff who were suitably qualified, skilled and knowledgeable to carry out their roles effectively.

New staff completed a comprehensive induction programme and all staff were suitably supported in their roles.

People praised the standard of care delivered and the quality of the meals. Dietary needs were met and

people received appropriate support to eat and drink. People were supported to access healthcare services when needed and to attend hospital appointments.

People were cared for with kindness and compassion. Staff interacted with them in a positive way. They spoke about people warmly and demonstrated a detailed knowledge of them as individuals.

People were cared for with dignity and respect and were treated in a kind and caring way by staff. Staff know people well, encouraged people to remain as independent as possible and involved them in decisions about their care.

Staff protected people's privacy and responded promptly when people's needs or preferences changed. They involved people in the care planning process and kept family members up to date with any changes to their relative's needs.

People received personalised care and support that met their needs. Care plans provided staff with detailed information about how they should support people in an individualised way.

People had the opportunity to access to a range of suitable activities. There was an appropriate complaints procedure in place and people knew how to make a complaint.

People and their families felt the home was run well. The provider was actively involved in running the service and there was a clear management structure in place.

Staff were happy in their work and felt supported by the provider and the manager.

There was an open and transparent culture in the home. Relatives could visit at any time and were made welcome.

There was an appropriate quality assurance system in place and where issues were identified, action had been taken promptly.

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.

Appropriate recruitment procedures were in place.

There were enough staff to meet people's needs and arrangements were in place to ensure that a suitable skill mix of staff was available for each shift.

People felt safe and staff knew how to identify, report and prevent abuse.

Individual and environmental risks had been identified and were managed safely.

Medicines were managed and administered safely. They were ordered, stored and disposed of correctly.

Procedures were in place to protect people from the risk of infection.

Is the service effective?

Good

The service was effective.

Staff were skilled, knowledgeable and competent to carry out their roles.

New staff received a robust induction period before they worked independently with people and staff felt supported in their role.

People were supported to eat a variety of suitable meals and were encouraged to drink often.

Staff followed legislation designed to protect people rights in line with The Mental Capacity Act 2005.

People had access to healthcare services and professionals if they needed them.

Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's privacy.

Staff respected people's independence and encouraged people to do things for themselves.

Staff supported people to meet their cultural and religious needs.

Is the service responsive?

Good

The service was responsive.

People received care and support in line with their personal preferences. Care files contained detailed information to enable staff to provide care and support in a personalised way.

Care and support was planned in partnership with people, their families and healthcare professionals where appropriate.

Staff responded promptly when people's needs or preferences changed.

Staff were kept up to date on people's changing needs.

Most people received appropriate mental and physical stimulation and had access to activities they enjoyed.

The provider had arrangements in place to deal with complaints.

Is the service well-led?

Good

The service was well-led.

People were happy living at The Warren Residential Lodge and felt the service was well-led.

The provider was engaged in running the service and there was a positive and open culture.

Staff were organised, motivated and worked well as a team. They felt fully supported and valued by the registered manager.

There were robust auditing processes in place. The quality of the

service was monitored and appropriate actions were taken when required.

The Warren Residential Lodge

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 and 24 August 2018 and was unannounced. On the first day of the inspection there was one 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. On the second day of the inspection, there was one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed the information in the PIR, along with other records we held about the service including previous inspection reports and notifications. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

We spoke with 12 people living at The Warren Residential Lodge, four relatives and four visiting health professionals. We also spoke with the provider, the registered manager, the deputy manager, the medicines manager, six care staff, a kitchen assistant and one domestic assistant. We looked at care plans and associated records for five people, staff duty records, staff recruitment files for six staff, policies and procedures and quality assurance records. We also spent time observing the care and support people received in communal areas of the service. We 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.

The home was last inspected in July 2017 when it was rated as 'Requires Improvement' overall with a breach

of Regulation 17 of the Health and Social Care Act 2008 relating to Good Governance.

Good

Is the service safe?

Our findings

People told us they felt safe at The Warren. Their comments included, "Oh yes, if I didn't I would let them know" and, "Yes, I always feel safe."

The service used an external agency to manage their staff employment responsibilities. In addition, they employed an administrator who supported the senior management of the service, to monitor staff recruitment procedures and records Relevant checks were carried out before a new member of staff started working at the service. These included the completion of Disclosure and Barring Service (DBS) checks, which would identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Staff files included application forms, references and health declarations. There was a formal approach to interviews with records kept demonstrating why applicants had been employed.

There were sufficient staff to meet people's needs and to ensure they were safe. However, we received mixed feedback from people and their relatives in regard to staffing levels during the peak leave period. Comments included, "They are short staffed lately. They have holidays at this time of year", "There's a shortage, I can see they're rushed off their feet" and "They are short staffed quite often, but it's OK." We observed staffing levels over the two days of our inspection and found that there were enough staff to meet people's needs. Staff were able to respond quickly to people and spent time with them when they needed it. Staff agreed that there were enough staff to meet people's needs. One staff member said, "I wouldn't say staffing levels are an issue. We work as a team and get things done." Another commented, "There is always plenty of time to spend with people."

Staffing levels were assessed using a dependency tool, which was calculated according to each person's individual level of need. The tool produced a score with was used to determine the amount of staffing hours required to support people appropriately. The registered manager reviewed the score regularly, to ensure that staffing levels continued to be appropriate if people's needs changed over time. There was a duty roster in place which was completed by the registered manager. They told us that they ensured there was a suitable skill mix of staff for each shift and that a head of care or senior staff member was always available. Absence and sickness was mainly covered by existing staff working additional hours or by the 'on-call' management for each day. Agency care staff were also used by the service if there were no other resources to cover a shift.

Staff had received safeguarding training and knew how to identify, prevent and report abuse. Staff had access to phone numbers for the local authority safeguarding team and were aware of how to contact them should the need arise. The management team encouraged staff to make use of a safeguarding application that could be downloaded onto a mobile phone. The application provided guidance for staff on how to recognise signs of abuse and had a direct contact line in the event of an emergency.

Individual risks to people were managed effectively. Risk assessments had been completed using a risk rating score, along with actions taken in order to reduce the risk of harm. Where people had specific medical

conditions, a risk assessment was in place which contained a full explanation of the risks associated with the medical condition. This included, common signs and symptoms for staff to recognise and clear information on how to manage the risk. Other potential risks to people had also been considered and recorded within their care plans, including moving and handling and skin integrity. For example, one person's care plan contained a falls risk assessment which identified that they were taking blood thinning medicine. This recognised the additional risks to the person if they fell, due to the effects of the medicine and provided staff with clear guidance on what actions to take if the person had an injury.

Where people had fallen, the service had a robust falls assessment procedure in place, which included the completion of a falls risk assessment, recording of an accident log and following a clear post falls assessment protocol. This meant that staff followed a 48-hour observation period and completed a body map which identified any signs of injury. The registered manager used this process to monitor any trends and patterns in falls and identified action taken to minimise the risk of falls re-occurring.

Environmental risk assessments had been completed appropriately to ensure each risk identified was managed effectively. Gas and electrical appliances were serviced routinely and there were plans in place to deal with foreseeable emergencies. Fire safety systems were checked and audited regularly and staff received training in fire awareness. We saw records of recent fire drills that had taken place and staff had been trained to administer first aid. In addition, each person had a personal emergency evacuation plan (PEEP), detailing the individual support they would need if the building had to be evacuated.

The service had a medicines manager in post, who was responsible for the effective management of medicines within the service. We saw that people were administered their medicines safely by staff members who had received appropriate training and they had their competency to administer medicines checked, to ensure their practice was safe. Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. People's care plans also contained a 'medicines administration profile', which detailed clear guidance for staff to ensure each person received personalised support when receiving their medicines. For example, one person's medicines profile stated, 'Staff to give me the medication pot, then I can put them out in front of me and pick a few up at a time. I find it easier to take my medication like this rather than in one go.' The profile also covered key areas of medicines administration to consider, such as, time critical medicines, 'when required' (PRN) medicines and whether there were any foods or drinks the person should avoid taking with their medicines.

There were suitable systems in place to ensure that medicines were securely stored, ordered and disposed of safely and correctly. Full stock checks of medicines were completed regularly to help ensure they were always available to people. Controlled drugs were stored in accordance with legal requirements and there were robust auditing systems in place to ensure that all medicines were given as prescribed and managed safely. For example, a daily check was documented and signed to state which staff member was responsible for every medicine round of every day. Safe systems were in place for people who had been prescribed topical creams.

There were appropriate systems in place to protect people by the prevention and control of infection. Staff had attended infection control training and confirmed that they had access to personal protective equipment (PPE). People told us that staff used PPE when needed. One person said, "Yes. They don't come without gloves." Staff followed clear procedures to ensure the risk of cross contamination was minimised where possible. For example, a staff member described how they processed soiled linen using special bags that could be put straight into the washing machine. All areas of the home were clean and cleaning schedules were in place to help ensure cleaning was done consistently, using appropriate products.

Systems and checks were in place to ensure people were protected from the risks associated with water borne infections, such as Legionella. The registered manager was able to describe the actions they would take should there be an infectious outbreak at the home and infection control audits were undertaken at regular intervals as part of an overall quality monitoring process. The home had been awarded five stars (the maximum rating available), for food hygiene by the local environmental health department.

Good

Is the service effective?

Our findings

People, their families and healthcare professionals told us effective care was received from experienced and competent staff. A person said, "Oh, yes. They're very good, they work very hard", and a relative said, "I can't fault the care, [relative] is well cared for here." A healthcare professional commented, "I love it here. This is one of the best ones I go to."

The service used a system to record the training that staff had completed and to identify when training needed to be updated. This included training in areas such as moving and handling, safeguarding adults and fire safety. We identified that some staff training was not up to date in line with the provider's policy, however we found this did not pose a risk to people as staff demonstrated an understanding and knowledge of relevant topics in relation to their role. We discussed this with the registered manager who acknowledged where there were gaps in staff training and showed us a list of upcoming training that had been booked or was planned for the year. People, their families and healthcare professionals described the staff as well trained and skilled to support people effectively. A healthcare professional said, "The staff here are brilliant, they are so willing to learn and they are all very knowledgeable. Staff were positive about the training they received and said they could ask for any additional training they felt would benefit people. One staff member told us, "The training is good. If you say you lack confidence in something, you will get support." Another said, "There are always lots of [trainers] coming in."

New staff completed a comprehensive induction programme before they were permitted to work unsupervised. Arrangements were also in place for staff who had not worked in care before, to undertake training that followed the standards of the Care Certificate. The Care Certificate is a recognised set of standards that identifies the knowledge, skills and behaviours expected of staff working in health and social care. In addition, a high proportion of experienced staff had completed, or were undertaking, vocational qualifications in health and social care.

Staff were supported appropriately and felt valued. Staff received one to one sessions of supervision. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns and discuss training needs. Supervision records viewed were detailed and the registered manager told us that supervisions sessions were often based on an informal format. Staff told us they felt supported in their role and were able to raise a concern at any time, alongside regular 'catch up' sessions with the registered manager or another senior staff member.

People were complementary about the food provided and were offered alternative choices at mealtimes if they wanted something different. One person said, "There's plenty, more than you need. There is lots of choice." Another person said, "[The food] is very good and very varied. They will make something else, they are very understanding." Mealtimes were a social experience and people were encouraged to sit in the dining room for lunch, however other people ate in their bedrooms if they preferred. Where people required assistance to eat or cut up their food, this was provided promptly in a patient and supportive way. Throughout the inspection, we saw that people were offered hot and cold drinks and staff prompted people to drink regularly. People confirmed that they were able to have drinks and snacks in the evening or night if

they wished. People were able to express their views on the variety of the food and drink at the service. For example, we saw minutes of a meeting held with people who live at the service, which had recently been held to discuss this topic and possible suggestions.

When new people moved into the service, important information such as people's allergies was passed to the cook in addition to people's likes or dislikes. For example, we saw information in the kitchen about whether people's food needed to be pureed or whether they preferred white or brown bread. We spoke with a kitchen assistant who was aware about people's individual dietary requirements and explained what action they would take if people were losing weight.

Staff protected people's rights by following the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. Records showed that where people lacked capacity, decisions made on their behalf were done so in their best interest and with the support of people who had the legal authority to make those decisions. Where relevant, people also had a mental capacity care plan in place for day to day decisions, which included consideration toward people's level of capacity and whether this may fluctuate at different times of the day.

Staff understood their responsibilities regarding people's consent and choice. Where people were able to, they had signed a relevant form to consent to different areas of their care. This included signed consent forms for personal care delivery, administration of medicines and use of photography. People's care plans also contained a document titled 'My Rights', which detailed key information for staff to follow in order to ensure people's rights and choices were respected in all aspects of their care and support. For example, one person's care plan stated, 'I receive visitors in the privacy of my own room and I will refuse to see anyone if I wish.'

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). 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. We found the provider was following the necessary requirements. DoLS authorisation had been approved for one person and the registered manager was reviewing whether applications were needed for other people living at the home. A risk assessment was in place to support the application that had been approved and this was detailed and informative.

The design of the home was suitable for the people living there. Corridors and doorframes were wide to allow easy access for people with mobility aids and wheelchairs, and handrails were fitted appropriately around the home to provide extra support to people. People were able to choose where they spent their time and there were a number of communal areas available to people, including a dining area and a large lounge. A smaller lounge was also available for people to use at the rear of the building, which the registered manager explained was often used by visitors for parties with their relative or to discuss private matters. People had access to a pleasant garden area which had seating and tables available. People's bedrooms were decorated to their preference and contained personal possessions, pictures and pieces of furniture. The registered manager showed us a 'business refurbishment plan' and told us about plans to redecorate some communal areas of the home, including the dining room. The registered manager planned to involve people living at the home in the redecoration by creating a design board, where they could pick which style and décor they preferred.

Staff were knowledgeable about people's individual health care needs and people were supported to access appropriate healthcare services when required. We saw records in people's care plans which evidenced regular visits from health and social care professionals, such as community health teams, district nurses, opticians and chiropodists. For each visit from a health or social care professional, a consultation form was completed which detailed the type of visit, the outcome and any further action taken. This was kept in people's files to help monitor their health and medical conditions. A health care professional said, "They [staff] are good at contacting us, even if it's just for a bit of advice, they will always pick up the phone."

Information in relation to people health needs and how these should be managed was clearly documented within people's care plans in a 'health management plan' format. Each plan described people's specific health conditions, how this affected the person, signs and symptoms of the condition and how to manage the condition. For example, we looked at a plan for one person who had high blood pressure, which stated, 'To help control [person's name] blood pressure, it is important for staff to encourage [person's name] to; eat a healthy, low fat, balanced-diet, be active, maintain a healthy weight."

Good

Is the service caring?

Our findings

People were supported by kind, caring and compassionate staff. People spoke positively about the staff and told us they were looked after well, one person said "They are very kind and very caring. They are cheerful." A relative said, "They are absolutely lovely."

Without exception, all interactions we observed between people were positive and supportive. Staff addressed people using their preferred name, knelt to their eye level and used touch appropriately to provide reassurance. Staff spoke with people in a polite and patient manner and took time to engage with people on a personal level, even where they were busy with other tasks. For example, we observed one person asking a staff member for a different drink to the one they had been given, after they had changed their mind. The staff member was already occupied with another task during a busy lunchtime, however they replied, "That's ok no problem, I will get you another cup." The staff member then got the person a different drink promptly. On another occasion, we observed the cook asking people what they would like for lunch later that day, one person had forgotten what they had requested, so the cook sat with them again and discussed what the options were. A visiting health professional told us, "The staff are always great with their interactions with people, like [the staff member] I've just been in with, we have a laugh and a joke. It's never just about the care responsibilities they have."

During the inspection we saw that staff had developed positive relationships with both people living at the service as well as their relatives. Staff commented on the positive impact this had on their job. One staff member said, "It's really friendly, even with relatives, we get to know each other on first name terms." Another staff member spoke with us about the 'family feeling' of the service and described how people and their relatives often asked about staff member's children.

People's cultural and diversity needs were explored during pre-admission assessments. These were further developed in people's care plans over time, with the person and their relative's involvement where appropriate. People's care plans contained a 'preferences' section for each area of their care, where information was recorded, such as whether they preferred to be supported by a male or female staff member for personal care. One of the areas address within the care plan was 'religion and language', which described people's needs, preferences and goals to follow their faith or culture. We saw that people had been supported by the service to maintain their faith. For example, one person of a particular religion had indicated that they missed that aspect of their life when they moved into the service. The registered manager responded by contacting the local community and arranged for the person to be supported to attend church services to ensure they maintained their faith. The service had also made links with the local church, who visited regularly to provide a service for people who wished to receive it.

The service had considered people's individual communication needs to ensure they received information in a way that they understood. People had a 'communication care plan' in place to guide staff on the best way to speak with people or present them with information. For example, one person's care plan stated, "Please refrain from using slang terms. Use question and answer technique to clarify understanding."

People confirmed their privacy was always protected when they were supported with personal care. One person said, "When they help undress me, they make sure the door is locked, that sort of thing." During the inspection, we observed staff knocking on doors and asking people's permission before entering their bedrooms. Staff were able to describe the practical steps they took to preserve people's dignity and privacy when providing personal care. For example, one staff member said, "If someone knocks the door, I make them aware that I am doing personal care." Other actions described included ensuring doors and curtains were closed and making sure people were covered. Furthermore, the service had recently appointed a 'dignity champion' as part of a wider scheme of 'champions' across the service, such as a 'safeguarding champion' and a 'falls champion'. We spoke with the staff member appointed as the dignity champion for the service, who demonstrated their passion and drive for encouraging the awareness of dignity across the service and staff.

Staff were considerate of people's privacy when discussing confidential or personal matters with them. People's comments included, "They are very considerate in the way they speak to you. They have a very quiet way of speaking to you and no one else" and, "If they have anything important to tell you, they tell you in your room." A relative also commented, "If they have to say something, they call me to one side." Confidential information, such as care records, were kept in the manager's office and could only be accessed by staff authorised to view it.

Staff respected and promoted independence by encouraging people to do as much as possible for themselves. One staff member told us, "I ask them to do some bits for themselves. If they can do it, I say 'You do that bit. Are you ok with that? Do you need a hand?'" Another staff member said, "If I know someone can do something themselves, I encourage them, I say 'Let's try and do it again.'" People's care plans highlighted to staff what people could do for themselves and when support may be needed. Comments included, 'I am able to transfer from wheelchair to chair in the shower. I need assistance to stand up when staff wash my lower half, but can support myself when I hold onto the rail' and, 'can pull up clothes and help pull my tops down.'

People were free to come and go from the service when they wished to and visitors were welcomed into the service at any time. One person said, "They [relatives] come in the evenings and weekends. They let them in whenever they want to come." Another person said, "You can go out anytime with your family. I go shopping with my daughter."

The registered manager was aware of how to request the services of independent advocates if needed. Advocates can be used when people have been assessed to lack capacity under The Mental Capacity Act 2005 for a specific decision and have no-one else to act on their behalf. They are independent people who spend time getting to know the people they are supporting to help make decisions that they believe the person would want. The registered manager spoke with us about a person who had used an advocate to be involved in decisions about their care planning.

Good

Is the service responsive?

Our findings

People received highly person-centred care and support that met their needs. One person said, "They [staff] are very good, they would get anything for you." A relative told us, "[The staff] are lovely with [family member]. She wanders in the evening, so they sit down with her."

People were supported to access a range of different mental and physical stimulation. People spoke positively about the range of activities available at the service. One person said, "There's a Monday club in a hall, they have singing groups and activities, it's interesting. Every week, there's a taxi coming." A relative commented, "There's always quite a lot going on. Someone comes in and plays an electric keyboard once a month and they have bingo." During the inspection, we observed most people were either sat in the main lounge or in their bedrooms watching television or pursuing their own interests. For example, two people had their own pets, one person knitted and another person listened to music. On the second day of the inspection, we observed a group discussion activity taking place in the main lounge of the service, which was well attended. We also saw plans for upcoming activities displayed on a noticeboard in the main reception area of the service, such as a 'pamper day'. The registered manager spoke with us about the actions they had taken to obtain people's views of which activities they would like to do and their plans to introduce an activities committee.

Initial assessments of people's needs had been completed when they moved into the service and care plans were developed to help ensure that people's needs could be met appropriately. As part of the assessment process, relatives were involved to ensure staff had an insight into people's personal history, their individual preferences and interests. Information of this type helps to ensure people receive consistent support and maintain their skills and independence levels.

The provider was in the process of introducing a new format of care plans and was transferring information from people's old care plans into their new care plans. The new format was well organised and provided comprehensive information to enable staff to deliver care and support in a personalised way. The care plans were centred on the needs of each person and took account of their medical history, their preferred daily routine and how people wished to receive care and support. For example, one section describing a person's washing and dressing needs stated, "I prefer to get washed and dressed after my breakfast and cup of coffee." Another section said, "I prefer staff to leave my call alarm on the arm of my chair in my room when I sit there in the day." A third said, "I do not wish to wear my glasses constantly throughout the day, I will put my glasses on when I require them." These records helped to ensure that people received the care they required in line with their needs, wishes and preferences. Care plans were reviewed regularly by nominated key workers. A key worker is a staff member who takes a particular interest in a named person, ensures the person's care plan is up to date and acts as a point of contact with family members.

The service was responsive to people's changing needs. Records showed that when people's health deteriorated, the service referred people to appropriate health care professionals. People's care plans also contained detailed information for staff about what actions were required if people's needs changed. Healthcare professionals confirmed they were contacted appropriately, in a timely way and that staff always

followed any recommendations they made. One healthcare professional said, "They are quick to contact me if they need me, they know when it is appropriate to do so." Another healthcare professional told us, "I've never had any concerns in the times I've been coming here. There is always a member of staff and someone about to respond." Staff were kept up to date on people's changing needs through verbal handover meetings which were held in between the day shifts. These meetings provided the opportunity for staff to be made aware of any relevant information about risks, concerns and changes to the needs of the people they were supporting.

Staff demonstrated a good awareness of the individual support needs of each person living at the home. Staff knew how each person preferred to receive care and support. For example, those people who needed to be encouraged to drink, the support each person needed with their continence and where people liked to spend their day. Staff promoted choice and respected people's autonomy by empowering them to make as many of their own decisions as possible. We heard people being offered choices throughout the inspection. Staff also used a daily report to summarise and monitor people's presentation and mood throughout the day and to highlight any important appointments or visits. This helped staff to monitor how people's needs were being met and ensure that any potential deterioration in their health was identified promptly.

The provider had arrangements in place to deal with complaints. People and their relatives told us that they felt able to raise a complaint and the provider and registered manager were 'approachable' to discuss concerns. One person said, "If it's not up to scratch, I would pick it up with them. Usually I don't need to." A relative said, "Yes, we would go and see the people in the office or I would see [the provider]." The registered manager described how staff were able to identify changes in people's behaviours, that may indicate they were worried about something. Staff supported people to talk about any concerns they had, in order to resolve them effectively. We viewed records of recent complaints. These had been investigated thoroughly and responded to promptly, in accordance with the provider's policy. The registered manager described how they used complaints to help identify learning and to improve the service.

People were supported to make choices about their end of life care and their families were consulted. People care plans contained information about people's next of kin and basic end of life details, such as the funeral provider people would want. The registered manager showed us an example of questions that would asked in order to explore people's end of life preferences further, as part of the new format of care planning.

Good

Is the service well-led?

Our findings

At our previous inspection, in July 2017, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to take appropriate steps to assess, monitor and improve the quality and safety of the service. At this inspection, we found sufficient action had been taken and the provider was no longer in breach of this regulation.

People told us they were happy living at The Warren Residential Lodge and felt the service was well-led. People's comments included, "It's always ok here" and, "They all know their jobs." A relative said, "The general attitude and the care is good. They do it well."

There was a clear management structure in place consisting of the registered manager, deputy manager, heads of care and senior care staff. Each had clear roles and responsibilities and the management team worked well together. Staff spoke positively of the leadership of the service and told us that they felt confident to raise any issues with the senior management of the service, knowing they would be listened to. Their comments included, "I feel so secure. I can go to [the registered manager] with a concern and she does it, she deals with it" and, "[The registered manager] and [the deputy manager] are a good management unit. I feel really comfortable to raise anything." Staff also told us that the registered manager and deputy manager completed regular care shifts alongside them, or would step in if needed. The registered manager commented, "I find it useful to do care shifts to see how people are getting on and working together."

Staff told us they enjoyed their jobs and there was a good sense of team morale amongst their colleagues. One staff member said, "It's a nice place to work, it's friendly. I think we all work together well, I'm lucky to work here." Another said, "It's a lovely place to work. The residents are always happy and smiling, that speaks for itself really." Staff told us they felt valued in their roles and were often recognised by management when they had shown hard work. For example, one staff member spoke with us about how they had been recently praised by the registered manager for an academic achievement in their career as a senior member of staff.

The registered manager described the values of the service as those of providing a 'home from home' environment, high quality care and treating people as individuals. Staff were aware of the provider's vision and values and how this related to their work. Staff meetings provided the opportunity for the provider and registered manager to engage with staff and reinforce the vision and values.

The registered manager told us they felt supported by the provider, who visited regularly. They said, "[the provider] is a god send for me. He is always on the end of the phone, he is brilliant for knowing what to do. We will always have a catch up or we talk on the phone." Staff also confirmed they felt the provider was visible and supportive. They commented, "[The provider] is here regularly. They have an 'eagle eye' and will spot things to improve on."

There was an open and transparent culture within the home. The provider's performance rating from their last inspection was displayed in the entrance lobby. Visitors were welcomed any time and were able to

come and go as they pleased. There were good working relationships with external professionals and the provider notified CQC of all significant events. A duty of candour policy had been developed, and was being followed, to help ensure staff acted in an open and honest way when accidents occurred.

An appropriate quality assurance system was in place. This included auditing aspects of the service, such as infection control, medicines, care planning and fire equipment. The audits demonstrated that where concerns had been noted, actions were taken in a timely manner. A maintenance log was also kept for staff to record any issues that were identified, which was then actioned by a maintenance staff member. Policies and procedures viewed were appropriate for the type of service and were accessible to people and staff members if required.

The service worked in partnership with the local authority, healthcare professionals and social services to help ensure that people received effective and safe care. Healthcare professionals described the positive relationships they had built with the registered manager and staff members for the benefit of the people living at the service. The registered manager told us about the work they had done recently with the local area's community care team, including their involvement with a care home forum. The registered manager said, "They are so helpful, they pull homes together so we can see the common problems we are all facing and we can find solutions." The registered manager also spoke with us about their involvement with the community, such as links with the local church and primary schools in the area.

Communication was effective within the service and people and their relatives were updated with important information appropriately. One person said, "Well, I keep myself to myself, but I read the notices so I know what's going on." A relative said, "They will come over to us." The registered manager told us relative meetings were previously held, however these had not been attended well and it was difficult to get people together on the same date due to work and personal commitments. As a solution, the registered manager told us they sought feedback regularly from people and family members when they met in the home and an annual quality survey was also sent to relatives. We also saw there was a suggestions box in the reception area, alongside a notice which welcomed people to give their views of the service if they wished.