Warwick Park Care Home Limited

Warwick Park Nursing Home

Inspection report

55 Warwick Park
Tunbridge Wells
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was carried out on 28 and 29 June 2016 and was unannounced. Warwick Park Nursing home provides care and accommodation for up to 25 older people. There were 22 people living in Warwick Park at the time of our inspection, nine of whom lived with dementia.

There was a manager in post who was in process of being registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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.

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

There was a sufficient number of staff deployed to meet people's needs. Thorough recruitment procedures were in place which included the checking of references.

Medicines were stored, administered, recorded and disposed of safely and correctly. Staff were trained in the safe administration of medicines and kept relevant records that were accurate.

Staff knew each person well and understood how to meet their support and communication needs. Staff communicated effectively with people and treated them with kindness and respect. People were not able to spend private time in quiet areas when they chose to due to lack of such space, however the building of a quiet lounge was included in the building works that were in progress.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options had been considered. Staff sought and obtained people's consent before they helped them. Staff received regular one to one supervision sessions and all essential training for their role. However, their training in mental capacity and DoLS was not effective. Staff were not able to identify how people were subject to DoLS. People's mental capacity was not appropriately assessed about particular decisions. When necessary, appropriate meetings were not held to make decisions in people's best interest, as per the requirements of the Mental Capacity Act 2005. We have asked the provider to take action and will check that remedial action has been taken at our next inspection.

The staff provided meals that were in sufficient quantity and met people's needs and choices. Staff knew about and provided for people's dietary preferences and restrictions. However, two people told us the food

was often 'bland' and this was confirmed by our observations. There was no attention paid to food presentation to encourage people living with dementia to eat. We have made a recommendation about this.

Although information was provided about menus, activities and how to complain, there were no pictorial elements that may help people living with dementia understand this information. There was no pictorial signage throughout the home to help people living with dementia help orientate themselves. Although there was a plan to include pictorial signage when the building works were completed, people needed to be currently oriented in the home. We have made a recommendation about this.

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

People were involved in the planning of activities and an enhanced activities programme was in progress. People's feedback was actively sought at relatives and residents meetings.

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

There was a system of monitoring checks and audits to identify any improvements that needed to be made. The management team acted on the results of these checks to improve the quality of the service and care. The audit system had not identified shortfalls in regard to mental capacity processes.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

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

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

Staff knew how to refer to the local authority if they had any concerns or any suspicion of abuse taking place.

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

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were not knowledgeable in the principles of the Mental Capacity Act 2005 and about the Deprivation of Liberty Safeguards (DoLS). The documentation in regard to MCA processes was not appropriate and demonstrated a lack of understanding about the processes to follow in line with legal requirements.

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

People were provided with a choice of suitable food and drink; however some people told us that food often tasted bland. The food was not presented in a way that took account of the needs of people living with dementia or a small appetite.

There was a lack of signage in the home to help people understand what was on offer and help orientate themselves.

People were referred to healthcare professionals promptly when needed.
Staff had a good knowledge of how to meet people's individual

needs.

Is the service caring?

Good

The service was caring.

Staff communicated effectively with people and treated them with kindness, compassion and respect.

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

People's privacy and dignity was respected by staff.

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

Is the service responsive?

Good

The service was responsive to people's individual needs.

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

The delivery of care was in line with people's care plans and risk assessments. A daily activities programme that was inclusive, flexible and suitable for people who lived with dementia was being developed.

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

Is the service well-led?

Requires Improvement

The service was not consistently well-led. The provider and manager had not identified that some staff training was not effective and that mental capacity assessment processes were not appropriately followed.

The provider had not ensured appropriate signage throughout the home to help people living with dementia understand information and orientate themselves.

The manager placed emphasis on the continuous improvement of the service. There was an open and positive culture which

focussed on people.

The manager welcomed people and staff suggestions for improvement and acted on these. Staff had confidence in the manager's style of leadership.

Warwick Park Nursing Home

Detailed findings

Background to this inspection

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

This inspection was carried out on 28 and 29 June 2016 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

We looked at 20 sets of records which included those related to people's care and medicines. We looked at people's assessments of needs and care plans and observed to check that their care and treatment was delivered consistently with these records. We reviewed documentation that related to staff management and six staff recruitment files. We looked at records concerning the monitoring, safety and quality of the service, menus and the activities programme. We sampled the services' policies and procedures.

We spoke with 13 people who lived in the service and 5 of their relatives to gather their feedback. Although most people were able to converse with us, others were unable to, or did not wish to communicate. Therefore we also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the director (the provider), the manager, two nurses, six care workers, an activities organiser,

one chef, a person responsible for the maintenance of the premises and one member of the housekeeping team. We spoke with a pharmacist and an optician assistant who provided support in the home and obtained their feedback.

Good

Is the service safe?

Our findings

People told us they felt safe in the service. They told us, "The staff help me with whatever I need, they make me feel safe", "I feel confident in the staff as they are always around, there seems to be plenty of them" and, "I feel safe here they make sure we are kept safe and they are here to help me and I feel confident when they help me with the hoist." Relatives told us, "[Our relative] feels safe because there are always plenty of staff on hand to attend to her needs."

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

Staff who worked in the service understood the procedures for reporting any concerns. All of the staff we spoke with were able to identify different types of abuse and were clear about their responsibility to report suspected abuse. They were aware of the whistleblowing procedure in the service and expressed confidence that any concerns would be followed up. Staff were up to date in their training in the safeguarding of vulnerable adults. The manager had updated a detailed safeguarding policy in February 2016 that reflected local authority guidance.

The home's fittings and equipment were regularly checked and serviced. Safety checks had been carried out throughout the home and these were planned and monitored effectively. These checks were comprehensive, appropriately completed and updated. They addressed the environment, water temperature, appliances, fire protection equipment and quarterly servicing of the lift. Equipment that was used by staff to help people move around were checked and serviced annually, last checked in September 2016. Wheelchairs were inspected monthly and serviced if necessary. Portable electrical appliances were checked regularly to ensure they were safe to use.

Each person's environment had been assessed for possible hazards. People's bedrooms and communal areas were free of clutter. The premises were well maintained and systems were in place to ensure the service was secure. There were works in progress to build an extension to the home and precautions had been taken to separate the building work from the rest of the home with a partition that blocked any dust and noise. Due to a drop in the ground level outside an exit which posed a risk to people, the exit had been condemned and an alarm had been fitted to alert staff should anyone attempt to use it. There was a system in place to identify and log any repairs needed and action was taken to complete these in a reasonable timescale. A risk assessment about the lift breaking down did not contain clear measures to preserve continuity of care for people on the upper floors. We discussed this with the provider and the maintenance manager who told us this risk assessment will be completed to reflect this aspect.

Staff were familiar with the process for evacuating the service in case of a fire and there was appropriate signage about exits and fire protection equipment throughout the service. People had individual personal emergency evacuation plans in place which detailed the level of assistance they would require if it was necessary to evacuate the service. These were included in a 'grab bag' that was located in the entrance for easy access. There were detailed plans in place concerning how the service would manage an emergency such as flooding, failures of heating system and severe weather. Regular checks on fire equipment were carried out and fire drills were completed in accordance with the home's policy. There was a detailed fire risk assessment in place.

Accidents and incidents were being monitored to identify any areas of concern and any steps that could be taken to prevent accidents from recurring. Appropriate logs were completed, inputted in a computerised system, analysed and audited by the manager to identify any trends or patterns. An audit had highlighted that a person experienced falling during certain times of the night. As a result, staff had been instructed to carry out 15 minutes checks on the person to check they were safe.
Appropriate arrangements were in place in relation to the storage, and recording of administration of medicines. The service used a Monitored Dosage System (MDS) provided by an external pharmacist, which delivered a four-week supply of each individual person's tablets and capsules in packs, to be taken at specific times and dates. The external pharmacist was carrying out a routine support visit. They told us, "All the nursing staff here welcome advice, ask the right questions, demonstrate good practice; the home has robust medicines audit trails."

People's medicines were stored, managed and administered safely. Some medicines needed storage in a dedicated fridge. The room and fridge temperatures were recorded and monitored daily. The air cooler system was switched on if temperature rose beyond the recommended range. The medicines administration records (MARs) were detailed and clear, with handwritten entries double signed to evidence checks had taken place. The MARs were appropriately completed and did not contain any omissions without a reason being recorded. We observed medicines being administered to people, including an injection. Staff introduced themselves to each person, explained what their medicines were and asked if it was convenient for them to take these medicines at this time. Staff gave people time and support to take their medicines without rushing. Medicines trolleys were locked between each administration. A person told us, "They never forget; I always get my tablets on time."

Clear protocols were in place for the individual taking of medicines "as required". People had an additional recording sheet that gave an overview of the person's use of such medicines over the past year, to assist their medicines reviews. The application of any topical creams that were applied by staff as part of personal care was recorded in daily MARs and their usage was guided by body maps. These creams were dated once opened, re-ordered in time and returned appropriately. GPs had signed forms to approve the use of homely remedies. The service's medicines policy was comprehensive and staff followed the procedures outlined in the policy.

Risk assessments were centred on the needs of the individual and were reviewed monthly, or sooner when people needs changed. Staff were aware of the risks that related to each person. Assessments in regard to falls took account of people's previous falls history, their medicines, their medical condition, their balance and abilities. Control measures to reduce the risks of falls included specialist equipment such as pressure pads to alert staff when a person got out of bed, and the help of two care workers. A person had requested bed rails to keep them safe while in bed and the risks had been assessed and discussed with the person and their family. People who were at risk of weight loss due to reduced appetite were closely monitored, and people who were at risk of skin damage were provided with specialised mattresses. These were regularly checked to ensure they were suitable for people's individual weight.

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

Requires Improvement

Is the service effective?

Our findings

People said the staff gave them the care they needed. They told us, "When they use the equipment to put me into bed they know what they are doing", and a relative told us, "The workers seem efficient."

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

The Care Certificate had been introduced for new staff as part of their twelve months induction. This certificate was launched in April 2015 and is designed for new and existing staff, setting out the learning outcomes, competencies and standard of care that care homes are expected to uphold. Staff completed workbooks to evidence their knowledge that were reviewed at three intervals over a period of twelve weeks. Staff whose English was not their first language were supported with English lessons at the provider's cost. A member of staff told us, "My English has improved no end, it is so useful." Observations of practice were carried out by the manager, the deputy manager and head of care. As a result of an observation, group supervision had been held and one member of staff had received additional training. Care and nursing staff received one to one supervision sessions every three months and were scheduled for annual appraisal of their performance.

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. The training that was provided included health and safety, first aid, dementia care, manual handling, safeguarding and infection control. Additional training included dignity in care, end of life care, care planning, how to care for people with a catheter, after a stroke, and for people who lived with Parkinson's disease or Diabetes. The service participated in a local hospice scheme where staff could access specialist training, such as the managing of common symptoms at end of life, end of life care for people who lived with dementia, the use of syringe drivers (portable pumps that are used to provide a continuous dose of medicine through a syringe) and verification of death.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). 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. Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied, or who had bed rails to keep them safe while in bed. The manager had considered the least restrictive options for each individual to keep them safe. When appropriate, Independent Mental

Capacity Advocates (IMCAs) were enlisted to help represent people's views when families were not available.

The training in mental capacity that had been provided to staff was not effective. Staff who had received training were unable to recall either principles of the MCA or what the MCA meant in practice. Records indicated that people's capacity to consent had not been accurately assessed, recorded and acted upon by staff. For example, in each people's care file the service used a standard template titled 'Mental capacity Assessment' for staff to use. This template listed 13 questions relating to the person's ability to make decisions about activities of daily living such as eating and drinking, and what to wear. Opposite each question there was a tick box where staff had entered either 'Yes' or 'No'. The form was reviewed each month and updates such as 'Still able to make simple daily decisions' were entered, even when there were multiples 'No' listed as replied to the questions. Another update made a general statement 'Does not have mental capacity' even though there were several 'Yes' listed in the template. There were no individual documented mental capacity assessments to show how people's mental capacity had been assessed regarding each specific decision, nor of any meetings having taken place to reach a decision in their best interest. This meant the requirements of the MCA were not properly applied in practice. We discussed this with the manager and the provider who said they would improve staff training in mental capacity and introduce clear processes for staff to follow and document without delay. As records of mental capacity assessments and of related meetings were lacking, people could not be confident that legal processes were followed and that appropriate decisions were taken in their best interest.

The failure to consider and act in accordance with the MCA is a breach of Regulations 11(1) (3) of the Health and Social Care Act 2008 (regulated Activities) 2014.

Staff sought consent from people before they helped them move around or before they helped them with personal care. A relative told us, "I see the staff are kind and polite, they always check and ask before they do anything."

There was an effective system of communication between staff. Staff handed over information about people's care to the staff on the next shift twice a day. Information about new admissions, accidents and incidents, referrals to healthcare professionals, people's outings and appointments, medicines reviews, people's changes in mood, behaviour and appetite was shared by staff appropriately. This system ensured effective continuity of care.

People gave us mixed feedback about the food. They describe it as, "fine", "OK", "all right I guess, not very exciting apart from lovely soups" and, "quite bland". One person told us, "The food is not so good, it's badly cooked and bland; I did have a conversation with the cook and it's a bit better now, there is always plenty of it in fact too much; we do get a choice, they usually ask us in the morning." Another person told us, "It's all right, some days very nice other days it is quite bland." A relative told us, "Every time I come the food looks very good and my relative loves it." While building works were in progress, the kitchen was used only to prepare cooked breakfasts, light meals and snacks. The service used a sister home's kitchen to prepare the food, and meals were brought over in specialised containers. Staff checked the temperature and served the meals onto individual plates after having checked people's dietary requirements, preferences and special requests. Several people had their breakfast late in the morning as they preferred, and cooked breakfasts were available when requested. We observed lunch being served in the dining areas and in people's bedrooms. People were offered a choice of two main courses and of alternatives. People were supported by staff with eating and drinking when they needed encouragement and aids were available. Although the food appeared well balanced, we noted that there was little attention paid to presentation to stimulate people's interest or appetite. A person who lived with dementia whose appetite and weight had reduced was provided with fortified drinks; however they were presented with the same plate of food as other people,

which did not provide any visual or sensory interest. We were unable to distinguish fish from mashed potatoes when a person was served 'fish pie and mash', and dessert consisted of chocolate mousse served in plastic containers.

We recommend that improvements to food presentation are made in accordance with published research and guidance for those living with conditions such as dementia and sensory impairment.

People were weighed monthly or weekly when there were concerns about their health. Fluctuations of weight were noted in a dedicated care plan. People's food and fluid intake was recorded and monitored by nurses daily. People were referred to the GP or a speech and language therapist (SALT) when necessary, and their recommendations were followed in practice.

People's wellbeing was promoted by regular visits from healthcare professionals. People were able to retain their own GP or were registered with local GP surgeries. A podiatrist visited every six to eight weeks to provide treatment for people who wished it. A visiting optician and dentist service was available. An optician assistant was visiting a person in the home to check on their optical prescription. They told us, "We communicate well with this service." People were offered routine vaccination against influenza when they had consented to this.

People had been referred to healthcare professionals when necessary. For example, to a GP for physiotherapy, occupational therapy, a community psychiatric nurse and mental health services. When people became unwell, information was promptly communicated to staff at handovers so effective follow up was carried out. This ensured that staff responded effectively when people's health needs changed.

There was no pictorial signage throughout the home to help people find their way around other than fire exits. The food menus, activities programme, service user guide and complaint procedures did not contain any pictorial elements that may help people living with dementia understand. There were no pictorial signs on bedroom doors, on communal areas doors or on toilets doors. As bedroom doors were not personalised, people living with dementia may not find it easy to locate their rooms. The provider told us a re-decoration programme was to be implemented once the building works would be completed, and that this included appropriate signage. However people needed to be currently oriented in the home.

We recommend that any improvements to facilities and the environment are made in accordance with published research and guidance for those living with conditions such as dementia and sensory impairment.

Good

Is the service caring?

Our findings

People told us they were satisfied with how the staff cared for them. They said, "The carers are very kind"; "They are all really lovely here I am quite happy" and, "I have been here four weeks and so far I have been very well looked after, the care is very good." A relative told us, "The care has improved, the team works together as a team and they are all happy, it makes a difference; they are all so friendly now, not just when you visit but all the time."

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

People were not able to spend private time in quiet areas when they chose to due to lack of such space. They had the options of either joining a lounge where activities took place, or remaining in their room. We discussed this with the provider who assured us the provision of a quiet lounge was included in the building works that were in progress. They told us, "Warwick Park will be a very different home from what it is now, there will be more space for our residents and quiet spaces where they will be able to see their visitors and talk in private or just relax in."

People were assisted discreetly with their personal care in a way that respected their dignity. A person told us, "They are always very respectful; they will ask me if I want to be left when I am on the commode." The manager reminded staff about 'dignity in care' at staff meetings. Staff were careful to speak about people respectfully and maintained people's confidentiality by not speaking about people in front of others. People's records were kept securely to maintain confidentiality. People's privacy was respected by staff who knocked gently on bedroom doors to announce themselves before entering.

Specific communication methods were used by staff when necessary. People had communication care plans that clearly outlined any challenges people may face and how staff could overcome this. A person could no longer use email as they had lost some use of their hands. They dictated letters to a member of staff who typed on their behalf. Another person with visual impairment had contributed to their care plan which stated, "I want staff to be patient with me, understand my fears and anxieties, give me some quiet times and remember that it is frightening to be in a room full of people that I cannot see but I can hear and I do not know them." Staff took care to gently lead that person when they walked and to describe their surroundings to them.

Staff encouraged people to do as much as possible for themselves. Staff checked that people were appropriately dressed and all people were well presented with comfortable clothing and footwear. People washed, dressed and undressed themselves when they were able to do so. A person told us, "I like to be

independent and they encourage that; I shower myself but if they need to help me they will." People followed their preferred routine, for example some people chose to have a late breakfast, or stay in bed. A person told us, "I choose when to go to bed." Staff presented options to people so they could make informed decisions, such as what they liked to eat, to wear or to do, to promote their independence.

Attention was paid to equality and diversity. People's spiritual needs were met with the provision of a monthly religious service held for people of all faith denominations. Staff who came to work in Warwick Park from abroad were supported by the management team to familiarise themselves with English culture and perfect their command of English language.

Clear information about the service and its facilities was provided to people and their relatives in a service user guide. A brochure informed people about the home's philosophy of care, the services and the activities available. There was a website about the service and sister services that was informative and user-friendly. The complaint procedures was displayed in the entrance and there were an informative leaflet from the Alzheimer's Research UK that invited people to apply for information booklets to answer any questions they may have about different types of dementia.

People were involved in their day to day care and in the reviews of their care plans when they were able to and when they wished to be. A relative told us, "I come when there is a big review of my mum's care plan and we sit together to discuss each part of it." Care plans were updated following events such as an illness or a period of hospitalisation. People had been consulted and many entries in their care plan were reported in their care plan in the first person and word for word. A member of staff told us, "They tell us what they want; they are the ones to decide."

People or their legal representatives were consulted about how they wished the service to manage their care and treatment when they approached the end of their lives. When appropriate, people were invited to take part in 'advance care plans' (ACP) titled 'Thinking ahead' and were supported by staff during the process. These plans give people the opportunity to let their family, friends and professionals know what is important for them for a time in the future where they may be unable to do so. This included how they might want any religious or spiritual beliefs they held to be reflected in their care; their choice about where they would prefer to be cared for; which treatment they felt may be appropriate or choose to decline; and who they had wished to be their legal representative. When people had chosen not to complete an ACP, the service used another document titled 'Looking ahead' where families and friends were invited to participate and represent people's views at a time where they may have lost the ability to communicate and may approach the end of their life.

People's wishes regarding resuscitation were appropriately recorded. People had pain management plans and plans were written in advance in regard to their possible use of pain relief medicines, to avoid any delay should people's needs suddenly increase when they approached the end of their life. Therefore people could be confident that best practice would be maintained for their end of life care.

Good

Is the service responsive?

Our findings

People gave us positive feedback about how staff responded to their individual needs and wishes. They told us, "I used to be able to knit but my arthritis stopped me so they find me a good book to read", "I love gardening and I've planted sunflower seeds here" and, "There are activities and I am given the opportunity to join but I choose not to." A relative told us, "The staff are never putting pressure on the residents, if someone says they'd rather do this or that instead, they go with it."

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

Staff followed care plans that reflected people's individual needs and wishes. There were risk assessments that were carried out before people came into the service, such as risks of choking or falling. This information was included in an initial care plan that was in place when people moved into the service. Care plans included people's life history and what was important to them, so staff could appraise their perspective. Individualised care plans about each aspect of people's care were developed further as staff became more acquainted with people, their particular needs and their choices. Specific care plans had been written in response to individual needs, such as for a person's mental health when they experienced confusion, for a person's recovery when they had an infection, and for another when they approached the end of their life. Care plans were summarised in an overview so staff could refer to them quickly and gain specific vital information about people's care.

All care plans were routinely reviewed and updated by the deputy manager and nurses on a monthly basis or sooner when needed, such as when people had experienced a fall, an illness or a period of hospitalisation. Care and nursing staff were made aware of any changes and updates at daily handovers and at weekly 'care meetings'. People's families or their legal representatives were invited to be involved with the reviews of their care.

People were encouraged to personalise their bedrooms as they wished and bring their own articles of furniture to make them feel at home from the beginning of their stay. We noted a person's bedroom had not been personalised even though the person remained in their bed and we discussed this with the manager. The registered manager told us they had contacted the person's relative who was due to visit from overseas so they could bring photographs and artefacts to make the bedroom more welcoming.

Staff took into account people's preferences, likes and dislikes about people's routine, activities and food. These were noted in their care plans and members of staff we spoke with were aware of what people liked to do, which routine they preferred and what they favoured to eat. One person had expressed the wish to be washed early in the mornings, another liked to go to bed straight after supper, and these preferences were respected.

People were able to express their wishes or comment on the way staff delivered their care at monthly residents meetings. These meetings were recorded and indicated that people who remained in their bedrooms had also been consulted to gather their feedback. People were invited to comment on their care, the catering, laundry, activities and the environment. People and staff had discussed together what picture they would like printed on a large canvas to cover un unsightly container at the font of the building to improve the view from the lounge. They had agreed on a sunflower field and this had been implemented.

People were invited to comment on how the service was run. Satisfaction surveys took place annually and people and relatives were provided with a questionnaire to complete that was analysed by the provider. An action plan was produced as a result to improve people's experience when they were living in the home. The last survey carried out in June 2015 had led to an improvement of cleanliness in the home, to individual preferences about routine being noted and acted on, and to the provision of an informative user guide in people's bedrooms. A current satisfaction survey was in progress. Positive comments from people's relatives included their thanks about "[staff] patience and understanding and about dealing with [their relative's] particular demands", and for "appreciating him, accepting his proposals and understanding him."

People we spoke with were aware of how to make a complaint. They told us, "I do complain whenever I am not happy and they [staff] put it right." Two complaints had been made in the last three months and these had been investigated and responded to in line with the provider's policies and procedures. Detailed information on how to complain was provided for people in the service user guide and displayed in the entrance.

A range of daily activities that were suitable for people who lived with dementia was available. The provider employed two activities coordinator who shared their time between the home and another sister home. These members of staff had only started in their post one month prior and were in process of devising a programme of activities in consultation with people. One activities coordinator spoke to us about trying different activities to learn about people's preferences. They had spoken with people and their relatives and consulted their care plans to find out more about individual interests. They had researched people's favourite music on the internet and had compiled a selection of music and songs that were important to people. People participated in Art and crafts, Bingo, quizzes, poetry reading, competitive skittles, word and reminiscence games. A person who liked gardening had planted seeds in pots; a knitting group knitted towards a specific project. The activities coordinator showed us their action plan which had been submitted to the provider for funding. This plan included options such as setting up clubs, combining themed events with regular outings, visiting the local cricket club, competitions, involving the local school and local Brownies. The provider had made funds available to boost the activities programme. Monthly outings were scheduled to take place to the coast, to the river, to local cafés, a castle, a farm and garden centres. As a person used to work in a forge, a trip to visit a forge was planned. An outing to go train spotting had been suggested to a person who had a special interest in trains. The activities programme was inclusive and how to motivate people who remained in their rooms had been considered. Themed events such as a birthday tea party for the Queen's birthday had taken place. A musician, a singing duo and 'Pat the dog' visited the home once a month; ducklings and rabbits were scheduled to be brought into the home for people to enjoy. Activities such as cookery had been suspended due to building works. However, the activities coordinator had brought a butter churn and people had enjoyed making butter and eating it on tea cakes.

Requires Improvement

Is the service well-led?

Our findings

People, relatives and staff told us the service was well led by the provider and the management team. People told us, "I know the name of the manager", "She is approachable" and, "The manager pops in and ask how I am doing." A relative told, "I had a questionnaire checking I was happy with my relative's care." Another relative told us, "If I need to complain I just go to the office and see the manager, she is very approachable and she knows the residents and the staff well."

They manager had applied to register with the CQC and this application was in progress. They had been in post since December 2015 and were the registered manager of a local sister home. They divided their time between the sister home and Warwick Park and were well supported by the director, a deputy manager and a head of care. We enquired how effective this division of time was in regard to the running of the service. The manager told us that they were going 'back and forth' but that as they were well supported by a core of senior staff, this 'worked well." Staff we spoke with confirmed this was effective. They told us, "The manager is very good, we see her quite a lot and she is there at least half the time, she is very involved and always available at the other end of the phone or in person, the other home is only 20 minutes away." People we spoke with were aware of who the manager was and told us they felt able to talk with them and discuss any concerns. The director told us that although this arrangement was effective and that they had full confidence in the current manager, they were attempting to recruit a suitable manager to assume a permanent and consistent presence in Warwick Park.

Staff were positive about the support they received. They told us, "We are respected here" and, "I feel very supported, with the language, the studies, and I get all the guidance I need." The provider had conducted a recent confidential staff survey and staff suggestions for improvement had been included in a monitored action plan. As a result, the provider was researching training courses on stress management for staff and an enhanced activities programme was in progress to improve people's experience in the home.

There was a thorough system in place to monitor the quality of service provided for people. The manager regularly walked around the premises to get an overview of the day to day running of the service, checked documentation and observe the environment people lived in. This included talking with people, relatives and visitors and gathering their feedback about the environment, the cleanliness, the care, the food and activities. When any concerns were raised, action was taken on the day or as soon as possible. When people had complained that the food was not hot enough, a hot plate had been purchased to improve food temperature. These checks were recorded and audited in a quarterly 'provider observation form'. Such an audit had highlighted a delay in staff supervision and appraisals and this had been remedied.

The manager also selected people's care files at random to check these were appropriately completed, and carried out a monthly audit. The actions that had to be taken were clearly planned, allocated to specific staff and followed up until completion. An audit had highlighted a lack of certain information and a need to evidence how people and/or their relatives had been involved in reviews. As a result, the information had been sought and completed in all care plans and consent forms and reviews had been signed by people or their legal representatives. There were monthly audits carried out for infection control, accidents and

incidents, medicines and complaints. A recent audit on infection control showed that the cleaning of hoists needed to be documented and this had been implemented. People and relatives surveys were analysed to identify how to improve the service. As a result of the last survey, a new cleaning log had been put in place to remove an unpleasant odour and monitor the cleanliness in the home.

A system of weekly meetings was in place to discuss any concerns relating to people's care, equipment, staffing or about how the service was run. These were attended by the director, the manager, deputy manager, head of care and senior care workers. Further weekly meetings were attended by the director, the manager and heads of departments to discuss issues concerning cleaning, maintenance, the kitchen and activities. All staff meetings were documented and set up action plans that designated who were responsible for any follow up action. Actions were reviewed at the next meeting to check they had been followed up. A need to purchase a new tap in a sink and how improve the maintenance logs had been discussed, and action had been taken in response.

The manager was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. They were fully aware of updates in legislation that affected the service. They had written a comprehensive action plan to check that each requirement of the Health and Social Care Act 2008 were met by the service. However they were not aware of the appropriate documentation to use in order to meet the Mental Capacity Act (MCA) requirements; their system of audits had not identified the shortfalls in regard to mental capacity assessments, best interest meetings process and relevant staff training.

The service's policies were appropriate for the type of service and clearly summarised, to help staff when they needed to refer to them. However the policy in regard to mental capacity was not clear about the processes to follow in practice. Policies were reviewed on an on-going basis, were up to date with legislation and fully accessible to staff for guidance. Records were clear and well organised; they were kept securely and confidentially. Records were archived and disposed according to legal requirements.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People's mental capacity had not been appropriately assessed and best interest meetings had not been held when necessary as per the Mental Capacity Act 2005 requirements.