Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Warmley House Care Home

Tower Road North, Warmley, Bristol, BS30 8XN

Tel: 01179674872

Date of Inspection: 30 May 2013

Date of Publication: June 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Management of medicines	✓ Met this standard
Staffing	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	Lunan House Limited
Registered Manager	Mrs. Susan Maria Horsewell
Overview of the service	Warmley House Care Home provides nursing and residential care for up to 58 people within the Bristol and South Gloucestershire area. The home also provides care to people living with dementia. It is one of the services provided by Four Seasons Healthcare (Laudcare Limited).
Type of services	Care home service with nursing Care home service without nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

	Page
Summary of this inspection:	
Why we carried out this inspection	4
How we carried out this inspection	4
What people told us and what we found	4
More information about the provider	5
Our judgements for each standard inspected:	
Consent to care and treatment	6
Care and welfare of people who use services	8
Management of medicines	11
Staffing	13
Complaints	14
About CQC Inspections	15
How we define our judgements	16
Glossary of terms we use in this report	18
Contact us	20

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 30 May 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

People told us they gave consent to the support they received. There were arrangements in place for assessing people's capacity and the outcome of assessments were documented.

We spoke with one visitor who said they felt the care home was very friendly, that their relative "always looked clean, well cared for and as comfortable as they could be". Another visitor told us they got on well with staff and thought Warmley House was "fine".

We met a visiting social worker. This was their second visit to the home that they described as 'open' as they were given the opportunity to review two people's care records. They said the staff were friendly and helpful and that the people's family were happy with the service.

The home provided a service for people who required nursing or personal care and there was a dedicated unit for people with a diagnosis of dementia. A range of opportunities were available for people including trips. Assessment and care plans were well documented with people involved in the process.

There were arrangements in place for the management of medicines including an assessment of the competence of staff. Medicines arrangements were monitored by the supplying pharmacist.

Staff were allocated to the nursing and residential units. The staff of the residential unit also worked in the dementia unit. One visitor told us they thought there wasn't enough staff.

There was a system in place for the handling of complaints and the procedure was displayed.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

People we spoke with said they gave consent to the care and support they received.

Staff told us they felt people gave consent to the care they received. They said that continuity of staff was important as they felt people were more likely to accept support from staff they were familiar with. One member of staff said they felt that people exercised choice and were able to identify signs of when people did not want support.

We looked at the organisation's consent to treatment and physical examination policy. It gave information for staff relating to why consent is crucial, when consent should be sought and what to do in an emergency.

The organisation had recently introduced a form for use in the home. Its aim was to gain people's consent to the care planning process. It recorded when people were able to agree, if they were unable or unwilling and if their relative was unable or unwilling to give consent.

We saw that care plans recorded where people could make choices. For example in one of the care records we looked at, we saw that it stated that the person would make day to day decisions about their care but would like the support of their family for more complex decisions. The care plan stated that the person should be enabled to make choices and given time to do so. Another person's care plan recorded that they were forgetful so needed to be given information in a clear manner. In another care plan we looked at, it recorded that the person had the capacity to consent and stated that they "expected their decisions and choices to be respected".

Mental capacity assessments were recorded. Where a person was unable to give consent their record showed that 'best interests' decisions would be made with the person, their daughter, GP and staff.

Care plans were supported by a 'biography' of the person. People were given a choice whether they wished to complete any, or all of the document and this was recorded.

We saw that where people had elected to not be resuscitated a record of this decision was signed by their GP.

We saw that people signed to indicate their consent to the use of bed rails, flu vaccination and for being photographed. We noted that one person's consent to being photographed form had not been signed.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

The home was separated into three sections to provide residential care, nursing care and care for people with a diagnosis of dementia.

One person we spoke in the dementia unit described the food as "beautiful" and said staff were helpful. They told us that they did not like some of the conversations that happened between other people in the unit and we saw that this was cross recorded within their care file.

Others described the food as "good meals" and "very nice". One of them told us they though that rooms were good and that the staff were "very good". They said that their relatives were made to feel welcome.

There were a range of activities held within the home. These included games and visiting entertainment. On the day of our visit we met people who were looking forward to playing Scrabble during the afternoon. There were photographs of various activities and outings displayed in the home. The home used the local community transport service for trips.

The manager told us that the local church was supportive and we saw there were regular services held in the home. The hairdresser visited the residential unit during the morning of our visit and we saw there was a 'not for profit' shop in the grounds. We were told the shop was open each day and sold a variety of goods, of people's choosing including, drinks, magazines books sweets and toiletries.

The manager told us about the Wednesday 'coffee morning' held in the conservatory for ladies and the gentleman's morning on Friday. They said they were planning to introduce visiting speakers for the groups. A drinks and snack trolley is taken around the home in the evenings.

The activities coordinator compiled albums of photographs to record people's stay in the home. These were given to family members, as a memento, when people left the home.

We observed the lunch being served in the dementia unit. There was a choice of steak

and kidney pie or sausages served with vegetables followed by a choice of dessert. We saw that special diets were catered for.

We conducted a Short Observational Framework for Inspection (SOFI) over the lunchtime in the dementia unit. We observed the interactions between three people and with staff. People were generally in good spirits engaging with each other and with staff in a positive way.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We looked at the care and treatment records for 11 people who lived in the various parts of the home. There was personal information recorded including contact details for relatives and any known allergies. Each care file had a photograph of the person and a biography.

We saw that the biography was written in the 'first person' and listed information related to the person's choices, history, relationships, in addition to their spiritual, cultural and sexual welfare. They also showed what a good day looked like for the person and similarly how a bad day looked. There were sections that showed what was important to the person and how they wished to be supported and what was important in their daily activity.

The organisation had introduced a new system for care planning based on outcome profiles. The profiles were developed based on assessment that rated people's needs as low medium or high. They related to people's rights, consent and capacity, medicines, mobility, nutrition and continence. In addition there were profiles related to personal hygiene, dressing and sexuality along with skin integrity, psychological and emotional needs. There was the option for additional profiles to be included and we saw they related to communication and wound assessment. Where an assessment had identified risks there were plans for how to minimise the risk. An overview of the profiles was maintained to ensure there was monthly review.

To support the care planning system we saw a variety of documents relating to supporting the person. These included nutritional screening tools, assessments of skin viability and records of falls. Each person had an individual fire safety risk assessment related to when they were in their bedroom. We saw that records were kept of communication with relatives and visits by healthcare professionals. A visiting social worker we spoke with described the records as "organised and clear".

People were referred to health care professionals as required. We saw that one person had a personal exercise programme. The visit record indicated that the physiotherapist had demonstrated the exercises to staff so that they could support the person with the programme. The record of a follow up visit showed that staff had failed to do so. The provider may wish to note that when people are expected to be supported with health related programmes they should be followed as directed.

When people suffered pressure areas or wounds, there was monitoring of the condition using dated photographs and body maps. Pressure relieving equipment was used to prevent pressure areas developing.

The service received referrals for end of life (palliative) care and where this was the case we saw there were specific plans in place. Where people had elected to not be resuscitated a record of this decision was signed by their GP and we saw it recorded within their end of life care plan. We saw that the organisation had produced leaflets for

relatives. One of these was entitled "Information to help those close to someone who is old or ill". The other was called "What to do if someone you know has been bereaved". Copies of these were available for visitors to take away from the reception area.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

Care plans recorded that people were happy to be supported in taking their medicines. One person's plan stated that the person preferred to take their medicines from a spoon with a glass of milk. Another care plan recorded that the person liked to be told what the medicines were prescribed for.

The four Seasons medicines policy stated that it "seeks to ensure people in Four Seasons care homes receive the correct dose of the correct medicine at the correct time".

We saw there were competency checks for administration of medicines for registered nurses and senior care staff.

Medicines were safely administered. We looked at the medicines arrangements within the dementia unit. There was a procedure for staff to follow and signature verification record. Medicines were kept in a locked trolley that was fixed to the wall when not in use. A monitored dosage system was used for the bulk of the medicines, supplied in blister packs. Medicines administration records were kept.

When we looked at the records we saw that on one day there was no signature to show that the person had been given their medicines even though they were not in the blister pack. We also noted that sometimes there was no code used when people refused PRN (as and when required) medicines.

Body maps were used to show where topical creams and solutions were to be applied.

We saw there had been an audit of arrangements, in December 2012, by the pharmacist that supplied medicines to the home. Recommendations made related to checking the temperature of the medicines fridge in the residential care unit and recording minimum temperatures in the fridge on the nursing care unit. In the residential unit we saw that the record had been completed on only six days in May 2013. There were gaps in the record in the nursing care unit also. The provider may wish to note that fridge temperatures should be recorded on a daily basis to ensure the efficacy of the medicines stored in them.

The home had experienced some discrepancies with the supply of medicines where wrong medicines had been delivered in error. Staff had been diligent in examining new stocks of medicines and they were returned to the pharmacy for exchange.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

A visitor we spoke with said they felt the staff did a "fantastic job" but that there was a shortage of staff at times.

We spoke with the manager about staffing levels. For the nursing care unit there were two registered nurses throughout the day supported by five care staff. At night there was one nurse and two carers.

The staff group for the residential care unit and dementia unit comprised of two senior carers for the morning shift and one for the evening and night shifts. They were supported by three carers throughout the day and two at night.

In addition there were two chefs, a kitchen assistant and domestic, cleaning staff. The home also employed a full time activities coordinator and part time administrator.

Staff we spoke with in a group said they worked together to ensure that the staffing level was effective in meeting the needs of people. They told us how they picked up extra shifts if needed and how there were 'bank' staff available. This meant there was little use of agency staff.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available.

Reasons for our judgement

Most of the people we spoke with had no complaints but told us they would speak to the manager if they did. One person we spoke with said "staff could be more attentive". Others were unhappy with the time they had to wait for a response when they called for staff. One person told us that staff would say that they would be with them within two minutes but sometimes they had to wait much longer. Another person we spoke with said "the response to call bells is variable". We raised this with the manager who said they would monitor the time it takes for staff to respond.

When we spent time with a visitor we asked them about complaints. They told us they had no cause for making a complaint as when they asked for something to be done informally they received the desired response. This was echoed by another visitor.

People were made aware of the complaints system. The complaints procedure was displayed and staff we spoke with told us they felt people knew how to complain if they were unhappy about any aspect of their care.

We saw that complaints were recorded and stored with any correspondence relating to the investigation and response to complainant.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk

Copyright Copyright © (2011) Care Quality Commission (CQC). This publication may be reproduced in whole or in part, free of charge, in any format or medium provided that it is not used for commercial gain. This consent is subject to the material being reproduced accurately and on proviso that it is not used in a derogatory manner or misleading context. The material should be acknowledged as CQC copyright, with the title and date of publication of the document specified.