Derby City Council

Arboretum House

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Arboretum House is a residential care home and is registered to provide personal care for up to 38 people. At the time of the inspection, two people were receiving long-term care, and six people were receiving support in a 'discharge to assess' bed. This is a stay in a residential care setting, which allows an assessment of the person's health and social care needs.

People's experience of using this service and what we found
Four out of the ten people we spoke to, reported a poor experience of a 'discharge to assess' bed at Arboretum House. People had not completed the existing feedback questionnaire. The registered manager advised a different type of questionnaire had been created and would be used in the future instead. People had not always been discharged with sufficient medicine, however the registered manager had investigated this and new processes had been implemented.

We found there were enough staff to support people safely while they stayed at Arboretum House. However, there were not always enough senior staff to support people when they left assessment placements. The provider had recognised this and was recruiting another senior staff member.

Staff records were not always comprehensive enough. This could impact external professionals' ability to assess people's needs and arrange suitable discharge. Care staff did not have access to visiting professionals records, this could impact their understanding of a person's needs

The provider had recognised that some improvements were needed to assessment bed placements at Arboretum House. An action plan showed that plans were already in place to improve the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Requires Improvement (published 19 March 2020).

Why we inspected
The inspection was prompted due to concerns received about the safety of discharges from Arboretum House assessment placements. A decision was made for us to inspect sooner and complete a targeted inspection into discharge planning at Arboretum House.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Arboretum House

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection on a specific concern. We had received concerns from professionals and people using the service that people were not discharged from assessment placements in a safe way.

As part of this inspection we also looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
An inspector visited the service. An assistant inspector made phone calls to people and relatives who had previously used the service.

Service and service type
Arboretum House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection, we had received concerns from people and professionals about the safety of the discharge planning process from Arboretum House assessment placements. We reviewed the information we received and discussed our concerns with the Local Authority Commissioning Team. We focused our inspection planning on concerns we had received, in order to assess if people were discharged safely from Arboretum House assessment placements.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We phoned five people and five relatives to gather their feedback on their previous assessment stay at Arboretum House. We looked at the records of three people who were currently staying at Arboretum House on an assessment placement. We looked at the records of three people who had now left Arboretum house (but had used it for a assessment placement in the past).

We spoke with the assistant manager and four care staff. The registered manager was unavailable due to annual leave commitments, however we contacted them by email to discuss our inspection findings. We also spoke to two therapy professionals. These therapy professionals are not employed by Arboretum House but visit regularly to assess and advise on discharge planning.

The service is a joint venture between the Local Authority and the NHS. Multiple professionals are involved with the service, in order to support discharge planning processes. This includes health therapists and social care staff. During the inspection, we were mindful that while these professionals have a large part to play in discharge processes, they are not employed by the service and therefore cannot be inspected as part of the regulatory activity. This inspection was therefore only focused on the role that Arboretum House staff had on the discharge safety process.

After the inspection
We continued to seek clarification from the registered manager to validate evidence found. We looked at training data and quality assurance records.

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about

The purpose of this inspection was to check a specific concern we had about discharge planning safety. We will assess all of the key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management

● We found poor quality recording by staff for people who were on assessment placements. This could make assessment of people's needs and discharge arrangements difficult to do by external professionals who were reliant on these records. The registered manager had already identified this and had devised training to improve this recording

● Visiting health therapists and social care staff assessed and supported people. They recorded their information on external computer systems. These external professional notes were not easily accessible by Arboretum House staff. This could impact care staff's understanding of the assessment and discharge process.

● There was an admission and discharge policy in place to guide safe discharges. The assistant manager was unaware that this was in place. This was of concern, as the senior staff team were responsible for some discharge arrangements.

● The service policy is that discharge planning should be discussed every day. Care staff reported that they often did not know a person's discharge plan until a few hours before the person was due to leave. Poor communication between external discharge staff and Arboretum House care staff could impact preparing the person for a person-centred discharge.

● Staff had not received training in dementia, stoma care and catheter care. There was also limited guidance in care plans. This could impact staff ability to support the assessment of these needs.

Staffing and recruitment

● Senior staff were responsible for supporting a person's discharge (including arranging their belongings and organising medicines). Senior staff told us that there were sometimes not enough staff to do this process safely, particularly when people were discharged at the same time as each other.

● Senior staff had reported their concerns, and the provider was arranging the employment of an additional senior staff member to support discharge processes. We will assess the impact of this at our next inspection.

● Excluding discharge processes, we observed there were enough staff to support people receiving care in an assessment bed placement.

Using medicines safely

● Before the inspection, we had received concerns that people had been discharged from the service without enough medicine. One person had been impacted by needing to go to hospital. We saw an investigation had occurred and new processes were in place to ensure people were discharged with enough

medicine in future.

Learning lessons when things go wrong

● When people left the assessment placement, we were informed that they were given a questionnaire to complete about their experiences at Arboretum House. We were told that no-one had completed the questionnaire. The registered manager advised that a different type of questionnaire would be used to gather feedback from people in the future.

● Care staff reported that there were not always aware of how people's discharge had gone. This can impact learning. A staff member said, "We don't reflect on how the discharge has gone. We don't know if it could have gone better or what to do next time. One person came a few times and we wonder why it didn't work or what we could do different." While external professionals (social care staff) would review people's discharge, this had not been communicated with the care staff team.

● Before the inspection, we received multiple concerns about the safety of discharge planning at Arboretum House. We phoned and found four out of the ten people/relatives phoned were unhappy with the once the period of assessment had been completed. The lack of response to questionnaires, would prevent these people's concerns been recognised and improvements made to the Arboretum House care experience

● The provider had recognised that some improvements were needed to assessment bed placements at Arboretum House. An action plan showed that plans were already in place to improve the service.

Preventing and controlling infection

● We were assured that the provider was admitting people safely to the service. By considering any possible Covid-19 diagnosis and shielding as needed. The provider also had clear methods to assess people's risk of Covid-19 while using the service.

● We were assured that the provider was preventing visitors from catching and spreading infections. Visitors were restricted, and arrangements were in place to meet close relatives discharge planning purposes.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider's infection prevention and control policy was up to date.

Inspected but not rated

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check a specific concern we had about discharge planning safety. We will assess all of the key question at the next comprehensive inspection of the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- We found four out of the ten people/relatives phoned were unhappy after the period of assessment. We also received negative feedback before inspection from professionals and people using the service
- The service used questionnaires to gather people's feedback on the service. However, this was ineffective as none had been completed. The registered manager had identified this, and a different questionnaire would be used to gather feedback in the future.
- External social care staff would review people's outcomes. However, this was not passed to care staff at Arboretum House, which could impact on staff learning and improvement.

Working in partnership with others

- Arboretum house is very reliant on good partnership working. Discharge safety is largely reliant on good quality health and social care staff involvement. Records showed us that these external professionals were involved with discharge planning. Their processes have not been assessed as part of this inspection as they are not employed by the service.
- We identified that processes used by Arboretum House staff could impact effective partnership working. As described in this report, staff did not always have access to other professional's records, staff did not always have sufficient warning of a person's discharge and there were insufficient senior staff available to support a safe discharge process. These poor processes within Arboretum House could impact on system wide processes.