Advinia Care Homes Limited

Arncliffe Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on the 7 and 8 August 2018. The visit on the 7 August 2018 was unannounced and the visit on 8 August 2018 was announced.

This was the first inspection of the service under the registered provider Advinia Care Homes Limited.

Arncliffe Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Arncliffe Court accommodates up to 150 people across five separate houses, each of which have separate adapted facilities. Two of the houses specialises in providing care to people living with dementia. At the time of this inspection 91 people were living at the service.

A registered manager was not in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we identified breaches of the regulations in relation to the need for consent and the implementation of the Mental Capacity Act 2005, safe care and treatment and good governance.

Risks to people's health, safety and welfare were not always fully considered. Not all identified risks to people and others had been fully assessed and where possible, minimised. This related to infection control practices and the management of medicines.

The service had failed to ensure that appropriate action was taken quickly to assess and mitigate any risks in relation to the telephone system within the service not working. For a period of four days, no calls could be made to or from the service. No risk assessment had been completed to inform others of the current situation. After a four day period we contacted the registered provider who took immediate action to ensure that phones were accessible to staff.

The service had failed to informed others of any potential risk in relation to the identification of a water bacteria being present in the service. Although the bacteria had been assessed as a low risk, and was being regularly checked, no information had been made available to advise people of its presence.
Systems were in place for the recording and monitoring of accidents and incidents. However, effective reports were not always maintained.

Systems and procedures were in place in relation to the Mental Capacity Act 2005. Records demonstrated that more knowledge was required around the implementation of the Act to ensure that people's rights were promoted and maintained.

Each person had their own individual care plan. However, not all of the care planning documents to support people's needs contained detailed, up to date information. In addition, alternative approaches to how to support people were not always considered. This could put people at risk of not receiving the care and support they required.

The quality assurance systems in place were not effective. The provider failed to identify and act upon a number of issues which we identified during the inspection. These were in relation to health and safety, care planning and supplementary care records.

Personal records relating to people were not always stored to protect people privacy.

We have made a recommendation about the environment. The environment lacked wayfinding and orientation for people living with dementia.

People had freedom of movement around the service and told us that they had a choice where they spent their time, and what time they went to bed and got up. However, people's personal choices and preferences were not always respected in relation to their planned care.

Policies and procedures were in place and available to all staff. The new registered provider had a service level agreement with the previous provider to continue to utilise the policies and procedures in place for a period of 12 months. Within this timeframe the registered provider would develop and implement their own procedures and guidance.

People using the service felt safe and told us that they knew who to speak with if they had any concerns. A complaints procedure was in place and people knew who they would speak to if they wanted to raise a complaint.

Systems were in place to ensure that people's medicines were safely stored. People told us that staff supported them with their medicines.

People told us that staff delivering their care and support were caring and knew what their needs were.

People had a choice of menu during mealtimes and regular drinks and snacks were available. People told us they were happy with the food they were served.

Weekly visits were made to the service by a GP and nurse practitioner to support people with their health needs. People told us that they felt they received the health care they needed.

People had access to representatives from local churches to assist them with maintain their worship and faith.

A number of social and recreational activities took place within the service to offer people with physical and mental stimulation.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures."

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Risks to people were not always considered and planned for.

The management of medication was not always safe.

Good infection control practices were not always being followed.

People felt safe living at the service.

Is the service effective?

Requires Improvement

The service was not always effective.

There was a lack of understanding of the Mental Capacity Act.

People had access to health care professionals.

People were happy with the staff that supported them.

People were happy with the food served at the service.

The environment lacked wayfinding and orientation for people living with dementia.

Is the service caring?

Requires Improvement

The service was mostly caring.

People's choices were not always considered.

People felt that the staff supporting them were caring.

People had access to representative from local churches to continue their worship and faith.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care planning documents did not always contain up to date detailed information about their needs.

Monitoring records and assessments relating to people's needs were not always maintained.

People had access to some social and recreational activities.

People and their visitors had access to the registered providers complaints procedure.

Is the service well-led?

Inadequate

The service was not well-led.

Quality assurance systems in place were not effective.

There was a lack of effective records management.

No registered manager was in post.

CQC were notified about most incidents that had occurred within the service.

Arncliffe Court Care Home

Detailed findings

Background to this inspection

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

The inspection was prompted in part by information we had received about care and management practices at the service.

This inspection visit took place over two days. The first day was unannounced and the second day was announced. The inspection team on the first day consisted of three adult social care inspectors, a Specialist Advisor in nursing and two Experts by Experience. An Expert by Experience has personal experience of using or caring for someone who uses a health, mental health and/or social care service.

On the second day of the inspection the inspection team consisted of three adult social care inspectors and an assistant inspector.

Records looked at during the inspection included assessments of risk and care planning documents, medicines, policies and procedures. We looked at the recruitment records of five recently recruited staff, and staffing rotas. In addition, we spent time looking around people's living environment and spent lunchtime with people using the service.

We spoke with and spent time with 50 people using the service, five visiting relatives, 25 staff members, and the assistant manager.

We used information the registered provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Prior to the inspection we assessed information we held about the service. This information included concerns and complaints received from people, their relatives and information sent to us by the provider.

We spoke with the local authority who commissioned services and the local authority safeguarding team to gather any information they had about the service. The local authority had no immediate concerns about the service. In addition, we contacted Health Watch Knowsley. Health Watch is the consumer champion for health and social care throughout England. Health Watch had no information to share with us about the service at the time of this inspection.

Inadequate

Is the service safe?

Our findings

Medication was not always administered to people safely. Some people were prescribed PRN medication. This is medication which is prescribed for people to be given when they need it, for example if they are experiencing periods of anxiety or pain. PRN medication should be administered at the request of the person or when care staff observe the need. However, we saw examples where there was no protocol in place with guidance for staff about when and how PRN medication should be administered. This could put people at risk of not receiving their medicines appropriately.

Two people were prescribed Lorazepam to be taken when required. Lorazepam is used to treat anxiety disorders. There was no PRN protocol in place to direct staff on the effective and safe use of Lorazepam. Two people's medication administration records (MARs) had been signed by staff to show that Lorazepam had been administered to both people on a regular basis. For example, one person had been administered Lorazepam each evening on twelve consecutive days, week commencing19 July 2018. There was no protocol or specific plans in place for the regular administration of Lorazepam for these people, however, we found no evidence to demonstrate that this had caused harm to people.

Covert medicines are when a person's medicines are administered in a disguised format without the knowledge or consent of the person, for example in food or drink. One person was prescribed medication to be given covertly. Staff explained that this had been introduced on the 5 July 2018 by a GP and was to be reviewed after a week to ensure the person's needs were still being met. Staff told us on the 7 August 2018 that the review had not taken place. There was no mental capacity assessment or records of a best interest decision to evidence that the decision to administer the person's medicines covertly had been made in their best interest. Even though the person had not experienced any harm, this demonstrated that appropriate planning around the use of covert medicines was not always in place.

We observed medicines being administered on Speke House on two occasions. We found the process was lengthy, for example, staff administered people's morning medicines until just before lunchtime. When asked, a nurse on duty told us that they commenced administering medicines at 0900hrs and generally finished at 1200hrs. They explained that they took this length of time as they had to administer medicines to 14 people. A system was in place for staff to record the times of which medicines were given throughout the day. We found that these were not always completed.

Care planning records failed to demonstrate that assessment and planning had taken place to explore and identify least restrictive and proportionate care for people. For example, one person had been prescribed a sedative medicine to reduce anxiety on an as and when basis. However, there were no care plans in place to offer guidance to staff as to the use of alternative least restrictive ways in which to support the person with their anxiety.

This was a breach of Regulation 12 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 as the registered provider had failed to ensure that effective systems were in place for the safe management of medicines.

The registered provider had failed in their oversight to identify and mitigate risks relating to the health safety and welfare of people using the service, staff and others. For example, we found that one person using the service had a communicable infection. Although treatment had been arranged for the person, no further actions had been considered in relation to the risk of the infection spreading or further prevention by sharing information with others who may be in the vicinity.

Specific assessments were used to determine if a person was at risk from malnutrition and skin pressures areas. Not all of these assessments had been completed correctly. For two people the assessments had not considered aspects of the health of the person when calculating the risk. The initial assessment demonstrated that both people were at high risk. When the assessments were re-calculated they showed that the people were at very high risk of developing skin pressure areas. Although we found that this had not had a negative impact on people, failure to accurately calculate and mitigate risks to people may result in them receiving unsafe care and support. We raised this with senior members of staff who assured us that these issues would be addressed.

Identified risks to people were not always assessed and where possible, mitigated. During the inspection we were informed that the telephone network within the service had not been working for two days. No calls could be made or received from any of the phones within the service. We were initially informed that there was a mobile phone on each house for staff to utilise, however we later found that staff were using their personal mobile phones to make calls relating to the service. No assessment had been completed to review the impact or actions taken to mitigate the risk of the phones not working. We discussed this with senior staff who completed a risk assessment and took action to inform staff of the situation. In addition, notices were put up to inform family members and visitors of the situation. After a period of four days of the telephone network not being in use, we contacted the registered provider and informed them of our concerns relating to the lack of phone availability within the service. Immediate action was taken by the registered provider in ensuring that alternative phones were purchased for use around the service.

As required, the service was monitoring the water supply for the risk of legionella, a bacterium that can be present in water systems. Three water outlets had been identified as having the presence of legionella at a level that was not deemed as a risk to people. These outlets were being flushed and tested on a regular basis. However, no risk assessment had been developed to assess the potential risk to people or any actions to identify, mitigate and inform of any potential harm to individuals. We brought this to the attention of the service and action was taken to carry out a risk assessment to identify any further actions in which any risk could be mitigated.

A system was in place for the recording and monitoring of accidents and incidents. Records were maintained of the type of accident or incident, the date and time, actions taken at the time and any lessons learned from the situation. However, as reported in the 'Responsive' section of this report, effective reports were not always maintained. Care planning records did not always demonstrate what care and support was planned or what care people had received following changes. For example, one person's records stated, "Two bruises to right upper arm at 1940 unknown cause" and "Had a scratch mark on right side of chest close to their armpit." There was nothing else recorded in relation to further investigation into the causes of the bruising or scratches. For another person, care planning documents demonstrated that two occasions staff had reported bruising to arms. Records demonstrated that an incident form had been completed on one occasion.

This was a breach of Regulation 12 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 as the registered provider had failed to ensure that effective systems were in place for the safe management of risk.

Safe infection control procedures were not always followed. For example, we saw in Gateacre House that wheelchairs were stained and had food matter on them. In addition, carpets in the communal lounge and dining area omitted a strong unpleasant smell on the second day of the inspection. On another house we found two mats in use to prevent people injuring themselves in the event of falling out of bed were heavily stained.

On two occasions during the first day of the inspection we saw a used urine bottle placed on a person's bedside table. There were two drinks and a water jug all in close proximity to the urine bottle. On both occasions staff entered the bedroom and failed to move or empty the urine bottle. This posed a risk of cross contamination and a failed to promote the dignity of the person.

This was a breach of Regulation 12 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. as the registered provider had failed to ensure that effective systems were in place for the safe management infection control.

Safe procedures for the storage of medicines were in place. Medication Administration Records (MARS) were in use for recording when a person had been offered or administered their medicines. At the time of this inspection a medicines audit was being carried out by the Community Health Trust. These audits monitor the management of medicines and offer advice to services to make improvements. The reports of these audits demonstrated different levels of compliance with medicines management across the service. For example, three houses were rated as 'in general adequate', one house was rated as 'poor' in some areas and 'requires improvement' in other areas. Following these audits an action plan would be sent to the provider to make improvements.

People's comments in relation to the management of their medicines included; "[Staff] come in with them [medicines] when I need them. I have that many, and they make sure I've got them all. They do stay while I take them, yes", "Yes, I have tablets to take. I don't know what they are. If I get a headache I can ask for paracetamol as well" and "I have a lot [medicines] and I get them, different ones four times per day. Don't ask me what they're all for. They can be left with me or taken bit by bit, on GP's recommendation. Some of the staff stay with me while I take the painkiller but not all."

Safeguarding procedures were in place and accessible to staff. During conversation, staff demonstrated a good awareness of how to report any concerns they had about a person. People told us that they felt safe living at the service. Their comments included; "Yes [feels safe]; I'm not worried about anything like the staff. I wouldn't go out [of the patio doors] on my own – you don't know who's out there, I go with [staff]. You've got to have someone with you if you go out, in case something happens", "I'm very happy in this little place [i.e. their room] and I prefer to stay here. Everything's fine", "There's always somebody around, that's the main thing, and they always like to know where you are too" and "I like it here, and I do feel safe all the time." People clearly told us that they knew who to speak to if they didn't feel safe.

A recruitment procedure was in place that aimed to ensure the safe recruitment of staff. The majority of staff files demonstrated that appropriate checks had been carried out prior to staff starting their employment. For example, we saw evidence of written references, evidence that formal identification had been sought and a check with the Disclosure and Barring Service had been carried out. These checks were carried out to help ensure that only staff of a suitable character were employed by the registered provider.

Requires Improvement

Is the service effective?

Our findings

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 make 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals 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. Prior to a DoLS application being made for assessment and authorisation, an assessment of a person's mental capacity was needed to establish their ability in their understanding. We found that applications for DoLS had been made prior to a best interest meeting and decision taking place. Records of best interest decision meetings failed to demonstrate that others, for example, family members, involved in the person's life had been included in the decision making. In addition, we found that the phrase of 'acting within the person's best interest's was used many times. We identified that a more robust understanding was needed of processes of what 'best interest' means within the framework of the Mental Capacity Act.

A DoLS authorisation was in place for one person, however, there was no evidence to show that the condition of the DoLS had been regularly reviewed to consider the person's circumstances. This included the absence of any care plans or care approaches that would meet the person's needs in a less restrictive way. In addition, we requested to see the person's capacity assessment in relation to the specific decision made but this was not available.

A DoLS application had been made to the supervisory body on behalf of a person who was prescribed sedative medicine on an 'as and when' required basis. The application did not contain any information regarding the use of this medicine. This demonstrated that the person's needs in relation to having their liberty restricted were not fully included in the application.

We saw examples of capacity assessments and best interest decision meetings for people that had taken place. The completion of these records showed a lack of understanding of the Mental Capacity Act and best interest decision processes. For example, in one person's capacity assessment the person's capacity was assessed as; "To apply for a Deprivation of Liberty Safeguards". Other generalised statements about people's understanding and their ability to retain information were recorded, as opposed to how the person was supported with practical steps to understand information about specific decisions. For example, where the capacity assessment asked if the person understood the information, it was recorded "Unable to comprehend what deprivation of liberty means to her."

This was a breach of Regulation 11 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

People's living environment did not always promote orientation or stimulation for people living with dementia. Bedroom doors were painted in the same colour and had room numbers. Memory boxes were mounted outside people's bedrooms however, not all of these were in use and therefore did not promote wayfinding for people. Lighting on corridors, in bathrooms and toilets was operated by movement. This meant that people had to walk towards unlit areas before the lighting activated. One person told us; "You have to flush the toilet to put the light on, because there is no switch. I find that a real irritation. Why can't they just have light switches. And there's a person in the next room, who wanders around, opens doors and stands there. It can be very confusing, all these doors looking the same, I suppose."

We recommend that the registered provider refers to best practice guidance on dementia friendly environments.

People had access to support from external health care professionals. People told us and records demonstrated that people had access to dietician services, speech and language therapist, memory clinic staff and physiotherapist when required. In addition, people had access to a GP and nurse practitioner who visited the service on a weekly basis. Records demonstrated that when required people received visits from specialist nursing services. For example, a tissue viability nurse and a nurse specialising in Parkinson's disease.

We saw some good evidence that people had received the health support they required. For example, action had been taken to support one person to reduce their weight successfully. On one House we found that when problems were detected with a person's skin integrity, district nurses were called quickly to assess the person's condition. People told us positive things about the health care support they received. Their comments included "Staff would get a doctor in the case of illness and you'd be taken into hospital if it was anything serious" and "If I'm going to go out, to hospital appointments etc., I need a black cab, which staff book. Staff always go with me. I had [illness] about six months ago and was in hospital, a carer called the ambulance because they could see I was pretty ill." A visitor told us; "The doctor has been called several times [Relative] has been to hospital three times but has always been ok. [Relative] has their feet done regularly."

People were served foods to meet their specific dietary needs and choices. For example, a low sugar diet was available to people living with diabetes. Soft and fortified foods were served to people who were at risk of weight loss and or chocking. Hot and cold drinks were offered to people throughout the day along with biscuits and snacks. People spoke positively about the meals they were served. Their comments included "The food is very nice. There's not a big choice but it's enough. There are times for tea and coffee and they always bring biscuits" and "I like my breakfast and always eat a cooked breakfast. I don't need a lot more snacks in between, but they're always there if you do want something. The food seems to be all right and I don't hear anyone complaining about it." One person told us that they had a fridge of their own where they kept their own food.

Training was in place to enable newly recruited staff to have an induction into their role. This induction was based on The Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of staff working within the health and social care sector. Training linked to this certificate included moving and handling, safeguarding, infection control, health and safety, fire safety, duty of care, equality and diversity and communication.

There was a lack of records available for staff who transferred over from the previous provider to demonstrate what training they had undertaken and when. The current provider was in the process of implementing an on-line learning system for all staff to access. This training was to include equality and diversity, dignity, the Mental Capacity Act, infection control, meaningful activities support, fire safety, safeguarding, first aid, fire wardens and tissue viability. In addition, a 12 week course on leadership was to commence for senior members of staff. The majority of this training was scheduled to commence in September 2018. Refresher training had taken place for approximately 30 staff in the subjects of moving and handling and safeguarding people. In addition, at the time of this inspection a number of staff were undertaking training in pressure area prevention and care.

A matrix was in place to plan supervision sessions for all staff every two months. This plan was in the process of being implemented at the time of this inspection. Staff told us that they felt the support they received had improved over the previous four weeks. They felt this was due to the arrival of the new manager.

Requires Improvement

Is the service caring?

Our findings

Not all of the care and support we observed was delivered in a person centred manner. We saw one person sitting on an arm chair and later on a sofa was unable to sit comfortably with their feet touching the floor. The person appeared restless and when asked they said that they were uncomfortable and wanted to put their feet down. We brought this to the attention of staff who said they hadn't noticed and brought a foot stool. The person said that they felt more comfortable and appeared at ease when using the foot stool.

We saw that for some people their plans for personalised care and support required improvement. Care plans gave the opportunity to record people's personal preferences in relation to their personal care and support. However, we found that these preferences were not always made available to people. For example, one person's choices in relation to washing and dressing stated that "[Name] prefers to have a bath." Supporting care records recorded "In best interest a wash given", only full body washes and showers were recorded. This information failed to demonstrate that the person had access to their personal choice.

In the lounges on two houses we found that two televisions were in use at the same time on different channels. At one house, we saw eight people sat near to the television, however, only two people were in full view of it. Clocks were not working in two houses and therefore not showing the correct time. On Paisley House, a CD player was on continuously playing a 'talking book' in the library area. As there was no door to this space, this meant that there was a continuous sound of a male voice in this part of the corridor. Both the lack of correct time available on clocks and the hearing of mixed sounds and unidentifiable voice within the corridor could disorientate people.

On Gateacre House we saw a member of staff supporting one person to eat their meal. The member of staff was sat side to side with the person which meant both needed to turn in order for the person to take their food from the staff. This process looked uncomfortable. After we raised this with the member of staff, they changed their position which resulted in a more comfortable experience for the person eating their meal.

Staff demonstrated a caring and effective approach when people became distressed. We saw a member of staff talking with one person who was showing some distress but who had difficulty in expressing themselves verbally. Staff showed a lot of skill and knowledge in their management of this, successfully diverting and distracting the person by asking simple questions and by talking about songs and singing with the person. Another person was seen to show some distress and staff were alert to this and used the person's interest as a way of comforting them.

People told us that staff respected their privacy when delivering personal care. They gave examples of staff always closing the curtains and door when someone was receiving personal care and knocking before entering rooms.

People's independence was promoted. They had freedom to move freely around the houses. People told us that they had a choice of what time they wanted to get up out of bed. Their comments included "This is my room now and I can do what I want, when I want", "You can get up and go to bed whenever you want", "I can

look after myself mainly, I'm quite independent, but they [staff] are there if you need them. They seem to know what they are doing, from what I can see."

People spoke positively about the staff that supported them. Their comments included "They [Staff] are ok. They take an interest in you", "They are all very nice. I get on quite well with them and they get on with me", "Staff are very kind, yes, and friendly. We can have a laugh and a joke together "and "Staff are very kind and friendly and I'm very comfortable with them. They ask me would you like help. They're very polite. I have a very good relationship with the staff." A visitor told us; "Not once has anyone been abrupt. The staff are all very nice and they're doing a difficult job in difficult circumstances."

People were supported to maintain their faith and religion by the support of local church representatives. People's comments included "There's a priest comes in if you want them" and another person told us that once a fortnight the priest comes to see them for communion.

Different language and wording was used by staff for effective communication. For example, one member of staff was seen to ask a person if they would you like a drink. When the person did not respond the question was made more specific in 'Would you like a cup of tea' and the person's slight nod was picked up by the member of staff as a positive response. One person told us that they had a hearing problem but didn't like to wear their hearing aid. They told us that staff can communicate with them if they speak up.

Visitors told us that staff always contacted them if there was a change in their relative's condition or health. They told us, "They [Staff] ring me straight away" and "They let me know straight away." Two visitors told us that the felt involved in their relative's care. Their comments included "Yes, the home involves us in any decisions" and "They have just been taken over so things are just settling in now. They keep us informed throughout the process."

Procedures were in place to ensure that personal information and records relating to people using the service and staff were stored appropriately. Lockable filing cabinets were available for the safe storage of paper records. Electronic records were password protected which ensured that they were only accessible to staff requiring the information.

Requires Improvement

Is the service responsive?

Our findings

Appropriate care plans and risk assessments were not always in place to promote safe effective care and treatment. For example, one person utilised a pump to administer medicines. There was evidence in daily records of when the pump was introduced and used and what actions had been taken when problems arose. However, there was no risk assessment in place around medicines administration, or a description of what the medicines were being used for or why it was being administered in that way. Another entry on the person's records stated that they could sit in a wheelchair without foot rests and self-propel themselves. There was no health and safety implications considered or risk assessment completed in relation to this.

Improvements were needed as to the level of information and detail contained in people's care plans, when people presented behaviours that may challenge the service. For example, one person's care plan had a basic description of what tone of voice to use when the person challenged the service. There was no detailed information as to what staff could do to keep the person and others safe from harm other than, "Leave the person in a safe position". It was recorded that the person bruised easily due to their prescribed medicines. However, there was no clear description of approaches that would demonstrate a least restrictive approach to supporting the person. The care plans did not give sufficient detail as to how staff could safely support them during times of distress.

Daily notes were made by staff to record what care and support people had been offered and received. We found that these notes were not person centred and did not reflect all of the care and support offered by staff throughout the day. Notes were updated once during the day and once during the night. For example, one person's night record written at 0430hrs stated "[Name] was in his room at the start of shift. [Name] had Ovaltine and sandwiches for supper. Assisted to bed, all personal care given. Regular checks throughout the night. No concerns at time of report." Another entry into the person's records stated "[Name] has had a good day spent most of it asleep. Chosen to have a relaxing day, has had good diet and fluids throughout the day. No concerns to be reported." This information was task based and failed to demonstrate any social interaction, what checks were carried out and what actual personal care was given. We discussed the content of people's records with senior staff members who demonstrated a commitment to ensuring these issues were addressed.

Monitoring charts in relation to people's positional changes, fluid and food intake were in use. These charts were in place to monitor that people's specific needs were being met. Observations showed that people were supported to have access to food and drink throughout our visit. However, not all of the monitoring documents in place were regularly updated or demonstrated that people were in receipt of the support they needed. For example, on the first day of the inspection at 1230hrs one person's fluid balance chart recorded only one entry of 200mls of juice being given at 1045hrs. Another person's chart recorded only one entry at 0940hrs. A food chart for another person recorded at 0935hrs 'cornflakes and toast' with outcome which stated, "Fast asleep". There was no further documentation to suggest that alternatives had been offered or that the person had been gently woken before presenting breakfast. We raised this with senior members of staff who assured us that these issues would be addressed. A lack of robust recording in relation to people's needs and the care and support delivered to them could result in people's care needs and wishes not being

met.

This is a breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014, as the registered provider did not have effective systems in place for the accurate recording of documents.

Dining tables were set with crockery, glasses, napkins and condiments and people had access to different sized and shaped cups to meet their personal needs and preferences. Further improvements could be made to promote people's dining experience as a more social occasion. We observed on some houses that mealtimes were seen as a social time and conversation was prompted and encouraged by staff. However, the level of interaction differed on each of the houses.

A plan of activities for the week was displayed in each house. However, the activities advertised did not correspond with the activities being provided during our visit. For example, cake making was planned on that day but we saw no evidence of this taking place. In addition, the information displayed stated that people on Gattacre House had an outing planned but this did not take place. We a sing along with people. This session was very interactive and enjoyed by all.

People told us "There's TV and dancing and yes staff have time to chat", "We have bingo on a Wednesday, there are other things going on but if the weather is nice I like to go for a walk to another house", "If there is something going on that I don't like, I just come to my room. I like my own company. Staff sometimes come in and sit on the end of my bed and have a chat." and "I like watching the birds [from their room] and I can watch what I want to watch on my television. If I don't like what's going on [in the communal area] I come back here to read." People told us that they went to the cinema and to the pub situated in one of the houses to have an alcoholic drink and play dominos. A visitor told us, "The activities person has tried to sit and chat [with relative] and asked me to bring some family photos to talk about."

Accessible information was not always available. For example, signage to orientate people around their home was not always clear or identifiable. The registered provider had introduced a new complaints procedure, however, complaints forms and contact information still referred to the previous providers procedure. This could cause difficulty in people raising a concern. Staff stated that information was available in standard or large written type only.

Specific care plans were available for use for people who were in receipt of end of life care. These plans were to help ensure that people received the support they wished for. Where a decision of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) had been made by or on behalf of an individual under the appropriate legislation, this was recorded and placed in a person's care file.

The registered provider had a system in place to manage, respond and review complaints made about the service. This system involved the service issuing a monthly report to the registered provider detailing the nature of the complaint, by whom it was made and the theme of the complaint. The provider had developed a new complaints procedure which was displayed around the service. We raised this with senior members of staff who removed these leaflets immediately. People told us; "I would tell one of the staff [if they had a complaint]" and "If I had a complaint I would tell the boss, the head nurse. But everything's fine, I can't complain about anything. If I want anything, it's there for me." One person told us "I'm quite happy here but sometimes I wish they'd be a bit quicker on the bell, especially when I want my water [urine] bottle emptied." We passed this person's views onto the senior members of staff who demonstrated a commitment to improve the service for the person.

A family member informed the inspection team of several concerns they had about their relatives care and support. These concerns were passed onto senior members of staff who promptly made arrangements to meet and discuss these concerns under the complaints procedure.

Inadequate

Is the service well-led?

Our findings

The registered provider had failed in their oversight to identify and mitigate risks relating to the health safety and welfare of people using the service, staff and others. We were informed that the telephone lines to the service had been out of use for over 48 hours. No risk assessment had been completed or actions take to minimise the risks associated with this. We found that one person using the service had a communicable infection. Although treatment had been arranged for the person, no further actions had been considered by the registered provider in relation to mitigating the risk of infection spreading or prevention of reoccurence.

The service through regular checks had identified the presence of bacteria in three areas of water supply within the service. Although this was deemed as a low risk and was being checked on a regular basis not all actions had been taken to update or share information with any relevant parties who may have been accessing the immediate vicinity.

The registered provider had a system of audits and checks in place to monitor the quality of the service that people received. This system comprised of recently developed audits by the new registered provider and a continuation of systems from the previous provider and were carried out daily, weekly and monthly. The auditing systems in use had failed to identify and address all of the issues that we found during this inspection. This demonstrated that there was a lack of effective and robust monitoring within the service. Checks had failed to establish that people's care planning documents were accurate and that assessments reflected people's current needs. For example, the skin pressure and malnutrition risk assessments not completed appropriately. Checks had failed to identify potential issues relating to the use of prescribed PRN medicines. In addition, records failed to demonstrate that people's rights were fully protected under the Mental Capacity Act and that wherever possible, a least restrictive plan of care was implemented.

No suitable arrangements were in place for the archiving of recent records. For example, we requested fluid and diet charts for one person from the 27 July 2018 to 7 August 2018. These records could not be located. Staff confirmed that archiving was a similar issue for everyone. It was difficult to carry out any analysis of records over longer periods of time to identify any issues due to the lack of availability of information.

Records containing the personal information of people who had previously lived at the service were found to be stored in an unlocked cupboard in one of the houses. This information could have been accessed by anyone and therefore failed to protect people's privacy.

A 'resident of the day' system was in place to enable a person's whole care experience to be reviewed and when needed, changes made. Part of this review usually involved the person's care plans being thoroughly reviewed along with food choices and attention being paid to them and their bedroom. We found that this system of review was not always effective. One person who was 'resident of the day' during the inspection was seen to be lying flat in their bed crying out between 1000hrs and 1200hrs. Their catheter bag was in full view on their bed next to their leg. The positioning of the catheter bag would not enable the catheter bag to drain effectively. We brought these issues to the attention of the nurse on duty who managed the situation. This demonstrated that the 'resident of the day' process had been ineffective for one person.

An Information board was available in the manager's office to inform senior staff of the needs of people using the service. For example, in relation to the use of bedrails and DoLS in place. The information displayed was used by senior staff to update the inspection team on the needs of people using the service. We found that the information on this board was not accurate. For example, the information stated that covert administration of medicines was not taking place within the service. However, during the inspection we identified that it was. In addition, the board recorded inaccurate information relating to people with skin pressure wounds. A lack of up to date information could put people at risk from not receiving the care and support they needed.

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

In April 2018 a quality and compliance review was undertaken by the registered provider. This identified several areas of improvement needed within Arncliffe Court. We saw that although a number of actions had been completed from the review, further actions were still identified as needing addressing. To address some aspects of the review the registered provider had developed tools to record and monitor safeguarding concerns, DoLS applications, infection control and skin pressure areas. These reports were submitted to the registered provider on a monthly basis for review and monitoring purposes.

There had been no registered manager in post since the new provider took control of the service in February 2018. A manager was recently in post and a representative of the registered provider told us it was the intention of the manager to apply to become the registered manager with the Care Quality Commission. Senior staff within the service told us that they felt supported by the manager. They told us that they always make time each day to discuss the service.

Policies and procedures were in place that were available to all staff. These documents were in place to offer staff best practice and guidance when carrying out their role. The new registered provider had a service level agreement with the previous provider to continue to utilise their policies and procedures which were in place, for a period of 12 months. Within this timeframe the registered provider would develop and implement their own procedures and guidance. A new complaints procedures and guidance around falls had recently been implemented.

The provider had notified the Care Quality Commission of the majority of significant events which had occurred in line with their legal obligations.

The service had been awarded a five star rating for food hygiene in July 2017.

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Systems in place had failed to ensure that the rights of people unable to make an informed decision were fully managed in line with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's care and treatment were not always planned and managed in a way that promoted the health, safety and wellbeing of people.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered provider's quality assurance audit systems were not effective in identifying and addressing areas of improvement needed within the service.

The enforcement action we took:

Warning notice to be issued in relation to Regulation 17