Sanctuary Care Limited

Arbury Lodge

Inspection report

George Eliot Hospital NHS Trust
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 4 May 2017 and was unannounced.

Arbury Lodge is a short stay nursing service located within George Eliot Hospital. The service has 16 individual bedrooms with shared toilet and bathroom facilities. There is a communal lounge and dining room. The local Clinical Commissioning Group (CCG) commissioned Arbury Lodge, on behalf of George Eliot Hospital, from Sanctuary Care, who are a large care provider.

Arbury Lodge provides accommodation, nursing and personal care for up to 16 people. All 16 beds, funded by George Eliot Hospital, are for in-patients who have been assessed as 'medically optimised.' This means people admitted to Arbury Lodge are 'medically stable' but need an additional short stay to assess their future care and support needs. The average length of short stay at Arbury Lodge is six weeks, and assessments include whether people require ongoing support care packages and for some people end of life care is required. At the time of the inspection 13 people lived at the Arbury Lodge.

Arbury Lodge is required to have a registered manager in post. 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 and associated Regulations about how the service is run. At the time of this inspection there was a registered manager in post.

Arbury Lodge opened in 2016 and this was their first inspection since their registration with us.

Care staff knew how to protect people from risks of harm and injury because they knew people's individual needs. However, information in people's risk assessments was not always accurate which meant staff did not have the information to refer to if needed. Some risks to people's wellbeing had not been identified or acted on.

Some staff felt under pressure on shift and thought staffing levels needed to be increased. We found staffing levels were not determined by people's levels of dependency on staff support. Higher dependency levels increased staff workload, and other important tasks, such as completing care records, were not always completed by staff.

People had their prescribed medicines available to them and were supported to take these by nurses. However, medicine records were not always accurate. People were protected against the risk of abuse because staff were trained and knew how to raise concerns and the provider completed checks to ensure staff were of good character.

Staff were trained and people felt they had the skills the needed to deliver care and support to them. Staff worked within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People

had choices offered to them about what they wanted to eat and drink and were supported to maintain their health by visiting healthcare professionals.

Staff had a kind and caring approach toward people and felt care staff promoted their privacy and dignity. People were able to choose where and how they spent their time.

People felt their care and support was personalised to them during their short stay at the service. People and their relatives felt involved in making decisions and planning care. There were planned group activities that some people were able to take part in and said they enjoyed.

The provider had systems in place to monitor the quality of the service provided. Some of the provider's checks had effectively identified areas requiring improvement. However, we found planned improvements had not always taken place or been sustained by staff. Care records were not always updated in a timely way and insufficient checks were made on them. Some care records were not written clearly and improvements had not been made as planned for by the provider.

Staff told us they felt supported by the registered manager whose positive vision for the service was shared by staff. People and relatives felt they had opportunities to give their feedback about the service they received.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Care staff knew how to protect people from risks of harm and injury. Some risks to people's wellbeing had not been identified or acted on.

Staff felt staffing levels needed to be increased on the day shift. Staffing levels were not determined by people's dependency on staff support and when people had higher dependency levels staff did not always follow the provider's policies or complete other important tasks.

People had their prescribed medicines available to them and were supported to take these by nurses. However, medicines were not always being managed or handled safely.

People were protected against the risk of abuse because staff were trained and knew how to raise concerns and the provider completed checks to ensure staff were of good character.

Is the service effective?

Good

The service was effective.

Staff had undertaken training to deliver care and support and people felt staff had the skills they needed. Staff worked within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People were offered choices and given the support they needed to eat and drink. People were supported to maintain their health and were visited by healthcare professionals when needed.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring towards them and relatives felt staff were friendly. People were involved in decisions about their day to day care and supported to express their views about what they wanted to do and how they spent their time. There were no restrictions placed on when friends and relatives

could visit people.

Is the service responsive?

Good

The service was responsive.

People's care was based upon their individual needs and wherever possible people and their relatives were involved them in decisions about their care.

There were planned group activities for people to take part in if they wished to do so.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had systems in place to monitor the quality of the service provided. Whilst quality monitoring audits had effectively identified areas for improvement, these had not always taken place as planned for or been sustained.

Staff told us they felt supported by the registered manager whose positive vision for the service was shared by staff.

Arbury Lodge

Detailed findings

Background to this inspection

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

The inspection took place on 4 May 2017 and was unannounced. One inspector and a pharmacy inspector undertook this inspection.

The provider had completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information we held about the service. This included information shared with us from relatives who had completed a 'share your experience' form on our CQC website. We reviewed statutory notifications sent to us from the provider. A statutory notification is information about important events which the provider is required to send us by law.

We spoke with five people who stayed at the service and spent time in communal areas seeing how staff engaged with people who used the service. We spoke with seven relatives who told us about their experiences of using the service. We spoke with staff including two nurses, three care staff, the activities staff member, the registered manager and regional manager. We also spoke with two discharge planning hospital staff members. Following our inspection we had a telephone conversation with the regional director.

We reviewed a range of records, these included care records for four people and seven people's medicine administration records. We looked at the provider's quality assurance audits and their actions plans.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe during their short stay at the service and protected from the risks of abuse. One person said, "I feel safe here because staff are about all the time." Relatives felt their family member was safe during their short stay at Arbury Lodge. One relative said, "I've never seen or heard anything of concern, I'd report it straight away if I had."

Staff told us they had received training on how to protect people from abuse and how to recognise concerns. One staff member told us, "I've never had any concerns about abuse here. If I had, I'd report it immediately to the manager. If nothing was done, I'd go to CQC, but the manager would do something." The registered manager understood their responsibilities to inform the local authority and us of any safeguarding concerns.

Overall, staff knew how to keep people safe from risks of harm and injury. One staff member told us, "Most people who are admitted here have previously had injuries from falls, so we always try to reduce their risks of further falls." Another staff member said, "Most people here at risk of falling out of bed. We don't tend to use bed rails (sometimes referred to as bed sides) here, because they present a risk of injury. Instead, people have their beds low to the floor and have a crash mat next to them and a pressure sensor mat on top of their crash mat." We saw staff frequently checked people cared for in their bedrooms and ensured their crash mat and pressure sensor mat was correctly positioned. This meant if a person rolled out of their low bed, the crash mat would reduce the risk of injury and the pressure sensor mat would immediately alert staff.

Information on moving and handling assessments was not always accurate, which meant staff did not always have the correct information to refer to if needed. For example, one person's moving and handling assessment stated they used a frame to walk and needed the support of two staff. However, one staff member told us, "This person has not walked since being admitted to us, we use a rotunda (stand-aid) hoist to help them transfer from the chair to wheelchair." This person's 'mobility aid care plan' stated they could not walk and staff should use a rotunda. Whilst this record was correct, it was inconsistent to earlier information in this person's care record.

Risks to people's wellbeing had mostly been identified by staff, but we saw some occasions where they had not been and actions to minimise potential discomfort had not been taken. For example, we saw one person had chosen not to drink anything for over 12 hours and their mouth and lips were very dry. We found no risk assessment or care plan had been completed for this person to be offered mouth care and no mouth care had been given. We discussed this with staff and they informed us mouth care sponges were available but had not been used or offered to this person. Following our discussion, immediate action was taken for this person, and others, who were potentially at risk of developing mouth and lip sores because their fluid intake was very low.

We looked at the risk assessments and care records of one person who had recently been admitted to the service. We found some important parts had not yet been completed. We discussed this with the registered manager and they told us their expectation would have been for the important parts relating to the person's

'high' dependency and 'end of life' care should have been completed by the night nurse on shift. The registered manager said they would ensure this was completed so staff had the information they needed to provide a consistent approach to maintain this person's safety and wellbeing. This person's hospital discharge information was available for staff to refer to if needed.

Some people were assessed as 'at risk' of their skin becoming sore or damaged. The registered manager told us people were sometimes admitted to the home with skin damage, to pressure areas. We looked at one person's pressure area management records. We found this person's dressing was not always changed as planned for every three days. Photographs were not consistently taken when wound dressings were changed, which the registered manager told us they would have expected the nurse to have taken. This meant that nurses would not always be able to monitor the progress or deterioration of people's skin damage effectively.

Some people had special equipment, such as chair cushions or airflow mattresses, to reduce the risks of skin damage. Staff knew how pumps for special airflow mattresses should be set according to people's individual body weight.

We identified an occasion when staff felt did not have the equipment they needed to minimise risks of skin damage to one person's heels that had become blistered. One nurse told us they did not have any special 'repose' boots available to use, records showed staff had used a pillow placed under the person's lower legs. The provider told us that guidance from their tissue viability (Skin care) nurses was followed about safe practices.

The provider's recruitment process ensured, as far as possible, that staff were of good character and safe to work with the people who lived in the home. Two staff members told us they had started working at the home over the past few months. One staff member said, "I applied to work here and after my interview had to wait to start until checks were done."

Over the past few months (February and March 2017) 420 hours of nurse and 168 hours of carer agency had been used. The registered manager told us they no longer needed to use agency staff because a nurse had returned to work from leave and a further two care workers had been recruited and were due to start this month.

There were not always enough staff on shift to safely meet the needs of people with high dependency needs who were being cared for. People and their relatives felt more staff were needed on shifts. One person said, "The staff are really good, but they are busy and could do with an extra pair of hands." One relative said, "The nurses and carers are under pressure" Another relative felt some things were not always completed, such as staff ensuring their family member's charts were kept up to date, because they did not always have the time to do so.

Nurses and care staff we spoke with all felt a further staff member was needed on the day shift. One nurse told us, "I have too much to do." We saw this nurse did not always follow the provider's safe handling of medicines policy and when we asked why this was they told us it was because of the pressure of getting things done. Another nurse said, "If I have a (specialist) skin wound dressing to change, it can take two or three hours to do. I might also then have the doctor's round to accompany them on and a staff meeting and new care plans to write for admissions, plus the usual things like people's medicines to give. We need four care staff on."

The registered manager told us that during the first 12 months of Arbury Lodge being open, there had been

over 150 admissions to the service. This meant nurses spent considerable time writing individual care plans for people's short stays to try to ensure staff had the information they needed to maintain people's safety and wellbeing.

The registered manager explained the provider had an agreement with George Eliot Hospital that the service would be staffed with one nurse and three care staff on a day shift, and one nurse and two care staff on a night shift. The provider's staffing levels were not linked to the individual dependency needs of each person, which meant when people's dependency needs were high and there continued to be admissions and discharges, staff could not carry out their responsibilities as well as they would like and nurses felt under pressure. The registered manager told us most of the people who were currently using the service had high dependency needs.

We discussed staffing levels further, during our inspection visit, with the regional manager and they agreed to take the discussion to higher management. Following our inspection, the regional manager asked us to have a telephone conversation with their regional director who told us consideration would be given to up-skilling a care worker to a nursing assistant. The regional director said they would have a discussion with the registered manager about staffing levels and the flexibility to potentially increase staffing when dependency levels were high.

Staff knew how to deal with emergencies that might arise from time to time. People had personal emergency evacuation plans (PEEPS) to tell staff the level of support they needed in to keep them safe the event of a fire. On the day of our inspection, the registered manager was the named first aider and they were able to tell us the first aid actions they would safely take if, for example, a person was choking.

We looked at how medicines were managed which included checking the Medicine Administration Record (MAR) charts for seven people. Although we found some areas of good medicine management we also found people's medicines were not always being managed or handled safely.

Medicines were available to give to people with a six week supply provided by the George Eliot Hospital pharmacy. People's MAR was handwritten and checked by two staff using the hospital patient discharge letter to check that the medicines were correct. The receipt of people's medicines was recorded onto the MAR chart and daily stock checks for each medicine were also documented. This system ensured people had enough medicines as well as checking that people had been given their medicines.

One nurse was observed administering the morning medicines. On one occasion the nurse left the locked medicine trolley unattended in order to take medicines to a person in another location of the building. However, people's MARs were left on top of the medicine trolley which meant that people's personal medicine information was accessible. We observed the nurse applying a medicine skin patch to one person in a communal lounge. This person's privacy and dignity was not protected. We also found that the available information documenting the site of the medicine skin patch on the person was not correct so the nurse could not easily locate the patch or be sure they were following the manufacturer's instructions to place the skin patch on a different area of skin. The nurse explained that they must have recorded information incorrectly. They also told us they knew it was wrong to leave the MARs unattended as well as not ensuring a person had privacy but they were under pressure to complete the morning medicine administration as well as undertake other nursing duties.

The service undertook their own medicine checks every month which identified that occasionally nursing staff did not always remember to record the administration of medicines. The registered manager said that all nursing staff had been reminded about the importance of recording medicine administration

immediately or using the correct codes to identify why a medicine had not been given. We found omissions on two people's MARs. One medicine was an antibiotic to treat an infection and the second medicine was to prevent blood clots. Both are high risk medicines that should be given as prescribed. We were able to determine that in both cases the correct amount of medicines had been removed from the containers however there was no record documented of the administration on people's MAR.

When people were prescribed medicines to be given 'when required' or 'when needed' we found supporting information was available to enable nursing staff to make a decision as to when to give the medicine. For example, when a person was prescribed pain relief the information detailed whether a person was able to ask for pain relieving medicines.

Good

Is the service effective?

Our findings

People felt staff had the skills they needed to effectively support them. One person told us, "I can't fault the staff, they are good. They know what they are doing." Another person said, "They use the hoist for me and I feel safe in it because they tell me what's happening and don't rush moving me."

Staff told us they received an induction when they started work at the service and completed on-line training sessions. One care staff member told us, "I only started a few months ago, I've completed a taught, face to face, session on moving and handling and some other online topic sessions." Another care staff member said, "I think I have most of the training I need, I'm meant to be doing a dementia care course soon which will be helpful." Both nurses we spoke with felt overall they had the skills they needed, although felt some further refresher training would be useful to extend their knowledge in, for example, 'tissue viability (skin care).' All of the staff felt they could carry out their job role more effectively if they had four care staff on a day shift. A member of staff told us they understood the importance of meeting not only people's physical needs but also the need to give emotional care and support. However, they felt time did not always allow for this and it meant they were not always fulfilling their job role fully.

The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff had a limited awareness of the Mental Capacity Act, but understood the importance of gaining people's consent and worked within the principles of the Mental Capacity Act. One staff member told us, "We don't force people to do things." The registered manager told us that the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) were discussed at team meetings so staff developed an awareness and understanding of how this impacted their role. The registered manager said they would continue to build on staff knowledge about the Act.

The registered manager understood their responsibilities under the Act when people had restrictions on their liberty. They informed us that none of people on a short stay at Arbury Lodge were deprived of their liberty. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services are called the Deprivation of Liberty Safeguards.

Prior to this inspection, we had received concerns from relatives about their family member being 'transferred from the hospital ward to Arbury Lodge', without any information, discussion or consent. At the time these concerns were received we had a telephone discussion with the registered manager and an improved system was implemented during 2016. Since this implementation, we have had no further concerns raised with us. All of the people and their relatives spoken with told us discussions had taken place prior to their admission to Arbury Lodge. We also saw signed consent forms were in people's care plans,

these had been signed by the person themselves or on their behalf by their relative.

People told us they were offered choices about what they ate and drank and enjoyed their meals. One person told us, "The breakfasts are cereals, fruit and toast. We choose from the menu in the mornings what lunch we'd like and there are different choices in the evening. I've enjoyed the food so far and have enough to eat and drink."

Care staff told us they prepared breakfast for people, however, lunch and evening meals were delivered to Arbury Lodge in a catering trolley from George Eliot Hospital. We saw there was a selection of meals and there were more meals available than people who used the service in case anyone changed their mind about what they wanted.

We saw people offered support from staff during lunchtime. Staff offered people choices of food and drink, and where they wished to eat their meal. One person told us, "I got up later today so I'm staying in the lounge to eat my lunch rather than move again."

Some people had been identified as 'at risk' of malnutrition or dehydration. We saw staff gave full support to some people with their meal and offered encouragement in an unrushed way. A few people declined food and drink offered to them and whilst staff attempted to encourage people, they did not force them. Staff did not, however, always complete people's food and drink charts as needed which meant that throughout the day opportunities were potentially missed to encourage drinks and snacks when intake had been low.

The registered manager informed us a doctor from the community urgent care team visited the service at least three times a week. The purpose of their visits was to review and assess people's needs as required following their recent discharge from hospital. A doctor from the community urgent care team also provided an 'on call' out of hour's service. One nurse told us, "The doctor's visit is like a 'ward round' and we go through everyone that is currently living here. It is useful that way because of the changing people we have here on short stays and we can discuss any concerns we have about them."

People could not always recall having seen a doctor when needed. However, care records showed people had been seen when nursing staff identified concerns and actions.

The registered manager informed us an occupational therapist was based at the service for 18 hours per week and a physiotherapist was available on an individual needs basis. These professionals completed planned assessments with people, such as assessing how well people could wash and dress themselves, use the 'rehab' kitchen or walk using aides such as frames. Two relatives told us they thought earlier intervention from the physiotherapist might have led to an earlier discharge for the person.

Good

Is the service caring?

Our findings

People felt staff were kind and caring toward them and they told us they had no concerns about their care. One person told us, "The staff are friendly and helpful to me." Relatives said staff were approachable and showed a caring attitude toward their family member. One relative said, "The level of care is good and they are professional."

We saw kind and friendly interactions between staff and people who lived there. We saw one person struggled to find their handkerchief and saw a staff member offer a tissue to this person and gently ask them if they needed any help.

Staff did not know the people they cared for well because it was a short stay service. One staff member told us, "It can be quite hard, because we don't really get to know people that well. The people living here are always changing, but we do our best to get to know them as much as possible."

People told us staff involved them in making day to day decisions about their care, such as where they spent their time during the day. One person told us, "Staff will ask me if I want to stay in my room or spend some time in the lounge."

Staff told us they encouraged people to do things for themselves if they could, one staff member said, "If a person can manage to wash their own face, we'll encourage this rather than do it for them." One staff member told us they thought it was important people maintained their living skills where possible.

Staff mostly supported and encouraged people to be independent whenever possible but we saw missed opportunities for furthering people's independent living skills. For example, one person told us they were going home in the next few days. We saw this person was handed a cup of tea by staff rather than staff taking the opportunity to encourage and support the person to make their own and then use the 'rehab kitchen' to wash up their crockery. Further opportunities were missed at lunchtime when staff could have promoted independence. For example, people had drinks handed to them rather than being encouraged to select and pour their own squash drink. When we discussed this with staff, they said it was a 'good idea' but had not identified these opportunities to continue occupational therapy activities to regain independent living skills.

People did not have their names on their bedroom doors, and one person told us this would make it easier for them to easily locate their bedroom. We discussed this with the registered manager and explained this did not give people 'ownership' of their bedroom for the duration of their stay or promote their independence in locating their bedroom. The registered manager discussed this with the regional manager and agreed 'name boards' would be placed on the wall next to each bedroom.

Care staff respected people and maintained their dignity and gave us examples of how they did this. During our visit, we saw examples of this happen, such as closing people's bedroom doors when they received personal care.

Relatives told us they were able to visit people at any time and there were no restrictions placed on them. One relative said, "Staff are busy, but always offer me a cup of tea with my family member, they are always friendly."

Good

Is the service responsive?

Our findings

People were positive about the care and support they received during their short stay at Arbury Lodge. One person said, "I've been here about four weeks, I'm well looked after and happier here than on the hospital ward because it is less busy here." Another person said, "I understand this place is for people to stay a short time. The manager tells me what is happening and I know about the plans for me to go back to my own home."

People and their relatives were involved in their initial assessment which took place whilst they were an in-patient on one of the wards at George Eliot Hospital. One relative said, "It was explained to us that although this home is a part of the hospital building, it is run separately. We had an initial meeting with the manager when my family member was admitted and have a further meeting to plan their future and what happens next." Another relative told us, "I was initially very apprehensive when my family member was admitted here, because of there being less staff than on the ward and them being isolated in their bedroom because they are cared for in bed. So far, though, I am impressed. My family member is being turned (repositioned) regularly, they are kept clean and the environment is clean. Also, my family member is less agitated here because it is quieter than the ward."

People and their relatives felt care was personalised to their needs. One person said, "When things are discussed about me having some physio or to meet with the occupational therapist, I am included in those meetings. My son also comes and he can remind me what is happening."

Some people were cared for in bed because they were very frail and some, although 'medically stable,' were receiving 'end of life' nursing care. One relative told us, "Although the staff are busy, they are attentive and check on my family member. They are always clean. I feel their needs are being met." Some people cared for in bed were unable to use their call bell to gain staff attention if needed, however we saw staff frequently checked on people cared for in their bedrooms.

Some people were able to take part in various activities in the service. One person told us, "There is an activities staff member, we did some flower arranging the other day." Two people showed us some spring flowers they had been supported to arrange in a display. Another person told us, "We made Easter bonnets; it's nice to have things to do." During our inspection visit, some people took part in a small group quiz. One person cared for in bed, had soft music playing to them which staff said the person found comforting. The activities staff member told us that due to the nature of people's short stays, they decided on what activities were offered such as the quiz, but agreed some activities for people who lived with dementia would be beneficial during their short stay at Arbury Lodge.

The provider supported people's faith needs. A few people told us they attended the George Eliot Hospital Chapel service on Sundays, one person said, "I am glad we can go to that, it's only around the corner from here."

We asked people and relatives about what they would do if they wanted to raise a concern or were unhappy

about an aspect of the home. People and their relatives told us they would speak to staff or the registered manager if they felt they needed to. People told us they had no current complaints.

One relative said their family member's false teeth and hearing aid had gone missing on occasions but these were located on the day of our inspection visit. This relative told us, "I've no complaints, but would like all staff to pay attention to the smaller things. For example, making sure my family member has their teeth in the morning and they are taken out and soaked at night time. Also, they are supported with their hearing aid."

The provider's complaints policy was displayed in the entrance to the service. Staff told us that if anyone had a complaint, they would share this with the registered manager so that it could be looked into. The registered manager informed us they had received two complaints and 53 compliments since the service opened.

Requires Improvement

Is the service well-led?

Our findings

People who stayed at Arbury Lodge knew who the registered manager was. We saw a person interact with the registered manager with ease, and the registered manager responded positively to the person's request. Other people told us they felt the registered manager was approachable, caring and kind, and listened to them. Relatives made positive comments to us about the registered manager, these included them being 'available' and 'listening to concerns'.

Staff gave positive feedback about the registered manager, and shared their vision for the short stay service to provide good care to people and to view each person as an individual. Staff told us they felt the registered manager was approachable.

There was a management structure in place to support the registered manager. The registered manager told us they had a deputy manager, who was on planned leave during our inspection visit. The deputy manager supported them with the overall day to day running of the shift. The registered manager told us they felt supported by their regional manager who visited on a regular basis.

The absence of the deputy manager, during their planned week of leave, combined with no additional support from the provider for the registered manager had impacted on the service provided to people. The registered manager told us their deputy would often work alongside staff. They would provide support to the nurse on shift, leadership and guidance to staff and ensure important information was communicated to them. During our inspection visit, we found examples of when this did not happen. The nurse felt pressured by the amount of tasks they needed to undertake and was therefore not able to provide effective leadership to staff on the shift. The registered manager was not always provided with accurate and important information. For example, a staff member had informed the registered manager that one person had been drinking, but we identified this person's fluid (drink) charts did not support this and showed they had not drunk anything for over 12 hours. The registered manager checked the information they had been given with a different staff member who confirmed the person had not been drinking. The registered manager then sought appropriate healthcare support for this person.

Relatives felt there were sufficient opportunities available to them to discuss their family member's care and support and future plans, with the registered manager. One relative said, "The manager is approachable and listens. We've had meetings that include my mother to discuss what is going to happen after their stay at Arbury Lodge."

There was a 'comments box' next to where visitors signed in, which meant feedback, could be given at any time. The registered manager also had planned dates for 'resident and relative' meetings. However, records showed these were not attended. The registered manager said this was most likely due to people having a short stay at the home and the meetings might have been more effective for a service which provided long term placements for people. The registered manager felt their 'open door' to relatives was more effective in dealing with any discussions or issues relatives might have and relatives spoken with agreed.

The registered manager told us they completed formal and informal checks on staff and observations around the service to ensure people received a good service. For example, nurses' had their competency in administering medicines assessed by the registered and deputy managers. Assessments were recorded, although were not dated, and nurses were confirmed as competent by a signing off process. However, we found good practice was compromised when working under pressure.

Systems were in place to audit the quality and safety of service provided to people. The registered manager told us a regional manager from Sanctuary Care visited on a monthly basis to complete 'quality and compliance' audits. In October 2016 and January 2017, the provider had scored themselves partially compliant and identified actions were needed to make improvements. However, some improvements had either not yet been made or improvement had not been sustained.

For example, the January 2017 quality audit had identified that people's care record entries made by staff were not always "accurate, legible, written in black ink or typed and are signed and dated". During our inspection visit, we found one person's fluid chart which inaccurately recorded the fluids a person had received, two care records where the meaning of the record could be misinterpreted, and a later than expected entry to a record informing of medicines attempted to be given to a person.

Care plan audits were not always effective because issues we found had not been identified by the provider. For example, one person's moving and handling assessment stated they required support from two staff when walking, however, this person had not walked at all since their admission to Arbury Lodge. Care plan information ensures staff take a consistent approach to meeting people's needs and checks on people's care records had not identified the need to change information.

Action had not always been taken to reduce the risks of cross infection, for example when people were sharing hoist slings. Staff told us there were not enough hoist slings for people to have their own allocated one for the duration of their short stay. The registered manager said they were aware of this, however, action had not been taken to minimise potential risks.

Accidents and incidents were recorded by staff and analysis took place at the provider's head office. The registered manager showed us three recorded accident records covering February and March 2017; these had been reviewed on an individual level and consideration given, by head office, as to how to prevent a reoccurrence of accidents.

Following our verbal feedback on the day of our inspection, the registered manager and regional manager told us improvements would be made in the identified areas. The registered manager acknowledged that some issues, such as record keeping, had previously been addressed but improvements had not been sustained.