

Barchester Healthcare Homes Limited

Arbour Court

Inspection report

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Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
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

This was an unannounced inspection which took place on 22, 23 and 24 November 2016.

We last inspected the service in January 2015. At that inspection we found the service was not meeting all the regulations that we reviewed.

At the last inspection on 5, 6 and 7 January 2015 we rated the service as 'Requires Improvement'. At that inspection we identified two regulatory breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014, which related to good governance. This inspection was to check improvements had been made and to review the ratings. We saw evidence to confirm that action required had been taken.

Arbour Court is registered with the Care Quality Commission (CQC) to provide personal and nursing care and accommodation for up to 60 older people living with dementia. The home is owned and managed by Barchester Healthcare Homes Limited. Accommodation is on two floors, all bedrooms are single and have en-suite facilities available. Car parking is at the front of the building. At the time of this inspection 58 people were living at the home.

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.

The location has a condition of registration that it must have a registered manager, but it does not have one. However, steps were being taken by the provider to recruit one within a reasonable timescale.

Following this inspection, the registered provider notified us that a registered manager was in post from 17 January 2017.

People who used the service and their relatives were complimentary and positive about the support provided and attitude of the staff team and management. They told us they were happy with the service provided and overall their needs were being met. They also told us the registered nurses and care staff treated people caringly, sensitively and with respect.

People were supported by sufficient numbers of suitably trained staff. We saw that recruitment procedures helped to make sure staff had the appropriate qualities to protect the safety of people who used the service and we saw they received the training and support required to meet people's needs.

Care staff and nurses we spoke with told us they had undergone a thorough recruitment process. They told us following their employee induction, training appropriate to the work they carried out was always available to them. This helped to make sure the care provided was safe and responsive to meet people's needs.

identified needs.

Individual staff training records indicated that all care staff had received appropriate training to carry out their roles effectively. Some staff were working towards a nationally recognised qualification in care such as a National Vocational Qualification (NVQ) in health and social care and the Care Certificate. The Care Certificate is a professional qualification which aims to equip health and social care staff with the knowledge and skills they need to provide safe care and support to people using the service. This qualification helped them to carry out their roles effectively. Staff members confirmed they had received safeguarding and whistle blowing training and knew who to report to if they suspected or witnessed abuse or poor practice.

Care records were in place to reflect people's identified care and support needs. Information about how people wanted to be supported, their likes and dislikes, when support was required and how this was to be delivered was also included in the care records we examined. Information regarding people's dietary needs was included in their care records and clear guidance for staff members helped make sure these requirements were met.

We saw written evidence that people and their relatives were involved in the decision making process at the initial assessment stage and during their care needs review.

Medicines were stored safely and administered by registered nurses (RN) who were trained appropriately to ensure medicines were given safely. Any specific requirements in relation to medicines to be taken when required (PRN) such as paracetamol, were clearly documented so that staff members could administer the medicine appropriately and were aware of any risk following administration of such medicines.

Where people who used the service did not have the capacity to make their own decisions, the service ensured that decisions taken were in line with the principles of the Mental Capacity Act 2005. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff members received regular supervision to help make sure they were carrying out their duties safely.

Complaints, comments and compliments were encouraged by the provider and any feedback from people using the service or their relatives was addressed by the registered provider. People spoken with knew how to make a complaint and felt confident to approach any member of the staff team if they needed to.

The registered provider had systems in place to monitor the quality of the service such as service user and relative surveys, to ascertain their views and opinions about their satisfaction of the service provided. Any feedback received was noted and used to make improvements to the service and the care and support being provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good 

The service was safe.

Employee recruitment processes were in place. The required pre-employment checks had been undertaken prior to new staff starting work at the service to help make sure people who used the service were safe.

Appropriate arrangements were in place to help safeguard people from abuse. Staff members were appropriately trained and knew how to protect people from the risk of harm and knew what action to take if abuse was suspected or witnessed.

Where risks were identified detailed care plans were in place to minimise the risk of harm. Medicines were administered by registered nurses who had been trained to ensure they were given safely.

Is the service effective?

Good 

The service was effective.

The registered provider and staff members were aware of the Mental Capacity Act (MCA) 2005 and what to do if any restrictions on people were in place. Where people were being deprived of their liberty the registered provider had taken the necessary action to make sure people's rights were considered and protected.

People had access to external healthcare professionals, such as hospital consultants, specialist nurses, physiotherapists and General Practitioner's, who contributed to care records.

Staff members received an employment induction, regular supervision and training to make sure they had the appropriate skills to provide people with effective care and support.

Is the service caring?

Good 

The service was caring.

People received care and support from staff members who knew

them well and made positive comments about the caring and supportive nature of the staff.

Relatives of people using the service knew the purpose of the care records and knew they were reviewed regularly in line with the person's changing care needs. They told us they had been included in decisions about aspects of their relatives care.

People's care records were stored securely so their privacy and confidentiality was maintained. Staff members knew how to use the service's confidentiality policy and understood how to work within its guidelines.

Is the service responsive?

Good ●

The service was responsive. □

People's needs were assessed prior to them receiving a service. Health care reviews were held on a regular basis or as necessary.

Detailed care records identified risks to people's health and well-being and included specialist guidance. Care records indicated people's interests and activities and people were supported to be involved in activities in and out of the home.

Whilst some relatives we spoke with weren't fully aware of how to use the complaints procedure they told us they felt confident in raising concerns or complaints with the registered provider or staff members.

Is the service well-led?

Requires Improvement ●

The service was well-led

The location has a condition of registration that it must have a registered manager, but it does not have one. However steps were being taken by the provider to recruit one within a reasonable timescale.

The registered provider was aware of their role and responsibilities regarding their legal obligation to notify the CQC about important events that affect people using the service and the management of the service.

The registered provider promoted a positive culture that was person centred, open and inclusive. There was a clear management structure in place and staff spoke positively about the registered provider and the team.

The registered provider had systems in place to monitor the quality of the service.

We saw that regular audits and system checks were undertaken on all aspects of the running of the service.

Arbour Court

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.

This inspection took place on the 22, 23 and 24 November 2016 and the first day was unannounced. The inspection was carried out by one adult social care inspector.

Before the inspection, the provider 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 also reviewed information that we held about the service and the service provider. This included safeguarding and incident notifications which the provider had told us about. Following the inspection we spoke with a person from the local authority adult social care team who confirmed they had no current concerns about the provider and the services that were being provided.

During our inspection we spoke with four relatives of people who used the service and three, people who used the service, two senior care workers, the operations manager, the ground floor head of unit, the first floor head of unit, a senior business manager, two care workers, the clinical development nurse, three registered nurses, two cleaning assistants, one laundry worker, the head chef, the maintenance manager, one activity coordinator and the regional director.

We looked at the care records that belonged to seven people who used the service, three employee personnel files including individual staff training records, records relating to how the service was being managed such as safety audits and a sample of the services operational policies and procedures.

Is the service safe?

Our findings

We spoke with two relatives of a person who used the service and they told us they felt their relative was safe living at Arbour Court. They said, "In the main, we are satisfied with the way they [staff] look after him [relative]."

We saw there were arrangements in place to help protect people from the risk of abuse. The service had an up-to-date safeguarding policy and procedure in place which was in line with the local authority's 'safeguarding adults at risk multi agency policy'. This provided guidance on identifying and responding to the signs and allegations of abuse. We looked at records that showed the registered provider had effective procedures to help make sure any concerns about people's safety were appropriately reported. Staff members we spoke with were able to give a good account of the risks associated to vulnerable adults, the safeguards in place to minimise these risks and explain how they would recognise and report abuse whilst demonstrating their understanding of the need to be vigilant about the possibility of poor practice.

They confirmed they had received safeguarding and whistleblowing training. They were able to share their understanding of the service's whistleblowing policy (the reporting of unsafe and or poor practice by staff) and told us they would contact the registered provider to inform them about any risk concerns. Staff training records showed they had received whistle blowing training. All of the staff members spoken with told us the service they provided was safe because they were aware of their responsibility to ensure people's safety.

An accident and incident policy and procedure was in place. We looked at the file used to record accidents and incidents and saw that any incidents had been reported properly to the Care Quality Commission. The registered provider told us that other appropriate authorities, such as the local authority adult social care team, would be notified immediately of such events when they occurred.

Records to show people had a Personal Emergency Evacuation Plan (PEEP) were in place. These plans detailed the level of support a person would require in an emergency evacuation situation such as fire evacuation. We saw that all staff had undertaken fire safety training at regular intervals.

A safe and effective recruitment and selection procedure was in place and was also used for the recruitment of agency staff such as registered nurses. We looked at six staff recruitment files and found that all of the staff members had been recruited in line with the regulations including the completion of a disclosure and barring service (DBS) pre-employment check and at least two recent references from previous employers. Such checks help the registered provider to make informed decisions about a person's suitability to be employed in any role working with vulnerable adults. All staff members were issued with an employee handbook which contained information about Barchester policies and procedures and the organisational expectations of staff.

We examined the care records that belonged to six people who lived at the home. The care records showed that risks to people's health and well-being had been identified. For each person who used the service assessments for a variety of physical and environmental risks had been completed including risk of falls,

behavioural risk and risks in relation to activities such as visits to places of interest. Risk assessments in relation to people's daily living routines were also in place. Any risk was included in a risk management plan which was linked into the person's care plan. For example, where there was a high risk to a person of choking, their risk management plan clearly identified the cause or factors which might increase the likelihood of the risk occurring. The plan stated what action had been taken to reduce the risk and the action staff members should take to minimise the risk, such as making sure small items like paper or fabric were removed out of the person's reach. Staff members spoken with understood these risks and risks identified in the care records of people who used the service. The person's relatives confirmed they were aware of the risk management plan in place and had been involved developing the plan.

Staff spoken with told us they felt there were enough staff to meet the needs of the people who used the service and the duty rosters we looked at confirmed there was a consistent level of staff in place to deliver care and support to people. Relatives of a person who used the service said about the staffing levels, "There is not always enough staff to keep their eye on all of the people who live here." The registered provider informed us that appropriate staffing levels were maintained in order to meet the support needs and level of dependency of people who used the service. We saw that the staff roster was planned to make sure there were enough staff to work closely with people to assist them to meet their specific needs and provide a consistent response to those needs.

The building was clean, well maintained and secured. The maintenance manager was responsible for making sure health and safety audits were carried out on a regular basis, including daily checks on the services mini bus, weekly building walk around to check the safety of windows, doors, lighting and heating. Records indicated that fire equipment was checked weekly and fire drills were carried out monthly. We saw records to show water, gas and electrical appliances and portable appliance testing had been undertaken at regular intervals. Environmental risk assessments had been undertaken and a clear system for documenting any required maintenance work and evidence that the work had been undertaken and completed was in place.

We spoke with six staff members who described their recruitment. They confirmed after completing an employee application form, they were invited to attend a face to face interview to assess their suitability for the job. Following a successful interview the registered provider carried out the necessary pre-employment checks which included proof of the employee's identification (ID) and two references, one from a recent employer. We saw evidence that staff members were not assigned any work until the appropriate ID, references and clearance from the DBS had been received and found to be satisfactory.

A medicines policy was in place that ensured the safekeeping and administration of medicines was followed, monitored and reviewed annually. Nursing staff were trained in the safe handling of medicines. We saw medicines were stored in a locked medicines trolley within a designated locked room. We saw a list of authorised medicine handlers [staff members] had been signed and kept up to date. Only registered nurses were able to administer medicines at the home and had received appropriate training in this topic. Medicines were provided in blister packs by the supplying pharmacist. This helped to make sure the correct dose was administered as prescribed.

Four registered nurses spoken with were knowledgeable about the process for checking the right dose according to the General Practitioners (GP) instruction and administering medicines following the homes medicine administration policy. They had good knowledge of why people required their medicines, the dosage, the desired effect and the action they should take in the presentation of possible side effects.

We looked at the medicine records for six people and found the records completed were up to date. We

asked three relatives of people using the service if their medicines were administered on time and they confirmed they were. This was confirmed when we observed an afternoon medicines round in the home.

We checked seven medication administration (MAR) records and saw they provided a detailed list of all the medicines prescribed, and when they needed to be taken. Registered nurses signed the MAR when people had taken their medicine and each MAR we looked at had been signed appropriately. A registered nurse told us the process followed should a medication error occur and said, "If we find there has been a medicines error such as a medicine not signed for by staff, we have to complete a medicines error report form and immediately inform the duty manager or if necessary seek advice from the person's general practitioner (GP), the out of hours GP or NHS 111. The form asks what the error was, what the recommendations are and how the error could have been prevented. The completed form is then sent off to the regional manager who shares the information within the medicines auditing system. The home manager was responsible for addressing the error with the staff member during their supervision meeting or sooner and a record would be made of the discussion or action taken such as medicines competency training. NHS 111 is the NHS non-emergency number where people can speak to a highly trained adviser; supported by healthcare professionals should they require any health or medical advice.

Staff had access to personal protective equipment (PPE) to help reduce the risk of cross infection. Staff members we spoke with told us the registered provider provided them with personal protective equipment such as disposable gloves and aprons which helped to protect them and people using the service from the risk of cross infection whilst delivering care. They were aware of the need to make sure they used the protective equipment available and one care worker said, "There is always plenty of equipment for us to prevent cross infection."

Is the service effective?

Our findings

When we spoke to a visiting relative of a person who used the service, they were complimentary about the staff and their ability to provide care and support. The relative said, "They look after me and my wife. They seem to know what they are doing."

Records we examined showed new staff members were given a seven day mandatory induction that covered topics such as, fire evacuation, control of substances hazardous to health (COSHH), risk assessments, organisational policies and procedures, medicines, good practice, use of hoists, health and safety, choking, first aid and identified areas for personal development. COSHH is the law that requires employers to control substances that are hazardous to health.

This was followed by a two week period working under the supervision of an experienced staff member within the home. This gave the new staff member the opportunity to get to know the people who use the service. A probationary period of three months could be extended if required. Non care workers such as kitchen and domestic staff underwent a similar induction period and learning was specific to their job. Additional induction training was provided via the Care Certificate. This is a professional qualification that aims to equip health and social care staff with the knowledge and skills they need to provide safe and compassionate care. This meant staff members had received appropriate training to help make sure people received safe and appropriate care.

Continuing staff training was available in topics such as, dementia awareness, safeguarding adults, first aid, medication, food hygiene and equality and diversity. The registered provider told us that where it was identified staff required training in other areas to meet people's specific needs training would be arranged for all staff.

A clinical development nurse was employed to oversee and manage any nursing concerns and to support the nurses at the home. Nurse training in clinical subjects for specific conditions such as wound care and tissue viability were addressed as part of the registered nurse individual competency learning and development. The clinical development nurse also carried out the registered nurses medicines competency checks. We examined a sample of the competency and supervision records which confirmed these checks had been carried out.

There was an ongoing annual staff appraisal and supervision system in place to discuss and evaluate the quality of staffs individual performance and where best practice or practice improvement were discussed and recorded. Staff we spoke with confirmed they received regular supervision at least every two months and an annual appraisal. Records examined showed a clear timetable setting out the times and dates for individual staff member supervision sessions. Supervision meetings provide staff with an opportunity to speak in private about their training and support needs as well as being able to discuss any issues in relation to their work.

We looked at what consideration the provider gave to the Mental Capacity Act 2005 (MCA). The MCA provides

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

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. This legislation sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. The Deprivation of Liberty Safeguards (DoLS) provides a legal framework to protect people who need to be deprived of their liberty to ensure they receive the care and treatment they need safely and where there is no less restrictive way of achieving this.

The registered provider and staff members were knowledgeable about the MCA capacity assessments in place for people who required them. 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. We saw mental capacity assessments had been completed and best interest decisions were recorded including any consultation undertaken and a rationale for reaching the decision made. We saw the provider had developed a check list that acted as a reminder to seek DoLS renewals in advance of the expiry date. Where authorised DoLS had expired and the provider was waiting for DoLS to be renewed, the provider had devised a risk assessment protocol that considered any apparent risk that might require an urgent DoLS application to be sent to the supervisory body (local authority).

The service supported people with varying levels of support needs ranging from people being able to mobilise around the home to requiring increased levels of support. Some people were able to plan and select their food choices with assistance from staff members. We saw that people had choice about what they wanted to eat and where required they were supported to eat their meals with prompts from staff. Care records we examined showed particular attention was paid to what people ate and drank. Daily record sheets indicated the type and amount of food people had eaten. This meant people's nutrition and hydration was monitored to ensure their needs were being met.

Care records showed people had access to external healthcare professionals, such as hospital consultants, specialist nurses, physiotherapists and GPs, and the notes were included in people's care plans. Where people had been assessed as having a risk associated with eating and drinking, such as choking, people had received specialist assessment and advice from the speech and language therapist (SALT) and the advice was followed. Other care files showed attention was paid to general physical and mental well-being, including care records which recorded people's weight, dental and optical checks.

From speaking with two relatives of a person who used the service and examining care records we could see that wherever possible people were involved in making decisions about their care and support and their consent was sought and documented. Staff members we spoke with had a good understanding of how and why consent must be sought to make decisions about specific aspects of people's care and support and said, "Sometimes it's difficult to get the consent from some people because of their dementia. But sometimes we ask the persons relative for their advice. Most of the people don't object to care being provided. We do it in a way that doesn't make them anxious so they are comfortable."

When we walked around the home we saw the home's design and layout were suitable to accommodate the number of people using the service. There was sufficient suitable equipment in place, such as hoists and wheelchairs to support people using the service. Toilets, bathrooms, lounge areas with appropriate seating

and a visitors waiting area in the reception area, were sufficient and relevant to the service being provided. The home was creating a more dementia friendly environment with individual memory boxes located on the wall outside people's bedrooms to help orientate people to their own rooms.

Corridors were clutter free and wide enough for trolleys, hoists and wheelchairs to manoeuvre adequately. Corridors were fitted with handrails to support people's mobility. The service maintained a homely environment to enable people's planned activities and routines to be supported effectively by staff members.

Is the service caring?

Our findings

We saw that the culture of the service was geared to the needs of the people who used the service. Respect and regard for the rights and dignity of people who used the service was central to the delivery of care and support, and we observed good interpersonal relationships between staff and people who used the service. A person who used the service described one of the nurses to us as lovely and said, "She [nurse] is lovely, I'm alright when she's here. I'm wearing lipstick and she helps me to put it on. I am comfortable here."

A person's relative said, "They [staff members] love him [relative] He's happy and content. We can tell." Another relative said, "The care is very good, I'm pleased with the care and the attention she [relative] gets. The staff are tremendous I have to say."

Care records examined had been written with understanding of people's individual needs. For example a care record described how a person who preferred to spend time in their room was no longer able to 'understand the significance of the nurse call bell'. The care plan went on to describe that whilst this was the case, the risks to the person were low; staff should make regular visual room checks during the day. Records to confirm such checks had been undertaken were in place.

We saw that staff had developed a good rapport and understanding of the people who used the service and treated the people and their belongings with respect. Staff understood people's particular communication styles and how to interact positively with them. Where people had difficulty communicating staff remained patient and took time to listen, acknowledge what they were saying and responded appropriately. For example, we saw interaction between a person with communication difficulties, who used the service and a staff member. We saw the staff member patiently respond, speaking softly and reassuringly. It was apparent the person was comforted by the staff's manner and tone of speech.

Care records showed and we saw people were encouraged to remain as independent as possible, and staff supported people to manage tasks such as maintaining personal hygiene within their capabilities. Through our observations it was apparent those people enjoyed the responsibility this afforded.

Whilst nobody was using an advocate at the time of the inspection discussion with the ground floor head of unit showed they were aware of how to access advocates for people when necessary. An advocate is a person who represents people independently of any government body. They are able to assist people in many ways; such as, writing letters for them, acting on their behalf at meetings and/or accessing information for them.

We were told the cultural and religious backgrounds of people were always respected, and when we talked with staff members they were able to demonstrate an understanding of the diverse needs of different cultures and religions. The staff learning and development plan showed equality and diversity training had been completed by most of the staff team and further training in this topic was on going.

We saw that all records and documents were kept securely in locked rooms accessible only by staff

members. This ensured that confidentiality of information was maintained.

The registered provider told us that whilst nobody using the service required end of life care at the time of the inspection, an end of life coordinator supported the home. Staff training would always be provided in this topic and the relevant professionals such as district nurse and GP would be involved. Any programme of learning for staff members to develop awareness and knowledge about end of life care would be put in place and an appropriate care and support plan would be implemented to consider how best to meet the person's needs at that time.

We looked at the home's end of life care policy and procedure which was person centred and geared towards helping the person to have as much control as possible about decisions relating to their future care and end of life needs. The document also made reference to what mattered to the person's family and friends.

Is the service responsive?

Our findings

People who used the service and their relatives told us that the service was responsive and met their needs. One relative said, "There is a unit nurse and I've had one or two reasonable conversations with her about my relative. She's been very good and listens to me. She's sorted a few things out and clarified things for me."

The registered provider told us that detailed assessments were undertaken by a registered nurse before a person began to use the service. Following the initial assessment which included a 'total care assessment', a comprehensive assessment would be completed and plans put in place to make sure people could be supported by the staff team. A risk assessment was completed within 24 hours of the person moving into the home. Consideration of social skills and interactions was given a high priority along with physical and mental health needs, and we saw evidence in the form of detailed care plans that had been drawn up to support the next stage of intervention.

We looked at seven care records which contained comprehensive information about each person and sufficient detail to guide staff on the care and support to be provided. Care records included the person's emergency contact details such as their next of kin, and General Practitioner (GP), risk assessments, current support needs, the care to be provided and the desired outcome from the care provided. They contained relevant information about people's health diagnosis and associated needs, a communication checklist, nutrition and hydration assessments that included information about recent weight loss, appetite, difficulties chewing or swallowing, mobility assessments, moving and handling, tissue viability pain, sleeping, behaviour, emotions, hopes and concerns for the future, cultural, spiritual and social values .

Detailed instructions were provided to support the person with specific tasks, such as eating and drinking which were broken down into clear instructions for staff to follow. Care plans were written in a person centred way and demonstrated a good understanding of the person. For example, in one care plan we looked at the person's personal history formed part of their care plan and included information about the person's family, family relationships, and their involvement in the person's care.

Where people's support needs were identified as requiring two staff, the reasons why were clearly documented. Specialist information and guidance from the relevant professionals involved in their care, such as speech and language therapist (SALT), was also contained within the care records. SALT provide specialist advice to ensure the support needs of people with language or communication difficulties and people with difficulty swallowing, eating and drinking are assessed and appropriate support identified. This information helped to make sure the service is meeting people's needs.

A daily record sheet clearly detailed the care and support provided to people during the day. Staff members were aware of the importance of the care review system and understood information about the person was reviewed to make sure it fully reflected their current support needs. A registered nurse said, "Any changes to a person's care following a care review were always shared with the staff team to reduce the risk of improper care being provided."

Person centred reviews were held every six months or sooner if required and involved the person who used the service where they had the capacity to be involved, family members or advocates and a staff member. Where necessary a social worker or another appropriate professional would also attend the review meeting. Where issues were identified this was noted and follow up action was recorded.

People were supported to take part in hobbies and interests and this information was recorded in their care records. Individual and group daily leisure activities were provided for people who used the service and records of the person's involvement were kept in people's individual care records.

A complaints policy was in place and copies of the procedure were displayed in communal areas in the home. When we looked at how the service managed complaints the registered provider told us that complaints were addressed following the organisations complaints process. Complaints were logged and allocated to a senior member of staff to investigate. These would be monitored and responded to by the regional director. We examined the services complaints log and found where complaints or comments had been made records were kept of actions taken to resolve the issue to the satisfaction of the complainant.

The policy in place allowed for a full investigation and all complaints were taken seriously. The policy allowed complaints to be escalated to the local government ombudsman if the complainant remains dissatisfied with the outcome. Where possible, action was taken from complaints to improve the quality of service delivery. The registered provider recognised that not all complaints could be dealt with satisfactorily. However they acknowledged that positive comments would help to ensure good care standards were maintained.

Whilst some relatives we spoke with weren't fully aware of how to use the complaints procedure they told us they felt confident in raising concerns or complaints with the registered provider or staff members. During the inspection the registered provider circulated additional copies of the complaints procedure in prominent places around the home for people to access if required.

Is the service well-led?

Our findings

It is a requirement under The Health and Social Care Act (2008) that the manager of a service like Arbour Court is registered with the Care Quality Commission (CQC). When we visited, a registered manager was not in place.

The location has a condition of registration that it must have a registered manager, but it does not have one. However steps were being taken by the provider to recruit one within a reasonable timescale.

The previous registered manager left the service in September 2016. The operational director said, "We haven't had a registered manager for six weeks. We are not going to recruit anybody to the post. We want the right person to manage the staff and the service."

Following this inspection the registered provider notified us that a registered manager was in post from 17 January 2017.

We found the home had good management support in the absence of a registered manager. For example the operations manager, head of units, senior business manager, clinical development nurse, and the regional director were present on each day of the inspection. Auditing records and discussion with staff members confirmed management presence was on going. The operations director told us Barchester was committed to providing continuing management support at all locations in the absence of a registered manager.

The registered provider, senior managers and staff members, understood their role and responsibility to the people who used the service and demonstrated their commitment to the service by having clear visions and values about the home.

The operational director told us they wanted to make sure people who used the service had as much control and choice as possible about the service they received. They told us that a person centred approach was designed to help people achieve their desired outcomes in their best interests and on what was important to the person. This made sure the service provided good quality support to people living with dementia at Arbour Court. Partnership work with professional bodies such as the local authority and contributing to Alzheimer's research projects helped the provider to further their knowledge in providing the best services possible for people living with dementia at the home.

There was a clear management structure in place and staff spoke positively about the registered provider and the team. They told us they enjoyed their work and whilst there was no registered manager in place they thought management responded well to the needs of the staff team and of the people who used the service. Staff spoken with said, "We work as a team, we are like a family", and "We support each other for the benefit of the residents" and "Any new manager working at Arbour Court will have to have the same goal". The operational director said, "There is a sense of teamwork and their willingness is obvious." Staff spoken with knew what was expected of them and understood their role in ensuring people received the support they

required and their responsibility to provide this in a caring way.

We saw records to show staff meetings were in place to discuss changes to practice and legislation and to allow the staff team the opportunity for reflection and discuss what works well at Arbour Court and what changes could be made to improve the service provided.

The operations manager attended provider meetings and training sessions within the community to ensure that information from the local authority and clinical commissioning group helped to improve the lives of people who used the service.

Meetings were held with people who used the service and their representative or relatives. People were given an opportunity to say what they liked about the service but also what, if any, improvements could be made. Notes of the meetings were kept to ensure an accurate account of people's verbal contribution.

We examined systems in place to monitor the quality of the service to ensure people received safe, effective and responsive care. We saw regular audits/checks were undertaken on all aspects of the management of the service and management team regularly reviewed the service delivery at the home. We saw evidence of recent audits on reporting systems, accident and incident reporting, people's risk assessments and environmental risk assessments. These showed where improvements were needed and what action had been taken to address any identified issues.

Accidents and incidents were recorded and had been regularly monitored by an internal auditing team to ensure any trends were identified and addressed. We were told that there had been no identifiable patterns in the last 12 months. Similarly, any safeguarding alerts were recorded and checked for any patterns which might emerge.

The registered provider shared with us copies of the services policies and procedures such as, complaints and suggestions, safeguarding adults, accidents and incidents, medicines, staff recruitment and whistle blowing. All of the policies we looked at had been reviewed regularly and the next policy review date was planned. A business contingency plan was in place which identified the provider actions when an exceptional risk though unlikely, would have impact on the service provided to people and staff.

A quality assurance system was in place to help the provider ascertain and respond to the needs of people who used the service, relatives, representatives and stakeholders. This system provided service consistency to the required Barchester standards, which is to provide high quality nursing care and support to their service users. Quality first visits, regulations and compliance visits were undertaken by the divisional director. Any action required to reduce identified shortfalls in service provision was undertaken within appropriate timescales by management who addressed and implemented the actions as required.

The operations director and the ground floor head of unit advised us of the future plans to develop the service and improve service delivery. They told us they were in the process of identifying employee champions within the home to flagship areas such as, staff recruitment, infection control, safeguarding, dignity and wound care. The champion scheme was to be discussed at the next planned team meeting along with plans about the home refurbishment during 2017.

Plans were in place to set up 'Friends of Arbour Court' meetings to support people who use the service, with a dementia diagnosis and their relatives on their dementia journey. Letters in relation to this initiative were sent to relatives informing them of the first meeting on 1st November 2016. Follow on meetings were planned for the first Tuesday of the month.

The provider recognised staff kindness and caring attributes through observations of staff practices and behaviours. The regional director told us that rewarding staff was an important tool for continued delivery of kindness. Barchester operated an employee reward scheme and employee of the month award. This helped the staff team to feel valued and maintain a good standard of care

We checked our records before the inspection and saw that accidents and incidents that the Care Quality Commission needed to be informed about had been notified to us by the registered provider. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.