Ramos Healthcare Limited

Arden Court

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 unannounced inspection took place on 5 May 2016.

Arden Court is owned by Ramos Healthcare Ltd and is located on a busy main road in Eccles, Greater Manchester. The home provides care for people with nursing, residential and continuing care needs. The home is close to local shops, bus routes and has adequate car parking facilities located at the front of the building.

At our last inspection of Arden Court in November 2015, we rated the service as 'Requires Improvement' overall and in three of the five keys questions against which we inspect. These included Safe, Effective and Responsive. We also identified a breach of regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Good Governance. This was because we found the service maintained poor records in relation to people's food and fluid intake.

Prior to the inspection we had been informed by the local authority that the provider had started to restrict admissions to the home, due to various concerns being raised about the quality of care being provided. The provider had also recently recruited a 'crisis manager', to oversee the daily running of the home. We also received information of concern from different sources regarding staffing levels, record keeping, the environment, management and infection control. We used this information as part of our inspection planning.

During this inspection we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to staffing, safe care and treatment, seeking consent, premises/equipment, person centred care, and good governance). You can see what action we have asked the provider to take at the back of this report.

We observed there were insufficient staff available to care for people living at the home. We observed several people having to wait to be taken to the toilet whilst staff appeared busy. Another person, who required re-positioning by two members of staff told us that on occasions, only one member of staff completed this task and that they didn't always use a slide sheet, as stated in their care plan. Feedback from staff about current staffing levels was poor.

We identified several instances of poor practice with regards to infection control. This included dirty soiled bed sheets being stored in a trolley in bathroom areas and on one occasion, in a person's bedroom whilst they were in bed. We also observed staff didn't wash their hands at appropriate times, such as after handling different people. This could increase the risk of the spread of infection.

People who lived at the home required staff to check that their pressure relieving mattresses and bed rails were safe and in good working order. This would help people prevent people developing pressure sores and falling from their bed. According to the homes paperwork, these needed to be completed twice during the

day and once at night. We were unable to see these checks were being undertaken to ensure people remained safe.

The service did not always mitigate risk well. On the day of the inspection, building and renovation work was taking place at the home. As a result, the home had implemented a risk assessment for this on going work. However we found specific control measures identified weren't followed. For example trailing wires needed to be neatly kept, signage about the on going work needed to be displayed and tools weren't to be left unattended. We found these measures weren't followed during the inspection, with secure doors also propped open.

The majority of people who lived at Arden Court were required to be re-positioned every two to four hours to prevent the risk of them developing pressure sores. However, when looking at records, we were unable to establish if this had been taking place as required. We found gaps in eight people's charts that we viewed. This could place people at risk.

We found three peoples risk assessments had not been reviewed each month, as was required. These were in relation to Waterlow, nutrition and Malnutrition Universal Screening Tool (MUST). Another person's care plan wasn't updated following a fall. This could place people at risk due to staff not having up to date information to refer to in care plans.

We saw staff had access to training such as safeguarding, moving and handling, infection control, and Health and Safety. Staff told us they were happy with the training available to them. However we observed two members of staff who, according to the training matrix, had out of date moving and handling training. We observed these staff assisting people during the inspection. Our specialist advisor (SPA) also case tracked a person who used a catheter, and we couldn't see any evidence staff had completed any training in this area. We also noted only 18 (50%) of current staff had completed training in the Deprivation of Liberty Safeguards (DoLS), whilst only nine (25%) had completed training in dementia.

We spoke with a nurse working at the home who said they aimed to ensure people drank a minimum of 1500 millilitres of fluid each day, however we found records did not support this had been offered to people. There was also no evidence if people had refused a drink. This could place people at the risk of dehydration. On certain days, people only had porridge or yogurt recorded as being the only thing they had eaten. This placed people at risk of becoming malnourished and again, there were no records of food being refused.

We identified five people who needed to be weighed each week to ensure staff could closely monitor their weight and ensure they remained safe. Despite this, we found inconsistent records to demonstrate this was being done as required. One person's care plan stated staff needed to monitor their food intake to ensure they did not become malnourished, however a nurse told us this had not been done.

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. We saw appropriate DoLS applications had been made, with confirmation they had been authorised.

We saw staff did not always seek consent from people when delivering care.

There were a limited number of adaptations to the environment to make it more accessible to people living

with dementia. There had not been improvements in this area since our previous inspection. The general manager said this was being considered as part of the ongoing refurbishment programme.

Prior to our inspection, we received information of concern that night staff were expected to wash and dress people as early as 5am in the morning, regardless of it being their personal choice. The information also stated this was an expectation of day staff, who would often be unhappy if this wasn't done. A member of staff confirmed with us this was the case, with this also being written in two people's daily records. This was not recorded in people's care plans as being their choice and did not demonstrate person centred care was being provided.

We observed staff did not always respond to people's requests in caring manner. For example, when providing assistance to people at meal times.

People we spoke with told us they liked living at Arden Court. People said they felt staff treated them with dignity and respect. During the day, we observed staff had a caring approach towards people living at home. We found interactions in areas such as the upstairs lounge, were limited throughout the day. This lounge area was often left unsupervised for long periods with staff appearing unable to interact and engage in conversation with people, due to being busy with other things.

People had care plans in place, which provided an overview of their care requirements. We found some of these were updated regularly, however three people's care plans we case tracked had not been updated since January or February 2016. These should be completed each month. We had also raised this concern during our previous inspection.

There was an activity schedule in place and we saw people engaging in an activity during the afternoon of our inspection in lounge. On the day of our inspection, it was a warm sunny day and this would have been a good opportunity for people to sit outside in the large garden area at the back of the building. However we saw people weren't encouraged to sit outside at any point during the day.

There was a registered manager in post, although they weren't present during the inspection. Our inspection was facilitated by the general manager. 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.

In the absence of the home manager, there was a lack of visible leadership during the day. There were two nurses working at the home, however they were completing medication rounds for long periods and completing paperwork at the nurses station. Staff did not always seem well organised in their deployment, such as when leaving lounge areas unattended regularly.

On the day of the inspection audits undertaken by the home manager could not be located, as they were stored electronically on a computer. We requested these were sent to us shortly after the inspection. These were sent and covered areas such as pressure sores, peg feeding, catheters and falls. However we saw no evidence of audits undertaken to cover staff training, care plans, medication and infection control. These were some of the areas where we had concerns during this inspection. Additionally, there was no auditing system in place to ensure accurate records were maintained by staff of food, fluid, re-positioning, bed rails and pressure mattresses. Again, this was an area where we found concerns.

Services such as Arden Court are legally required to submit notifications to CQC about significant events

such as any serious injuries, safeguarding or events involving the police. We found evidence that the provider had not submitted notifications to us as required in relation to serious injuries and safeguarding incidents. We are dealing with this matter outside the formal inspection process.

We found storage of confidential information was poor with documents such as care plans, elimination sheets and food/fluid intake often being left unattended on the nurse's station which was unstaffed. Care plans were stored in a metal filing cabinet, but this was not locked meaning anybody had easy access to the files, such as workmen in the building. We also found archived records were disorganised in the same filing cabinet and when we requested specific copies from staff, they were either missing, or could not be located.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

We are considering our enforcement actions in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

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 safe.

We observed staffing levels were insufficient to meet people's needs safely, with people having to wait for assistance.

On going maintenance work could have placed people at risk due to the area being left unattended, with hazards such as trailing wires. Peoples individual risk assessments weren't always reviewed regularly.

We observed poor practice with regards to infection control such as staff not always washing their hands after handling different people and storing dirty laundry in people's bedrooms.

People weren't always observed taking their medication by staff to ensure this was done safely.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

Staff did not always seek consent from people living at the home before providing assistance.

We identified some gaps in staff training such as moving and handling, dementia and catheter care.

According to records maintained by the home, people did not receive sufficient fluid intake to prevent the risk of dehydration.

We saw no improvements since our last inspection to make the environment more 'dementia friendly'.

Is the service caring?

Requires Improvement

Not all aspects of the service were Caring.

We observed staff did not always respond in a caring and respectful manner when people asked for assistance.

People said they liked living at Arden Court, as well as the staff

who cared for them. Visiting relatives also made positive comments about the home.

Interactions between staff and people who lived at the home were at times limited, although this seemed to be a result of staffing level restraints.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

Care plans were not updated each month as required, with some care plans lacking certain information about people's care.

A member of staff told us they were expected to get people up early in the morning, regardless of it being their choice. This was also reported to us as part of whistleblowing information prior to the inspection.

We saw any complaints were responded to appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

Leadership on the day of the inspection was lacking, with nobody overseeing what was going on at the home.

There were audits in place but they did not cover certain areas where we had identified concerns. We also identified a continuing breach of regulations from our previous inspection.

Record keeping and storage of confidential information was poor.

Appropriate notifications were not submitted to CQC as required.

Arden 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 unannounced inspection took place on 05 May 2016. This meant the provider did not know we would be visiting the home. The inspection was carried out by two inspectors from the Care Quality Commission and two specialist advisors (SPAs). One of the SPAs was a registered nurse, whilst the other was a general practitioner (GP).

Prior to the inspection we reviewed information we held about the service. This included records of any notifications the service are required to send us, such as notifications of any safeguarding incidents. We viewed previous inspection reports and also contacted other agencies who had involvement with the service based within Salford local authority.

During the inspection we spoke with the general manager and six people who lived at the home. We spoke with eight members of staff, including nurses and two visiting relatives. We also spoke with a visiting health professional.

During the inspection we looked at 10 care plans and three staff personnel files. We also looked at medication administration records (MARs) and other documentation related to the running of the home such as quality assurance documentation and training records.

Inadequate

Is the service safe?

Our findings

The people we spoke with told us they felt safe, as did any relatives we spoke with who were visiting during the day. One person told us; "The staff are very good with me and I have never had a reason to doubt my safety."

We spoke with staff about their understanding of safeguarding vulnerable adults. One member of staff said to us; "I have a good understanding of safeguarding. Verbal, physical and mental abuse can all occur. Bruising could indicate physical abuse, whilst shouting at, or upsetting somebody could be classed as verbal abuse." Staff also told us they were aware of the whistleblowing policy and what action to take if they had any concerns. Another staff member said; "If I had any concerns about safeguarding I would go to the manager, but we have telephone numbers for CQC and the local authority in the staff room if we want to contact someone directly."

Prior to our inspection, we received information of concern regarding staffing levels from a variety of different sources. We used this information to inform our inspection planning. At the time of the inspection, the home did not use a dependency tool to demonstrate people's care needs had been taken into account to inform staffing numbers within the home. Staff rotas were also unavailable in the absence of the manager and whilst we requested these documents to be sent to us following the inspection, these weren't provided. The general manager told us due to staff suspensions and sickness, there was a heavy reliance on agency staff to fill gaps on the rota. We were told staff recruitment at the home was currently on-going and were looking to over staff by 20%.

Staff we spoke with told us they felt there were insufficient numbers of staff to safely care for people. One nurse said; "My biggest concern is if a person had to go to hospital during the night because that would leave only two care staff and a nurse on duty to cover the rest of the home, which wouldn't be enough given people's needs. The medicines round is also taking a lot of time to complete as many people are cared for in bed and care staff aren't trained to administer medicines."

Another staff member told us; "We've been using lots of agency staff recently. Regular agency staff are good but sometimes communication is an issue if they aren't familiar. Some residents get upset if they don't recognise the agency staff member. I don't think we have enough staff because there are several people who need two staff to support them and this includes regular turns during the night. We don't have the time to sit and talk to people as we would like to do. I have concerns about some agency night staff who I've seen sleeping in the lounge, it's not a regular occurrence but it does happen. I've raised this in meetings but not sure what's been done about it."

On the day of the inspection, we arrived at the home at approximately 6.45am and found the home to be staffed by a nurse and three care assistants. This was to provide care to 36 people. One member of staff said; "It's very hard working here at night. There is a heavy reliance on agency staff who are used every night because we are always short. If an agency nurse is working at night, you can't always guarantee they will help out. Pretty much everybody on this floor needs re-positioning during the night, which takes two of us. It

also takes two to wash people as well. If there are only two of us, it's a struggle. The nurse on tonight does help, but that then leaves the other floor short."

We saw the day shift was staffed by two nurses and six care assistants, one of who was working at the home for the first time and was shadowing. This was one less care assistant than at our previous inspection in November 2015, where there was also one less person living at the home. At the time of the inspection, the home did not use a dependency tool, to establish how many staff were required to care for and meet the needs of people living at the home.

During the inspection we observed that staff were rushed and struggled to provide prompt assistance, such as when people needed to go to the toilet. At one point, we passed one person's room and they shouted: "I'm wet through". We saw that they had pressed the nurse-call buzzer and when staff attended they said to the person in an abrupt manner: "I'm helping someone else and you are going to have to wait." The staff member then said to us in a dismissive tone: "She's always asking for help. It was approximately 10 minutes before the member of staff returned.

We observed that another person was not independently mobile and required the assistance of two staff to get out of bed. We saw that the nurse-call buzzer was out of reach of this person and tucked away behind a chair which meant that the person had to shout for assistance rather than using the nurse-call system. This placed the person at risk because staff may not hear their calls for help unless they were in the vicinity of the room. We placed the nurse-call buzzer within reach of this person and asked staff to provide assistance. The person also pressed the nurse-call buzzer. Staff entered the room and told the person they would have to wait and would return shortly with another staff member who would assist them with mobilising.

On another occasion, we observed a person asking to be taken to the toilet at approximately 1pm. This person reported to a member of staff they had a 'dodgy stomach' and could feel they needed to go to the toilet. Two members of staff were both in the lounge area, adding food to plates to be taken to people in bedrooms. One staff member told this person they were busy with lunch and that they would have to wait. The staff then left the room and did not return until approximately 1.30pm, but still did not assist this person to go to the toilet and carried on assisting people to eat. All three of these people's care plans described them as being doubly incontinent and needing assistance with their toileting routine.

We looked at the care plan of a person who needed to be re-positioned every two to four hours by staff to prevent pressure sores from developing and that this needed to be done by two members of staff with the use of a slide sheet. The care plan described them as having 'tissue like skin' and at 'very high risk' according to their waterlow score. We spoke with this person who said that staff didn't always use a slide sheet and that turns weren't always done by two members of staff. We were told; "There aren't enough staff and that's one of the downsides. Sometimes two staff turn me but not always. I must say that when they do it on their own, they do a fantastic job. "I wouldn't say they always use a slide sheet to re-position me".

We spent time observing people in the upstairs lounge area of the home. On two occasions we observed the lounge area was left unsupervised by staff. The first occasion was at 9am, where five people were seated in the lounge area unattended for 15 minutes. We saw one person asking for a cup of tea and that they were ready for something to eat, however there were no staff to hear the request. The second occasion was at 11.45am where seven people were seated in the lounge. A member of staff did not come into the room until 11.55; however people were not supervised during this period. Staff said they had been busy assisting people in their bedrooms. This showed staff were not deployed in correct areas of the home.

This meant there had been a breach of Regulation 18 (1) of The Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014. This was because there were insufficient numbers of staff to meet people's needs safely.

We looked the systems in place with regards to infection control. We observed domestic staff were in the process of cleaning people's rooms using a variety of cleaning items that were stored in a mobile cleaning trolley. We saw that there were different coloured storage bins being used for different items such as bedding or soiled clothing. We also saw that staff used the correct personal protective equipment (PPE) when cleaning the rooms.

We noted there was a pervasive mal-odour throughout the home. We were told that an infection control inspection had recently been carried out by the local authority but a report had not yet been produced. We were told that items identified at the visit included the need for a sink in the sluice room and tiling to be updated, which we observed to be absent and the need to clear out cluttered rooms. During the inspection we observed several people's bins in their rooms that were full and in need of emptying.

We identified several other instances of poor practice with regards to infection control. This included dirty soiled bed sheets being stored in a trolley in bathroom areas and on two occasions, in a person's bedroom whilst they were in bed. We raised this with staff on duty who said that finding suitable storage was a struggle; however we had raised this as an area of concern during our inspection in February 2015. As part of the on-going refurbishment programme, we were told a room was being converted, so that adequate storage would be available. We also observed staff didn't wash their hands at appropriate times, such as after touching or handling different people. This could increase the risk if the spread of infections.

This meant there had been a breach of Regulation 12 (2) (h) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service was not adequately preventing the spread of potential infections.

On the day of the inspection, there was building and renovation work taking place at the home. As a result, the home had implemented a risk assessment for this ongoing work. However we found specific control measures identified weren't followed. For example trailing wires needed to be neatly kept, signage about the ongoing work needed to be displayed and tools weren't to be left unattended, however we observed the workmen outside on several occasions, leaving the area being renovated unoccupied. We also saw secure doors being propped open, leading near to a stair case. We raised this with the operations director who told us they had instructed the workmen not to carry out renovation work whilst the inspection was taking place.

People had risk assessments in their care plans that covered nutrition, mobility and pressure sores. There should have been evaluated each month by staff at the home. We found three people's risk assessments had not been reviewed each month, as was required. These were in relation to pressure care and nutrition. Another person's care plan wasn't updated following an unwitnessed fall, resulting in them going to accident and emergency (A&E). This person fell in February 2016, yet their mobility care plan was last reviewed in January 2016. This could place people at risk due to staff not having up to date information to refer to in care plans.

These issues meant there had been a breach of Regulation 12 (2) (b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service was not doing all that is reasonably practicable to mitigate any such risks.

We looked at how medication was handled. We were told the ordering of medication was usually done by the deputy manager and was undertaken on a monthly basis. We also noted medication was checked into

the home by two nurses. We looked at the controlled drugs book, which was accurately completed and signed by two staff when administered. We noted all MAR sheets were also accurately completed. We saw daily fridge monitoring of temperatures were completed, with records maintained by staff. Medication was stored appropriately in cupboards in the clinical room that was locked and also in a medication trolley that was also locked when not in use. We noted that any medication needing to be returned was placed into small plastic pockets that were sealed. The nurse showed us a locked store cupboard where a returns bin contained a blue plastic bag where the medicines were placed. These were signed by staff as required.

During the morning medicines round we observed that the nurse administering a medicine to someone in their own room was interrupted by another staff member who required assistance. We saw the nurse then left the room but did not close and secure the medicines trolley before leaving which meant that anyone could access the medicines stored in open medicines trolley. After taking a few steps the nurse realised their mistake and re-entered the room, closed the trolley and removed it to a safe place. The morning medicines round took over two hours to complete, which meant that there may not have been enough time in between rounds for the medicines to have the required effect, and raised the potential for an overdose.

At our previous inspection, we observed a nurse giving one person their medication, who then spat it out, with the nurse returning to the nurse trolley to sign the MAR sheet. Prior to this inspection, we received whistleblowing information alleging that medication is sometimes found on bed sheets in people's bedrooms. At one point during the inspection, we observed a person who had been given a tablet designed to dissolve in their mouth. We saw this was visibly coming out of their mouth and onto their clothing, with the nurse again returning to the trolley to sign the MAR sheet. This also left this person sat in an undignified manner and they seemed to be unaware and falling asleep. This meant staff would be unaware if a person had not had their medication as prescribed. We raised the issue with staff who attended to this person.

These issues meant there had been a breach of Regulation 12 (2) (g) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people did not always receive their medicines safely.

We found people were protected against the risks of abuse, because the home had appropriate recruitment procedures in place. We saw that appropriate checks were carried out before staff began work at the home to ensure they were fit to work with vulnerable adults. During the inspection we looked at three staff personnel files. Each file contained job application forms, interview questions, proof of identification, a contract of employment and suitable references. A Criminal Records Bureau or Disclosure Barring Service (CRB or DBS) check had been undertaken before staff commenced in employment. CRB and DBS checks help employers make safer recruiting decisions and prevent unsuitable people from working with vulnerable adults.

One staff member told us; "I had a three day induction when I first started which included shadowing other staff, but there was no assessment at the end of this. I had to undertake a DBS and provide references prior to starting in post. The training seems to be generally good".

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. At the time of the inspection, there were five people subject to a Deprivation of Liberty Safeguards (DoLS). We also noted all relevant documentation around these applications was available within peoples care plans. Staff told us they worked in people's best interest and involved family where possible.

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 procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager demonstrated effective systems to manage DoLS applications. In instances where people were deemed not to have capacity to consent to living at the home, the registered manager had completed standard authorisations which had been submitted to the local authority. There was a current policy in place detailing procedures.

We looked at how the service sought consent from people living at the home. We specifically looked at the care plans of two new admissions to the home since our last inspection. We found there was a lack of written consent in these care plans, where people could provide consent to the care they received. We requested these following our inspection, but were sent the assessment of a different person who had lived at the home for a while. We observed two instances where staff did not ask for consent before supporting people. In one instance a member of staff said to a person; "Open your mouth" when giving a person a drink, rather than asking them first. On another occasion a member of staff placed a tabard over somebody's head without establishing if that was what they wanted, whilst supporting this person to eat. This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to seeking Consent.

There were a limited number of adaptations to the environment to make it more accessible to people living with dementia. There had not been any improvements in this area since our previous inspection. For example there was no signage towards bedrooms, the lounge area and the dining room in order to help people navigate where they were going. We did note one bathroom had coloured 'grab rails' which stood out and would be easier to locate against a background wall. We had raised the issue about a lack of dementia friendly adaptations at our last two inspections; however no action had been taken. The general manager said this would be considered as part of the ongoing refurbishment programme.

We also observed the premises were not always being used for their intended purposes. This was because were observed hoists, zimmer frames and wheel chairs stored in bathrooms and corridor areas. This made the environment look cluttered and would be difficult for people to use properly. We told appropriate storage was currently being sourced.

This meant there had been a breach of Regulation 15 (1) (c) of The Health and Social Care Act 2008

(Regulated Activities) Regulations 2014. This was because the premises were not always suitable for the purpose for which they are being used.

Staff told us they were happy with the training available to them. One member of staff said; "I feel like I am getting enough training. I've done moving and handling, infection control, fire safety, safeguarding and mental capacity act. I feel supported but they need to employ more staff." However we observed two members of staff who, according to the training matrix, had out of date moving and handling training and we observed them assisting people with transfers during the inspection. Our SPA also identified a person who used a catheter, but we couldn't see any evidence staff had completed any training in this area, to aid their understanding.

We noted the homes training matrix identified 36 members of staff. We saw only 18 (50%) had completed training in DoLS and nine (25%) had completed training in dementia. This meant staff may not have the sufficient skills to care for people living with dementia, or who may be being deprived of their liberty.

This meant there had been a breach of Regulation 18 (2) (a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not received such appropriate training to enable them to carry out the duties they are employed to perform.

We looked at how people's nutrition and hydration needs were met. We found the meal time experience was not always a pleasurable experience. We observed the breakfast meal and saw that two people who had taken breakfast in the dining room had fallen asleep and remained in this unengaged state for over an hour. During this time staff came in and out of the dining room area, but did not speak to these people to ask if they were well, until they had woken up.

We also observed the lunch time meal, which was being served to approximately 15 people. We saw that there was a large time gap of approximately 50 minutes between the first person receiving their food and the last person receiving their meal. We saw adapted cups were being used by some people as identified in their care plan. There were four staff members present assisting different people to eat their meal. We observed some positive interactions between staff and people, for example one staff member jokingly said to one person; "Is it my conversation that's making you fall asleep," to which the person laughed. Other staff were observed to be gentle and patient when encouraging people to eat, with good eye contact and quiet conversation taking place throughout.

We asked people for their opinions of the food. A person who used the service told us; "I'm on a pureed diet and I eat what I can. The food looks okay when presented and I can get a snack or a cup of tea if I wanted. I get Weetabix for breakfast in my room but sometimes I have to wait a while if staff are busy." Another person said; "The food is nice and lunch and tea are both good."

We spoke with a nurse working at the home who said they aimed to ensure people drank a minimum of 1500 millilitres of fluid each day, however we found records did not support this had been offered to people. There was also not always evidence if people had refused a drink, or why more fluid wasn't offered or taken. During the inspection we saw six people's fluid charts indicated that low amounts of fluid had been consumed. This could place people at the risk of de-hydration. On certain days, people only had porridge or yogurt recorded as being the only thing they had eaten. We saw this in eight people's records that we viewed. We felt this was a recording issue as opposed to people not being given food and drink, as we saw people eating food and offered drinks during the day of the inspection.

We identified five people who needed to be weighed each week so that staff could closely monitor their

weight and ensure they remained safe. Despite this, we found inconsistent records to demonstrate this was being done as required. Although we noted nobody had suffered any substantial weight loss, staff could be unaware if somebody did begin to lose weight, due to not monitoring it closely. Another person's care plan stated staff needed to monitor their food intake to ensure they did not become malnourished, however a nurse told us this had not been done. We asked why this was and were told that at times, other nurses working at the home 'did things differently' than others. This again meant staff may be unaware if this person was becoming malnourished due to not closely monitoring what this person was eating. We have addressed the issues relating to recording of weights, food charts and food/fluid intake in the 'Well-led' section of this report.

There was a staff induction programme in place, which staff were expected to complete when they first began working at the home. Each member of staff we spoke with told us they undertook the induction when they first commenced their role. Staff we spoke with told us that they had completed a formal period of induction which included shadowing more experienced members of staff for three days until they were deemed competent to work independently. At the end of the probation period a formal meeting was held which identified that the staff member was competent. Staff also told us they received supervision as part of their on going development, with records to support this available in their files.

Requires Improvement

Is the service caring?

Our findings

The people we spoke with said they liked living at Arden Court and were happy with the care. One person said; "It's far superior to the previous place I lived, both food and care wise. The staff are brilliant and I'm not just saying that. Fantastic, all of them." Another person said; "I've been here for over three years and I like it here. The staff are very helpful. I'm going to the hospital this afternoon and staff will come with me and stay with me. Sometimes when I ring my buzzer I have to wait a while if staff are busy but I understand." A third person added; "The staff are nice with me and help me when I need them I usually don't have to wait for long".

The visiting relatives we spoke with told us they were happy with the care provided. One relative said; "I find the staff to be extremely supportive and caring." Another visiting relative told us; "I think the care here is exceptional and people are treated with respect. I see people getting snacks and drinks throughout the day when I've been here. [My relative] was having difficulties with eating and I told the manager and sat in on a meeting with the nurses and now [my relative] is on a soft diet which they can eat easily".

People told us they felt treated with dignity and respect by staff. Staff were also able to describe how they did this when delivering care. During the inspection, we observed staff knocking on doors before entry. Staff had respect for people when they spoke to them and we observed people were treated with dignity. One member of staff said; "If I was washing someone I would cover up the parts of the body that weren't being washed and obviously close the door first. Good communication is essential so you should keep talking to the person. We look at people's pre-admission assessments so that we understand their needs".

We saw staff trying to promote the independence of people living at the home where possible. Examples of this included placing cutlery in people's hands and encouraging people to independently eat their food. One person told us; "I'm very dependent but they try and get doing things for myself as much as they can".

We saw that interactions between staff and people who lived at the home were at times limited, although this seemed to be a result of staffing level restraints. We observed staff were unable to sit and spend time with people in lounge areas where people were seated, due to assisting people who were being cared for in bed.

We observed staff didn't always response to people's needs in a respectful and caring manner. At approximately 1.00pm we saw that one person was agitated and refusing to eat their main meal and calling out: "I want ice cream and nothing else." This person continued to repeat this statement another four times until eventually, about 30 minutes later, they shouted out in a highly agitated manner: "For God's sake I just want some ice cream." We saw that a nurse then came to the table and removed the main meal of another person who was sat at the same table, without removing the meal of the person who had stated they didn't want their food. The nurse then came back to the table with a bowl of ice cream for the other person and none for the person who had repeatedly asked for it. This raised the potential for an increase in aggravated behaviour which may have presented a risk to others sitting at the table. Several minutes later another staff member provided ice cream to the person who had originally asked for it. This meant there had been a

breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to dignity and respect.

We noted people were clean and were dressed appropriately, wearing both socks and shoes. Staff were kind and gentle and we observed staff transferring people and helping them to eat their food. We noted that when doing this, they were patient and caring.

People had care plans in place that provided staff with information about how they could effectively communicate with people and detailed whether any communication aids were required including glasses and hearing aids. One care plan we looked at contained information on how the individual expressed pain and emotions through facial expressions. This would help ensure any new staff were able to recognise and respond appropriately to these signs. During the inspection we saw that staff took the time to explain clearly what they were doing, such as when supporting people during transfers.

We observed one person was being supported to attend a hospital appointment. As the person was preparing to leave the building a staff member said to them in a light-hearted way: "Shall I scratch your back before you go" The person smiled and responded positively to the staff member who later explained to us that the person regularly enjoyed their back being scratched. This demonstrated the staff member was mindful of the things that the person enjoyed.

Requires Improvement

Is the service responsive?

Our findings

A visiting health professional said they were happy with the care being provided at the home and felt the home were responsive to people's needs. We were told; "It's a good home in my opinion. It seems well run and the staff are nice. I've no concerns and there doesn't seem to be an alarming regularity of pressure sores either. It is certainly not a home where I wouldn't want to put my own parents."

Each person living at the home had their own care plan. This provided guidance for staff to follow about how each person needed to be cared for. During the inspection we looked at 10 care plans of people who lived at the home. We noted care plans provided guidance around pressure care, personal care, physical well-being, nutrition, sight, hearing, communication, mobility, continence, oral hygiene and foot care. We noted care plans also took into account people's preferences, likes and dislikes.

Care plans were not always reviewed and updated regularly. Three of the people's care plans had not been updated since either January or February 2016. These should have been completed each month as part of the monthly evaluations. We had also raised this concern during our previous inspection. In two care plans we looked at, there was also missing information about people's care needs. One care plan was seen to have missing information about oral hygiene, foot care and mobility. The second care plan had no information in about the person's mobility. This meant staff would not have access to information about how to provide care in line with people's needs. We saw no evidence of recent care plan audits where these issues could have been identified.

Prior to our inspection we received information of concern that night staff had recently started to wash and dress people as early as 5am in the morning, regardless of whether this was people's preferred choice. We were told this was done because night staff would be 'bullied' by day staff if they did not complete this task before the day shift commenced. The information also stated that the manager was aware of this and had not taken action.

We asked a nurse about these allegations during the inspection. We were told; "We are expected to get some people up, washed and dressed before the day shift comes on duty. I think staff are afraid that they will be seen as not doing their job properly if they don't do this." We noted from looking at two people's daily record sheets that they had been washed and dressed at 5am on the day of the inspection. However, we couldn't see that this was recorded in their care plan as being their choice or preference.

This meant there had been a breach of Regulation 9 (1) (c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care did not always reflect people's preferences.

We saw that an activities plan was posted on a wall in the downstairs corridor. This included activities such as films, pampering, ball games, and quizzes. There was also another different activities board with activities that were suitable for a one-to-one situation such as reading, chatting, activities in people's rooms. There was a display of art work from a local high school in one corridor. On the day of our inspection, it was a warm sunny day and this would have been a good opportunity for people to sit outside in the large garden

area at the back of the building. However we saw people weren't encouraged to sit outside at any point during the day.

In the afternoon we saw that a quiz was taking place in the dining room area with approximately 12 people in attendance, supported by two staff members. We overheard lots of lively chatter and laughter between people as they took part. A visiting relative told us; "I've noticed that there isn't much going on during the day. There seems to be lots of people just sitting about. I think more staff are needed." A person who used the service said; "I get involved in activities and I like these." Another person commented; "I don't get involved in activities as I prefer to stay in my own room." Another person told us; "I like drawing and I have the materials to do this."

The home kept a log of formal complaints made. The procedure for making a complaint was displayed within the home for people to see. We saw responses to complaints had been provided, and actions had been taken when required. People living at the home and their visitors we spoke with told us they would feel comfortable making a complaint should they think this was required. A visiting relative said; "I would have confidence in raising a complaint if I ever had to. I was given information at the start that told you how to make a complaint."

The general manager told us that a 'clinic' was held with people who used the service and their family members each week on Tuesday and a similar meeting was held each week with staff on Thursday. However, there was no written record of these meetings available.

Inadequate

Is the service well-led?

Our findings

There was 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 2008 and associated Regulations about how the service is run. The registered manager was not present on the day of our inspection. The inspection was facilitated by the general manager.

Prior to the inspection we had been informed by the local authority that the provider had started to restrict admissions, due to various concerns being raised about the quality of care being provided. The provider had also recently recruited a 'crisis manager', to oversee the daily running of the home.

During the inspection, we asked staff for their view and opinions of management and leadership within the service. One member of staff said; "The manager is good. He has provided nursing cover in the past when we have been short staffed. He also helps the care staff as well, which other nurses sometimes don't do." Another member of staff told us; "I've always found the manager to be very supportive. Nothing seems to change when we raise concerns about staffing levels though."

In the absence of the home manager, there was a lack of visible leadership during the day. There were two nurses working at the home, however they were completing medication rounds for long periods and completing paperwork at the nurses station. Staff did not always seem well organised in their deployment, such as when leaving lounge areas unattended for long periods, where people were present. There was one permanent registered nurse on duty during our inspection, with the second member of nursing staff being an agency staff nurse. The permanent nurse told us they felt there was adequate nursing cover, but acknowledged that current use of agency staff did increase pressures in relation to completion and review of paperwork and care plans. From our observations we could see there was a high workload for the permanent nurse, and this limited the time they spent working 'on the floor', observing care being provided.

At our previous inspection we had concerns about record keeping within the home. We still found this to be an area of concern during this inspection. This was because we were unable to see that accurate records were maintained in relation to eight peoples food charts, six people's fluid intake sheets, eight people's re-positioning charts and nine people's bed rail and pressure mattress checks. Overall, we found consistent gaps in these records, with staff not always being able to locate these records on request.

People who lived at the home required staff to check that their pressure relieving mattresses and bed rails were safe and in good working order. This would help prevent people developing pressure sores and falling from bed. These needed to be completed twice during the day and once at night. We were unable to see these checks were being undertaken to ensure people remained safe. This was the case in nine of the sample records we checked. This meant staff would not be able to determine if there were any faults with this equipment, due to not undertaking regular checks as required. The majority of people who lived at Arden Court were required to re-positioned every two to four hours to prevent the risk of them developing pressure sores. However, when looking at records, we were unable to establish this if this had been taking

place as required. We found gaps in eight people's charts that we viewed. One of these people had a pressure sore on the day of the inspection; with a further two people being identified as being at 'very high risk' according to their risk assessment. This could place people at risk.

This meant there had been a breach of Regulation 17 (2) (c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because accurate, complete and contemporaneous records in respect of each service user were not maintained.

On the day of the inspection audits undertaken by the home manager could not be located, as they were stored electronically on a computer. We requested these were sent to us shortly after the inspection. These were sent these six days later and we saw they covered areas such as pressure sores, peg feeding, catheters and falls. However we saw no evidence of audits undertaken to cover staff training, care plans, medication and infection control. These were some of the areas where we had concerns during this inspection. Additionally, there was no auditing system in place to ensure accurate records were maintained by staff of food, fluid, re-positioning, bed rails and pressure mattresses. Again, this was an area where we found concerns.

We looked at the most recent provider audit which was done in February 2016. This provided a focus on care planning, treatment room, medication, staff recruitment files, staffing and rotas, finances, confidentiality, the environment, equipment, maintenance records, confidentiality and other observations. The audit did highlight some of the concerns we had found during our inspection such as care plan and risk assessments not being reviewed each month, confidential information not being stored securely and life histories not being completed in care plans. From looking at this audit, there was no action plan completed of how these areas were going to be addressed and as such, the same issues were identified during this inspection, several months later. From looking at the audit, no clear action plan had been set about how the issues would be addressed. This meant it was unclear to us if this audit was fully effective.

We found the actions taken by the provider had not been sufficient to address the concerns and shortfalls we identified in relation to record keeping at our last inspection and there was a continuing breach of the regulations. We also identified new breaches of the regulations and areas where standards had declined, such as in relation to staffing levels, mitigating risk, infection control, and person centred care.

This meant there had been a breach of Regulation 17 (2) (a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not effectively assessed, monitored and improved the quality and safety of the services provided in the carrying on of the regulated activity.

Staff told us they had raised issues about staffing levels with the manager but no positive response had been given. One staff member told us; "I've discussed this issue with the manager before and the response was to say the home doesn't have enough residents in to justify more staff. There's been very little management input to try and understand the situation."

We looked at the minutes from the most recent staff meeting which had taken place in March 2016. We noted some of the topics of discussion included staffing levels, competencies of agency staff and pay structures. 'Resident issues' was included as an agenda item, but did not appear to have been discussed according to the minutes. There was also no record of feedback from previous meetings or any record of how things raised had been responded to. Despite staffing levels being raised as a concern from staff during this meeting in March, numbers were no different on the day of our inspection. We also noted there had been no discussion about previous concerns raised in CQC inspections. This meant that unless staff read our

last inspection report, it may be difficult for them to know what our concerns had been. 'Any other business' was also an agenda item, but the details of the discussion had not been recorded in the minutes, such as if staff had other concerns about their work.

We also looked at the most recent residents meeting which had taken place in March 2016. Topics of discussion during this meeting included Bloom Care (the service provider), menus, staffing levels, activities and when the next meeting would be. We noted there did not appear to be any comments from residents about their recent experiences of the home. The homes renovation had also commenced on 18 March 2016, however we saw no evidence people had been consulted about how this would be done, or particular colour schemes they may like to see.

This meant there had been a breach of Regulation 12 (2) (h) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service did not effectively seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity.

Arden Court is legally required to submit notifications to CQC about significant events such as any serious injuries, safeguarding or events involving the police. We found evidence that the provider had not submitted notifications to us as required in relation to serious injuries and safeguarding incidents. For example, we were made aware that the local safeguarding team had 12 active cases shortly before our inspection, however this did not correspond with notifications we had received. We were also made aware of two incidents involving the unsafe of hoists. We received a notification about the first incident, although it did not detail there had been concerns over the use of a hoist and we did not receive a notification about the second incident. We were told there had been no injury; however the person had visited hospital to be checked over. We are dealing with this matter outside the formal inspection process.

We found storage of confidential information was poor with documents such as care plans, elimination sheets and food/fluid intake often being left unattended on the nurse's station which was unstaffed. Care plans were stored in a metal filing cabinet, but this was not locked meaning anybody had easy access to the files, such as workmen in the building. We also found archived records were disorganised in the same filing cabinet and when we requested specific copies from staff, they were either missing, or could not be located.

This meant there had been a breach of Regulation 17 (2) (d) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because records were not kept securely.

We observed the staff handover meeting that was conducted between the night staff and day staff. We saw that an update on any events that had happened during the night was given to the day staff who were coming on duty, such as if anyone had been given pain relief medicines or if they had a settled night. This meant that the day staff were aware of any significant issues that had arisen the night before.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care in line with their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not always asked for their consent before receiving care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises were not always being used for their intended purposes.

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 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive their medication safely. People were not always protected from the risks associated with cleanliness and infection control. The service did not always mitigate risk well within the home.

The enforcement action we took:

We issued a warning notice against this regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The quality of service was not always monitored effectively. The service did not always maintain accurate records. The service did not store confidential information securely. The service did not always seek and act on feedback appropriately in order to improve the quality of service provided.

The enforcement action we took:

We issued a warning notice against this regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always receive sufficient training to support them in their roles.

There were not sufficient staff deployed to meet the needs of people living at the home

The enforcement action we took:

We issued a warning notice against this regulation.