

Ramos Healthcare Limited

Arden Court

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

This unannounced inspection took place on 30 November and 12 December 2017.

Arden Court is owned by Ramos Healthcare Limited 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 February 2017, the home was rated as Requires Improvement overall and for each of the five key questions we inspect against. We identified breaches of the regulations with regards to person centred care, safe care and treatment, good governance and staffing. This inspection looked at the progress made since our last visit, to ensure the requirements of the regulations were being met.

During this inspection we identified two (continuing) breaches of the regulations with regards to safe care and treatment and good governance. You can see what action we have asked the provider to take at the back of this report.

At the time of our inspection, there was no registered manager in post, however the current home manager had submitted an application to register with CQC, which was in progress with our registration team at the time of the inspection. 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.

Improvements were still required to the handling, recording and storage of people's medication.

We found that accurate and contemporaneous records were not always being maintained in certain areas such as oral and personal hygiene, when people had received a shave and when they had their finger nails cut/cleaned. Staff were not always consistently signing people's fluid intake sheets to ensure the amounts consumed were sufficient and records regarding when people's drinks had been thickened were not being maintained consistently. This meant we could not be certain if people's care needs were always being met.

Since our last inspection, in June 2017, a person passed away at the home and their death was referred to the coroner for further investigation. The concerns related to the management of falls. Subsequently, a Regulation 28 report was issued to the home by the coroner which identified future deaths could occur unless the necessary action was taken to keep people safe. The home manager had provided a written response to the coroner, detailing any action that would be taken. We reviewed this response as part of the inspection.

People who used the service and their relatives told us they felt the service was safe. There were appropriate risk assessments in place with guidance on how to minimise risk. Staff recruitment was robust with appropriate checks undertaken before staff started working at the home.

At our last inspection, we received feedback (mainly from staff and visitors) that staffing levels were not adequate to safely meet the needs of people living at the home. Since then, we found staffing levels had increased with an additional member of staff added to both the day and night shift. Everyone we spoke with during the inspection including people living at the home, visitors and staff said there were currently enough staff working at the home to care for people safely.

We found staff received sufficient training, supervision, appraisal and induction to support them in their role. The staff we spoke with told us they were happy with the training they received and felt supported to undertake their work. At the last inspection we found not all staff were trained in moving and handling, however this training had now been provided.

We found appropriate DoLS applications were made to the local authority where people had been assessed as lacking capacity to make their own choices and decisions. The staff we spoke with had a good understanding in this area and told us they worked in people's best interests where possible. The relevant paperwork regarding these applications was held within people's care plans.

The people we spoke with said the food served at the home was of good quality and we saw people being supported to eat by staff. People were weighed on a regular basis and more frequently if they were identified as being at risk of losing weight.

We found the home worked closely with other health professionals and made appropriate referrals if there were concerns. Details of any visits from other professions was recorded within people's care plans.

At our last inspection, people reported there was a lack of continuity of care due to a high turnover of staff and regular use of agency staff. Since the last inspection, the home had recruited lots of additional members of staff and all of the staff working at the home during the inspection were permanent.

We received positive feedback from people we spoke with about the care provided at the home. People said they felt treated with dignity and respect. Staff were also able to describe how they aimed to do treat people well when delivering care.

Each person living at the home had their own care plan in place which provided an overview of their care requirements and any associated risks. These were updated each month or when people's care needs changed.

During our last inspection, there was a lack of consistency with regards to the recording of people's likes, dislikes and preferences as this information wasn't captured for each person. Additionally, the care plans we looked at did not demonstrate that families had been involved in them and whilst reviews were done, they were signed off by staff and did not involve people living at the home and their families. People's preferred choices of activities also weren't clearly documented in their care plans. We found this information was now clearly recorded in people's care plans for staff to refer to.

During the inspection we observed several activities taking place which people participated in. This included a quiz in the afternoon which people seemed to enjoy.

There were systems in place to monitor the quality of service being provided to ensure good governance, with a range of audits being undertaken by the home manager.

Staff meetings took place on a regular basis, giving staff the opportunity to discuss their work and raise any concerns about practices within the home. We also observed a handover taking place where the lead nurse provided an update on people's care needs.

Staff spoke positively about management at the home and said the manager was supportive and approachable. Staff said the manager had made changes for the better since starting working at the home.

Policies and procedures were in place and were being reviewed regularly.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

Not all aspects of the service were safe.

Improvements were still required to the handling, recording and storage of people's medication.

People living at the home said they felt safe and staff understood their responsibilities with regards to protecting people from abuse.

Staff were recruited safely with appropriate checks carried out before they started work.

Is the service effective?

Good ●

The service was effective.

The home was working within the requirements of the Mental Capacity Act (MCA), with appropriate DoLS referrals made where necessary.

Staff told us they received sufficient training, induction, supervision and appraisal to support them in their roles.

People said they received enough to eat and drink and made positive comments about the food provided.

Is the service caring?

Good ●

The service was caring.

People who lived at the home, visiting relatives and healthcare professionals made positive comments about the care being provided.

People were treated with dignity and respect.

We observed caring interactions between staff and people living at the home.

Is the service responsive?

Requires Improvement ●

Not all aspects of the service were responsive.

Accurate and contemporaneous records were not always being maintained regarding people's care.

Complaints were responded to appropriately.

A range of activities were available for people at the home to participate in.

Is the service well-led?

Not all aspects of the service were well-led.

We identified a breach of the regulations meaning the well-led key question can only be rated as Requires Improvement.

Everybody we spoke with made positive comments about management and leadership within the home.

Staff meetings and handovers took place so that staff could discuss their work and raise any concerns.

Requires Improvement 

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 inspection took place on 30 November and 12 December 2017 and was unannounced. The inspection team consisted of two adult social care inspectors from the Care Quality Commission (CQC), a pharmacist inspector from CQC who looked at how medication was handled and an expert by experience. An expert by experience is someone who has personal experience of caring for people with similar care needs to those living in Arden Court.

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

Prior to the inspection we reviewed all of the information we held about the home in the form of notifications, previous inspection reports, enforcement notices and safeguarding incidents.

We contacted relevant stakeholders from Salford City Council which included safeguarding, infection control, environmental health and the Clinical Commissioning Group (CCG). We also contacted Salford Healthwatch. This was to see if they wanted to share any information in advance of the inspection.

During the inspection we spoke with a wide range of people and viewed certain records in order to help inform our inspection judgements. This included the home manager, three nurses, eight care assistants, four people who lived at the home and two visiting relatives. We also spoke with the activities coordinator, the cook and a cleaner/domestic person and two visiting health care professionals.

Records looked at included eight care plans, six staff personnel files, 16 Medication Administration Records (MARs), training records, building/maintenance checks and any relevant quality assurance documentation.

Is the service safe?

Our findings

All of the people we spoke with said they felt the home provided safe care. One person insisted on locking their door when they went to the lounge and the staff supported them to do this. Another person said they left valuables and personal items in their room and had no concerns about leaving them there because they felt the home was safe.

At our last inspection we found the home was in breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because medicines were not managed safely. We found that the requirements identified at the last inspection had been met, but further improvements in the handling and recording of medicines were needed.

Our medicines inspector looked at the medication administration records (MARs) for sixteen of the 33 people living in the home. There were no 'gaps' in the records of administration and all the medicines people needed were in stock. The amount of medicine received from the pharmacy and any stock remaining from the previous month were recorded on each MAR. Medicines could be accounted for by comparing this amount with the administration record. We looked at a quarter of the morning medicines round on one floor and found that the number of tablets remaining matched the record on each person's MAR. This indicated that the medicine had been administered in the right way. Entries on charts that were written by hand were signed by two people. Checking by a second person reduces the chance of a mistake and is good practice.

The use of thickening agents to prepare drinks for people who had swallowing difficulties was not recorded on their MAR or fluid intake chart. People prescribed thickening agents are at risk of choking if their drinks are not thickened accurately, to the right consistency.

At lunchtime we watched nurses administer medicines on both floors of the home. Nurses gave people their medicines in a friendly and respectful way. Medicines due at a specific time were given on time. We noticed that one nurse had signed a MAR in the morning to show they had given a medicine when they could not have done so because the course had finished the previous day and none was available in the home. The nurse told us they had not given that particular medicine and had made an error.

Protocols (extra written guidelines) were in place for people prescribed a medicine 'when required' (PRN). The protocols were reviewed every month to check they were still correct and that people's needs hadn't changed. Nurses recorded the reason they gave a PRN medicine on the person's MAR. When people were prescribed a mild painkiller 'when required' the type or site of pain to be treated was not specified in the protocol. This could result in nurses giving pain relief tablets inappropriately instead of seeking medical advice.

Some people were prescribed moisturising or barrier creams that were applied by carers. We looked at seven people's cream charts and only two of these people's records showed carers were applying creams in the way prescribed. This meant people's skin might not be cared for properly. Medicated creams were kept in the medicines trolley and applied by nurses.

Medicines were stored securely. However, we saw that the medicine trolley on the upstairs floor was sometimes left unlocked when unattended during the lunchtime medicine round. Other people are at risk of harm if they can access medicines not intended for them. Medicines were kept at the right temperatures. However, the records did not show that the medicine fridge was at the right temperature throughout the 24 hours before each daily check.

Medicines that are controlled drugs (medicines subject to tighter controls because they are liable to misuse) were stored and recorded in the right way. Nurses carried out a stock check every week. We checked four controlled drugs and found that stock balances were correct.

This meant there had been a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to safe care and treatment.

Since our last inspection, in June 2017, a person passed away at the home and their death was referred to the coroner for further investigation. The concerns related to the management of falls and crash/sensor mats not being in place. Subsequently, a Regulation 28 report was issued to the home by the coroner which identified that future deaths could occur unless the necessary action was taken to keep people safe. The home manager had provided a written response to the coroner, detailing any action that would be taken. We reviewed this response as part of the inspection. The actions that had been taken included improvements to documentation regarding sensor and crash mats and where staff recorded that this equipment was in place for each person. Changes to internal moving and handling training had also been made, to cover the importance of crash/sensor mats not being unplugged so that they remained active. Additional detail had also been added to accident forms so that post incident observations could be recorded after a fall.

We looked in detail at how accidents and incidents were managed. These were investigated and preventative measures instigated to keep people safe and mitigate any further risk. Accidents and incidents were recorded and reviewed by the registered manager, this ensured any trends/themes were identified and appropriate action was being taken. Incidents showed where applicable health care professionals such as the falls prevention team or district nurses, dieticians and speech and language were informed and information shared to minimise the risk of repeat incidents and accidents.

We looked at how the service managed risk. Each person's file we looked at contained a series of risk assessments which contained appropriate information to manage any risks posed to each individual. Risk assessments were created to predict behaviour or events which could cause harm or injury to a vulnerable person and were designed to mitigate such risk. People's risk assessments covered areas such as allergies, diet, risks posed to people due to difficulty swallowing, self-neglect, mobility and behaviour which may harm others. Staff displayed a good understanding of risk assessment processes and were able to speak confidently about the measures they took to promote the safety and wellbeing of the people they supported.

Staff recruitment was safe. Recruitment processes were designed to enable a thorough assessment of the person before being successfully appointed to the role. We looked at six staff recruitment files and noted they contained documents and checks such as, a full employment history along with a satisfactory explanation of any gaps in employment history, health questionnaires to ensure full consideration had been made to any physical or mental health condition the applicant may be suffering with. An enhanced criminal record certificate was also sought. This is a mandatory criminal record and barring check on individuals who intend to work with children and vulnerable adults and satisfactory conduct in previous employment was also sought by requesting references from previous employers.

We found there were appropriate systems in place to safeguard people from abuse. A safeguarding policy was in place which highlighted the need for safeguarding to be everybody's business and that it was unacceptable for any person to experience abuse of any kind. The guidance also recognised the services responsibility to ensure all staff were aware of its principles and how to report concerns should they arise. In order to meet this requirement the service ensured literature was easily available to staff, visitors and people who used the service and that all staff received relevant and up to date training. We were able to confirm during the inspection that information was available and staff had received training in this area. Staff gave relevant examples of what constituted abusive practice and how they would report any concerns should they need to. One staff member stated, "Abuse can be anything such as physical, emotional, sexual." Whilst a second stated, "I would report safeguarding concerns to the senior nurses, managers, CQC or the social workers."

At our last inspection, we received feedback (from staff and visitors) that staffing levels at the home were not adequate to safely meet the needs of people living at the home. Since then, we found staffing levels had increased with an additional member of staff added to both the day and night shift. Everyone we spoke with during the inspection including people living at the home, visitors and staff said there were currently enough staff working at the home to care for people safely.

Comments from staff regarding staffing levels included, "It's improved at night now that we have an additional member of staff. Numbers were increased because it was difficult, and "It is much better now and we hope it continues," and "Quite a lot of staff have been recruited recently. Slowly it is getting better and the staff numbers are enough to meet people's needs," and "Right now there are enough staff now that numbers have increased."

The provider ensured processes were in place which maintained a consistent staffing team throughout the home. Comments from visiting professionals, people using the service and their families also supported this. People told us how staffing levels were now consistent and the use of agency staff had reduced significantly. One visiting health professional stated, "It is a fantastic place I no longer have any concerns. The staff team are very consistent. All staff know all residents now and are very helpful." Whilst a second visiting professional stated, "Things have changed for the better were everything is concerned, especially staff. I have noticed they have a regular staff team now and no longer use agency. The registered manager confirmed this and told us they had recently had a very successful recruitment drive and had recruited to all vacancies.

The manager used a dependency level tool to calculate how many staffing hours were required. This was reviewed on a monthly basis to ensure staffing levels were sufficient to meet people's needs safely. We saw evidence in each person's file of a, 'dependency classification form.' These were used to calculate the needs of each person, this information was then inputted into the dependency level tool to generate an overall staffing level. These processes enabled an appropriate level of staff to ensure the needs of people were met effectively. Comments from staff supported the effectiveness of the tool. Staff also reported they were able to safely support people on a daily basis and felt that current staffing levels were adequate.

Fire procedures were in place and each person had a personal emergency evacuation plan (PEEP) which considered areas such as level of mobility, responsiveness to an alarm and prescribed medication. Risk assessments were evident along with a record of fire systems, emergency lighting and fire alarm checks. Contingency plans were in place detailing steps to follow in the event of emergencies and failures of utility services and equipment.

Environmental risk assessments were also in place. These covered areas around the building both internal

and external. Areas such as the general location of people's bedrooms, room temperature, lighting, window restrictors, floor surface coverings, stairwells, corridors, bathrooms, outside garden were all considered. If a risk had been identified control measures had been put in place to ensure it was being managed appropriately. In addition the maintenance person also reviewed these risk documents to ensure they were still valid and current.

Equipment such as kitchen and bathroom aids were also examined by an external agency and were serviced in line with manufacturing recommendations. Daily, weekly and monthly checks required to be carried out such as electrical safety, gas safety, legionella flushing, water temperatures were carried out and 'Control of Substances Hazardous to Health' items (COSHH) were stored in line with current guidance. A maintenance person was employed to ensure any maintenance issues were resolved within an acceptable time scale. External contractors were also used when necessary to undertake the servicing of areas which were not assessed as the maintenance person's area of expertise.

We spent time walking around the building, looking at communal rooms. The environment was clean and free of malodour. A visiting health professional added, "It is always clean and pleasant smelling when I come and I am in here most days." We noted equipment was stored appropriately and the stair wells were free from clutter. The service employed a full time domestic team who were required to follow a cleaning schedule. We saw toilets and bathrooms were clean, tidy and contained appropriate hand hygiene guidance. We also looked in several bedrooms and found these to be clean and tidy. In addition we saw staff wore appropriate personal protective equipment (PPE) when assisting people with personal care and when assisting people to eat their food at meal times.

Is the service effective?

Our findings

The people we spoke with said they felt staff were well trained and were competent to carry out their roles. People said they were aware that staff received regular training and had seen training sessions taking place at the home.

Newly recruited staff followed a formal induction programme and were required to undertake a range of basic mandatory training and to read and sign certain policies prior to starting their employment. Areas covered during the induction included care plans, personal care, dignity/respect, confidentiality, dementia, medication, risk assessments, eating/drinking, moving and handling and training requirements. Staff also told us they were introduced to other residents and were given the opportunity to 'shadow' existing, or more experienced members of staff to gain an understanding of the role. One member of staff said, "The induction covered lots of things including online training. It gave me a good overview of working at the home and was helpful as well." Another member of staff said, "The induction was thorough and was exactly what I needed."

We looked at the training staff were provided with to support them in their roles and reviewed the training matrix. At the last inspection we found not all staff were trained in moving and handling, however this training had now been provided. The current training matrix showed staff had received training in areas such as safeguarding, health and safety, fire safety, infection control, DoLS, dementia care, first aid, medication and food hygiene. All of the staff we spoke with said the home provided enough training to staff and felt supported in their job roles. One member of staff said, "We do online training and it's updated as well. They do provide enough training to staff." Another member of staff said, "I've done training relating to tissue viability, end of life, medication, safeguarding and infection control. I would say enough training is provided." A third member of staff commented, "The moving and handling training showed us how to use all of the equipment such as the hoist."

Staff received the necessary supervision and appraisal to support them in their role and we saw records of this documentation during the inspection within staff files. One member of staff said, "I have supervision with the manager and had one within a few weeks of being here." Another member of staff said, "They seem to take place every three to four months or so. We can discuss training and any concerns we have."

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found the home was working within the requirements of DoLS and MCA, with applications made to the local authority as necessary, with paperwork kept in people's care plans. A record of which people were currently subject to DoLS and those awaiting

assessment was also maintained. The staff we spoke with had an understanding of DoLS/MCA and told us they had received training in this area. Staff were aware that DoLS were required when people lacked the capacity to make their own choices and decisions and therefore required others to make decisions in their best interests.

During the inspection we observed staff seeking consent from people living at the home prior to providing any assistance with tasks such as assisting people to mobilise, administering medication and helping people to eat and drink. People also had written consent forms in their care plans regarding answering questions, physical examination, health professionals viewing their records, photographs and use of bed rails. This meant people were able to provide agreement to receiving care and treatment in advance of it being delivered.

We looked at how people's nutrition and hydration needs were being met. We saw people had nutrition care plans and risk assessments in place providing an overview of people's dietary needs. People's body weight was kept under review with some people required to be weighed on either a weekly or monthly basis. Malnutrition Universal Screening Tool (MUST) assessments were completed and provided an overview of the level of risk presented to people regarding their nutritional status, with referrals made to other health professionals such as dieticians where people were deemed to be at risk.

Records of people's food and fluid intake were maintained and had been completed accurately up until the day of our inspection. Fluid records detailed the amounts offered to people by staff and what was consumed. The records we viewed indicated good levels of fluids were being offered to people and we saw drinks being served and available to people during the inspection. The daily menu was displayed at the home outside the dining room, with a choice of meals offered daily. People told us the food was plentiful, hot and tasty and that drinks and snacks could be requested at any time.

There were records in people's care plans to demonstrate they received regular input from health care professionals as required. These included doctors, dieticians, speech and language therapists (SALT), podiatrists and tissue viability nurses (TVN). The falls service had also visited the home during the inspection and spoke positively about practices within the home. Two of the visiting professionals we spoke with during the inspection told us they felt the home had improved and had no concerns with care delivery.

Is the service caring?

Our findings

Without exception, the people we spoke with said staff were always attentive, caring and considerate. During the inspection we observed lots of interaction and affection between staff and people who lived at the home. One visiting relative said, "My Uncle has received wonderful care and I have been informed of any changes in his care plan." A person living at the home also added, "Everybody is so nice and kind." A visiting professional thought the home had improved in recent months and had observed staff being patient when they had visited.

At our previous inspection in February 2017, people had told us they felt there was no continuity with staff due to the home using agency staff rather than those that were regular. Everybody we spoke with told us this had improved with the home having recruited lots of permanent staff since the last inspection. This meant people could receive care from staff who were familiar and had a good understanding about their care needs.

During the inspection we spent time observing how people were cared for and saw positive and caring interactions between staff and people living at the home. At one point, a person told a member of staff they were cold and were immediately provided with a blanket to help them get warm. Another person had a nose bleed and a member of staff noticed this and got them a tissue, whilst sitting with them and checking they were okay. These observations demonstrated the caring nature of staff who worked at the home.

We noted people appeared to be clean and well presented. We observed one person eating several bowls of porridge independently, and had food round their mouth and on their chin when they had finished. A member of staff recognised this and wiped their face down with a cloth shortly afterwards. Another person had spilt food down their clothing and we observed a member of staff assisting them to their bedroom a short while after so that they could change into fresh clothes.

Throughout the inspection we observed people being treated with dignity and respect by staff. For example, we observed a person sat in their chair with their clothing misplaced, showing their legs. A member of staff noticed this and offered to help cover them up immediately. On another occasion we observed two members of staff going into a bedroom to deliver personal care. The staff knocked on the door before entry and then closed the door behind them to ensure the person had privacy. A General Practitioner (GP) was visiting people at the home during the inspection. Staff offered people the opportunity to speak to the GP in the privacy of their own bedroom as opposed to in the lounge area where other people were present.

There were systems in place to ensure good communication between staff and people who lived at the home. Each person living at the home had a communication care plan which provided an overview of whether people could express their views and if they required any particular aids such as glasses or hearing aids and how staff would recognise symptoms of pain. We observed staff talking people through what was happening during transfers using hoists and this appeared to keep people calm during the process.

We observed people were offered choice throughout the day. This included being asked if they would like to

sit either upstairs or downstairs, what they would like to watch on the television and if they would like any specific condiments added to their food. We saw staff promoting people's independence during the inspection with tasks such as eating and drinking. People's personal hygiene care plans provided an overview of how staff needed to increase people's independence with tasks such as shaving and allowing people to wash their own face and parts of their body. This gave people the opportunity to be involved in the care they received instead of having things done for them by staff.

We saw people were provided with information about the service was available in the home's entrance, including a copy of the provider's Statement of Purpose. Each person was provided with a guide to the service which included information about the service and staff, along with a copy of the statement of purpose. A statement of purpose is a document that includes a standard set of information about a provider's service.

Is the service responsive?

Our findings

The people we spoke with and visiting relatives said they felt the service was responsive to people's care needs. A visiting relative said, "Staff are very responsive and this makes a huge difference to me and my family. We did raise a concern and it was dealt with immediately."

At the last inspection, this key question was rated as required improvement. This was because people's likes, dislikes and preferred choices of activities were not being consistently documented in their care plans. Information about people's life histories was not always being captured. We saw this had improved during this inspection. People's social histories were clearly documented and detailed information about where people were born, school days, family information, hobbies/interests and countries they had previously visited. People's preferred food choices were taken into account and we could see these meals were being provided when we looked back at records of what people had eaten. Any activities people enjoyed and had participated in were also documented with their care plans.

The provider had processes in place to ensure each person's needs were assessed before the service began to support them. Each person was required to have a pre assessment of their needs before living at the service. This was to ensure the service was provided with the appropriate amount of information to enable them to make an informed choice about meeting the person's needs safely and effectively. The registered manager explained that usually a local authority support plan was received and following this a senior member of staff from the service would meet with the person and their family and ask further questions. From this the services own paper work was created and developed into an individual care file.

Each person living at the home had their own care plan in place. Care files contained a number of care plan's appropriate to the individual person. Care plan areas included mobility, meal times, bed time routine, preferences, social life, health, skin integrity, mental health and hobbies. There was detailed information needed to ensure staff were equipped with the correct and relevant information to enable the person to receive care in line with their own preferences. People's equality, diversity and human rights requirements were also captured. For example, if people had any particular religious or cultural beliefs and if there were specific dietary requirements staff needed to be aware of. Staff were responsive towards people of different cultures, faiths or nationalities and respected their choices and decisions.

People's essential contact details were recorded as routine, such as health professionals, GP and next of kin. Staff displayed suitable knowledge of people's needs and could explain how support was provided to each individual in areas such as those relating to safety, choice, personal preferences and leisure pastimes and in a person centred way. Daily reports also provided evidence that people had received care and support in line with their support plan. We viewed a sample of records and found they were written in a sensitive way and contained relevant information which was individual to the person. These records enabled all staff to monitor and respond to any changes in a person's well-being.

We found that accurate and contemporaneous records were not always being maintained with regards to people's care. Each person had a document in their care plan which allowed staff to record when they had

delivered certain aspects of people's care, however we found these were not always being completed consistently. For instance we found some gaps in recording with regards to turning/re-positioning charts, mattress/bedrail checks, and when oral hygiene had been delivered. Nurses were also required to sign of people's fluid charts at 12am to ensure the amounts consumed were enough, however this was not always being done consistently.

This meant there had been a breach of regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to good governance. This was because there had been a failure to maintain securely an accurate, complete and contemporaneous record in respect of each service user.

The service had an activities coordinator who was employed full time and offered activities on a daily basis. Activities included, sing along, arts and crafts, quiz, pampering sessions and singers. During the day of inspection we saw the activities coordinator sitting conversing with people and in the afternoon people were encouraged to join in a quiz. There was also a board displayed near to the main dining room informing people of any upcoming activities or outings taking place at the home.

We looked at how complaints were managed. There was a complaints policy and procedure in place which had contact numbers for CQC and the local authority. We noted five complaints had been received since the last inspection in February 2017. Each of these complaints had been dealt with in line with the providers policy. In addition we saw the service had a file containing compliments received from people using the service and their families. Compliments thanked the staff for all their hard work especially around end of life care and support.

The service had a, 'you say we did board' which was visually displayed on the main corridor. The registered manager told us this was an effective visual tool to show people what was being done with their feedback. One of the outcomes from the surveys was to have a quiet room to allow ultimate privacy for people when having meetings or family visits; this had been created. Another example was people wanted better access to staff; again this had been listened to and the outcome was that the service operated an open door policy so people could speak with managers whenever they wished.

People's end of life care was dealt with in a sensitive way. When appropriate, and where people had chosen to, documentation was in place to ensure their end of life wishes were considered. This included decisions around resuscitation, which was clearly documented and reviewed by a GP where appropriate. A visiting health professional told us how the service had improved when dealing with a person nearing their end of life and that they were now working closely with the district nursing team to ensure a person's remaining days were as comfortable and dignified as possible.

Is the service well-led?

Our findings

At the time of our inspection, there was no registered manager in post, however the current manager had submitted an application to register with CQC, which was in progress with our registration team at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection, this key question was rated as Requires Improvement because confidential information was not being stored securely and governance systems were not robust enough in identifying the concerns we found during the inspection. Whilst we had seen improvements in others areas at this inspection, this rating remains as Requires Improvement due to finding breaches of the regulations within other domains.

The staff we spoke with said they currently enjoyed working at the home and felt there was a positive culture amongst staff. Staff told us they felt there had been lots of improvements at the home and that staff were working well together.

During the inspection, we spoke with the home manager about the homes previous inspection history and if they were aware of what our previous concerns had been. The manager told us they had read the last report in detail and had devised their own action plan as a result of the findings. Staff also told us leadership and management at the home was good and the new home manager had made a difference to how the home was run. Staff, people living at the home and families all said the manager was approachable, inclusive and was making a positive impact on the home. One member of staff said, "It's better now. The new manager has started and is very good. We feel supported and things are only getting better." Another member of staff said, "It's really good and we feel very well supported." A third member of staff commented, "The manager is very approachable and always helps out if we are struggling which is a really good help."

We saw the registered manager was visible within the home and actively involved in provision of care and support to people living at Arden Court. Throughout the course of the inspection we saw the registered manager walking around and observing and supporting staff and people who used the service. Staff also told us the manager often helped out 'on the floor' during busier periods to attend to people's care needs.

We looked at the systems in place to monitor the quality of service to ensure good governance at the home. At our last inspection we had concerns regarding the quality assurance arrangements at the home. This was because they had not been effective in identifying the concerns we found during the inspection and we found continuing breaches of the regulations. This meant the service was not continually improving as a result.

Since our last inspection, we saw there had been a range of audits undertaken that covered areas such as medication, weights, pressure sores, infection control, bedroom cleanliness, deaths,

complaints/compliments, falls, care plans, catheter care and hand hygiene. These were being consistently undertaken by the home manager and detailed any actions that needed to be taken. These checks meant that any shortfalls within the service could be addressed so that the quality of service could be improved.

At our previous inspection we raised concerns about the storage of records within the home. This issue had now been resolved and we found that all confidential information was now being stored securely. A notice had also been added to the cupboard where care plans were being kept, informing staff that they may face disciplinary action if this procedure was not being followed.

We observed a staff handover taking place during the inspection which provided them with the opportunity to discuss people's care needs from that day and if there were any concerns. We also looked at the minutes from the most recent staff meeting which had taken place since our last inspection. Topics of discussion during these meetings included introductions to new members of staff, training, policies and procedures, record keeping, recruitment/staffing and previous CQC reports. Team meetings provided staff with the opportunity to discuss their work and raise concerns with management. One member of staff said, "They tend to take place most months and I would say that staff are listened to."

The home had policies and procedures in place. This would provide staff with relevant guidance to refer to if they needed to seek advice or guidance about certain aspects of their work. These covered areas such as complaints, safeguarding, health and safety, infection control and medication. The policies were updated each year which meant guidance remained relevant and accurate.

The home sent us notifications about incidents at the home such as expected/unexpected deaths, serious injuries, police incidents and safeguarding incidents. This displayed an open, transparent approach and enabled us to seek further information if required and to inform our inspection judgements.

As of April 2015, it is a legal requirement to display performance ratings from the last CQC inspection. We saw this was displayed on a notice board on the ground floor and also in the manager's office. This meant people who used the service, their families and staff knew about the level of care being provided at the home and if there was any concerns.

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 12 HSCA RA Regulations 2014 Safe care and treatment Appropriate systems were not in place to ensure the proper and safe management of medicines.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Appropriate systems were not in place to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user.