Angel Healthcare Limited

Arden House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

The inspection took place on 23, 24 and 28 July 2015 and was unannounced. Arden House was last inspected on 5 November 2013 and no concerns were identified.

Arden House is a care home for up to 35 older people that require support and personal care. At the time of the inspection there were 20 people living in the home.

The people living at Arden House all lived with a degree of physical frailty. There were also people who were living with a dementia type illness, diabetes, Parkinson's disease and heart disease.

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'.

Summary of findings

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 on extended leave and there was an acting manager in post.

People spoke positively of the home and commented they felt safe. However, we found that there were some shortfalls that could potentially impact on people's safety and well-being.

People were at risk of not receiving appropriate care and support because guidance about how people should be supported was not always in place where needed. Two people did not have a care plan in place. Where people's health needs had changed considerably, care plans had not been updated. Staff did not have the most up to date information about people's health which meant there was a risk that people's health could deteriorate and go unnoticed. Risk assessments did not reflect people's changing needs in respect of wound and pressure damage. Accidents and incidents were not all recorded appropriately and steps had not been taken by the staff to minimise the risk of similar events happening in the future.

People were not protected against the risks of unsafe medicines management. The staff were not following current and relevant medicines guidance. We found issues with how medicines were managed and recorded. The risks we found with medication practices were identified immediately to the provider. Appropriate steps were then taken to safeguard people from potential harm of unsafe medicine practices. This included involvement from the dispensing pharmacy and GP.

Risks associated with the cleanliness of the environment and equipment had been not been identified and managed effectively. Emergency procedures were in place in the event of fire and people knew what to do, as did the staff, however the evacuation plans did not reflect the decrease in staff in the afternoon and night.

A quality monitoring system was in place but was not effective. It did not enable the provider to highlight the concerns identified at this inspection, such as unwitnessed incidents and accidents, inaccurate and incomplete care plans and medicines administration shortfalls.

Mental capacity assessments did not always meet with the principles of the Mental Capacity Act 2005, as they are required to do so.

Training had not been delivered where identified as needed and administrative processes to support training, staff supervision and appraisal were inaccurate and incomplete.

Care plan records did not always reflect that people were involved or had agreed to decisions and changes made about the care and treatment they received.

People were encouraged to express their views and completed surveys, and feedback received showed people were satisfied overall, and felt staff were friendly and helpful. People also said they felt listened to and any concerns or issues they raised were addressed. One person said, "If there is anything wrong, they sort it out quickly." However, staff said their feedback was not always taken forward and actioned.

When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the home. Staff were knowledgeable and trained in safeguarding and what action they should take if they suspected abuse was taking place.

People were encouraged and supported to eat and drink well. One person said, "I like the food and I can choose what I want". There was a varied daily choice of meals and people were able to give feedback and have choice in what they ate and drank. People were advised on healthy eating and special dietary requirements were met. People's weight was monitored, with their permission. Health care was accessible for people and appointments were made for regular check-ups as needed.

People told us they enjoyed the activities, which included singing, films, and trips out. People were encouraged to stay in touch with their families and receive visitors.

People felt well looked after and supported, and were encouraged to be as independent as possible. We observed friendly and genuine relationships had developed between people and staff. One person told us, "They treat us well, we are looked after very well, plenty to eat and my room is kept clean and tidy." A visitor told us, "Kind and helpful, we know our relative is safe and happy."

Summary of findings

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.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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

Arden House was not consistently safe. Management of people's individual risk assessments to maintain their health, safety and well-being were not in place for everyone or up to date and therefore placed people at risk.

Poor recording and unsafe administration of medicines placed people at risk of not receiving their prescribed medicines. Recording of skin creams was inconsistent. Medicines were stored safely.

There were not enough staff to meet people's individual needs. Staffing arrangements were not flexible to provide additional cover when needed, for example, during staff sickness or when people's needs increased.

Staff had received training in how to safeguard people from abuse and were clear about how to respond to allegations of abuse. Staff recruitment practices were safe.

Is the service effective?

Inadequate

Arden House was not effective. Processes were not in place to make sure each person received appropriate person centred care and treatment that was based on an assessment of their needs and preferences.

Training had been identified as required but not completed. This meant staff were working without the necessary knowledge and skills to support some people effectively.

Mental capacity assessments did not meet with the principles of the Mental Capacity Act 2005.

People received a wide variety of homemade meals, fresh fruit and vegetables. Home baked cakes and desserts were also particular favourites. People were provided with menu choices and the cook catered for people's dietary needs.

Is the service caring?

Requires improvement

Arden House was not consistently caring. People were not always involved in planning their care.

Staff knew people well and had good relationships with them. People were treated with respect.

People and relatives were positive about the care provided by staff

Is the service responsive?

Requires improvement

Arden House was not consistently responsive. People's care plans contained incomplete and contradictory information which meant there was a risk they would receive inappropriate care.

Summary of findings

Care plan reviews did not effectively cross reference relevant information in other areas of planning and support.

A complaints process was available, and contained all required information people needed to formally make a complaint.

People were asked their views about the service delivered and changes were made where possible.

Is the service well-led?

Inadequate 

Arden House was not well led. Checks and audits had not identified shortfalls found during this inspection or enabled the provider to meet regulatory requirements.

The service lacked a management plan to ensure continuous improvement and development.

The home had a vision and values statement but we did not see the values acted on during the inspection.

People spoke positively of the care, however, commented that staffing levels could impact on the running of the home. People and visitors had an awareness of changes of management and felt that the new management team of the home were approachable.

Arden House Residential Care Home

Detailed findings

Background to this inspection

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

The inspection took place on the 23, 24 and 28 July 2015. This visit was unannounced and the inspection team consisted of two inspectors.

Before our inspection we reviewed all the information we held about the service. We considered information which had been shared with us by the Local Authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the Local Authority and Clinical Commissioning Group (CCG) to obtain their views about the care provided by the service. CCGs are clinically led groups that include all of the GP groups in their geographical area.

During the inspection, we spoke with 11 people who lived at the service, three relatives, the acting manager, the provider, seven care staff, and the deputy manager. We looked at all areas of the building, including people's bedrooms, the kitchen, bathrooms and the lounge and dining room.

We reviewed the records of the home, which included quality assurance audits, staff training schedules and policies and procedures. We looked at seven care plans and the risk assessments included within these, along with other relevant documentation to support our findings. We also 'pathway tracked' five people living at Arden House. This meant we followed a person's life and the provision of care through the home and obtained their views. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Inadequate

Is the service safe?

Our findings

Although most people told us they felt safe, we found examples of care practice and concerns about the environment which were not safe and potentially put people at risk. People told us they felt safe and were confident the staff did everything possible to protect them from harm. They told us they could speak with the manager and staff if they were worried about anything and they were confident their concerns would be taken seriously and acted upon, with no recriminations. One person said, "I feel safe here, they know me well," and "Staff ensure the bell is nearby at all times, I know all I have to do is ring." However, we were also told, "I don't always feel safe because there are not enough staff, especially at night."

Where risks to people's health, safety and well-being had been identified, these were not consistently well managed. Not everybody had a care plan with accompanying health and environmental risk assessments completed. We found two people without a care plan. This meant staff did not have the information they needed to give safe care. This was discussed with the acting manager and provider. Care plans and risk assessments were completed for these two people by the last day of the inspection. We saw that risk assessments included the risk of falls, skin damage, nutritional risks and moving and handling had been completed. The care plans also highlighted people's health risks such as diabetes. However, despite risks being identified there was a lack of management plans for staff to follow to ensure people's safety was promoted and protected. Additionally, the majority of care plan information and risk assessments had not been updated for over six months. This placed people at risk from uninformed staff.

One person had complex health needs that included diabetes and some signs of memory loss. There was no information of the person's normal range blood sugar levels that would guide staff in identifying abnormal levels and treating the symptoms before it affected their health. Senior staff knew how to identify signs of low or high blood sugar, but we were not assured that new or inexperienced staff would recognise the symptoms as they were not recorded. For example, symptoms of a high blood sugar shows as increased thirst and blurred vision and increased urination. This meant the person's health was at risk. We also saw a sharps bin, insulin pre-loaded pens and blood testing equipment which was kept in an unsecure box in the person's wardrobe. This was not safe as the contents of the box could be accessed by people and visitors. Also, due to the change in the person's mental health and memory, we felt that the current storage practices of insulin were unsafe.

Another person had been identified as at risk from developing pressure damage to their skin. The person had a pressure relieving mattress in place to help reduce the risk of developing a pressure ulcer. However, the person had not been weighed recently to determine what the correct setting of the mattress should be. We also found the person had recent pressure damage noted by night staff, but this information was not handed over to day staff when they came on shift. The person was left sitting for long periods of time without an appropriate pressure relieving cushion. The person had been placed at further risk of a developing a pressure ulcer because staff were not aware of skin damage that had occurred and the person's care records were not up to date.

When we walked around the home, we found an unlocked bedroom on the second floor. The windows were wide open and no window restrictors were in place. People were at risk of falling from the window onto the concrete below. This risk had not been identified by the provider until our inspection. When we told the provider about our concerns they took action and window restrictors were fitted the next day.

Areas of the home were not clean and hygienic. Some people's bedroom carpets were badly stained and mal-odorous. One person's bedroom in particular was identified during our inspection for urgent cleaning as it smelt strongly of urine. Some ensuite bathrooms were dirty and were being used to store equipment which meant it was also a health and safety risk. Stair carpets and communal hallways were dirty and stained. The housekeeper said it was a huge task to keep the home clean. Care staff said that the premises was too big for just the one housekeeper. One staff member said: "It's never really clean, some of the carpets are really horrible." Another said: "We clean bathrooms on top of our care jobs and we don't have time to do either properly." One person's armchair was dirty and smelt unpleasant. The hoist in use was dirty and people did not have their own hoist sling to prevent the risk of cross contamination.

Inadequate

Is the service safe?

Accident and incident forms had been completed. However, there were people who had had repeated falls and there was no proactive plan put in place to prevent a reoccurrence. Incident and accident reporting did not support risk assessment reviews and did not, as reasonably as is practicable, mitigate against future risks. We saw that following an unwitnessed fall that the person's risk assessment had not been changed to reflect the fall.

People were not protected against the risks of unsafe medicines management. The service was not following current and relevant medicines guidance. We found issues with how medicines were managed and recorded. Due to our significant concerns about the way people's medicines were managed, we made a report to the local authority safeguarding team. We also asked the provider to raise individual safeguarding referrals. People's GP's and the dispensing pharmacy were also contacted.

The list of staff signatures of the staff deemed competent to administer medications and for assisting medicine audits was out of date. Not all staff had provided a sample signature. Photographs of people for identification purposes and for allergy information were not in place for the majority of people. The audit undertaken in May 2015 by the provider stated that these identity sheets photographs inserts were in place. Staff could not explain why they were now not in place.

We found staff administering medicines had received medicines training, however, we judged that this training was not adequate because of the issues with medicines that we found. Staff we spoke with confirmed that they thought the training they had received was not good. We were also told that medicine competency and training booklets had not been completed by staff as expected by the provider. Medicines audits were not effective as the issues we noted had not been identified prior to our inspection. Therefore, we were not assured that safe and effective systems were in place to ensure that people consistently received their medicine as prescribed and safely.

Locked medicine trolleys were kept in corridors and in the dining room. There was also a locked medicine fridge also located in the dining room. Trolleys were attached to the wall appropriately to ensure that they were secure. However, the temperatures of environment and the medicine fridge were not recorded consistently to ensure medicines were kept at the correct temperature. This put people at risk of receiving medicines that were ineffective or might do them harm.

Senior care staff were responsible for the ordering of monthly medicines and were able to evidence that copies for monthly medicines were stored in the staff office. However, there was no clear audit trial or checking procedure of medicines ordered. This lack of clear processes led to one person being without their prescribed diabetic medicine for five days. The acting manager said she had phoned the pharmacy but this was not recorded or documented. Staff were not recording the total received or the running total for tablets that were provided in boxes separate to the blister packs such as warfarin.

We looked at the management of the administration of medicines. This included looking at medicine administration records (MAR). A senior care staff member described how they completed the MAR and administered people's medicines. Some people had not received their medicine as prescribed. We found a large amount (in excess of 20) of missing signatures for people on MAR sheets. We checked the medicine to see if the medicine had been given. Four people had not received their prescribed medicine as the medicine was still in the pack. Other missing signatures were issues of poor recording of medicines which had been administered but not signed for by the staff. In addition to the above errors, the medicine records for warfarin for three people showed missing signatures as well as wrong dosage recording. We were not assured that this medicine had been given safely as the running total of medicine was not recorded and the prescription directions had not been followed correctly. We also found pain relief tablets in the trolley for one person that were not prescribed. Staff could not tell us the reasons for this at the time we asked. We were later told that they had been given to the person in hospital following a fall last year and were not as far as they knew being given now.

Topical creams were not always signed for and for two people there were no body maps to indicate where the differing cream should be applied. In one person's room there was tubs of topical creams with no name of the person it was prescribed for or what the cream was. Staff told us it was conotrane, a protective cream. This was a presumption and was therefore unsafe.

Inadequate

Is the service safe?

Where medicines were given to people when needed (PRN), there was often no guidance in place to support this and records were incomplete. For example, in the case of variable amounts, the amount of medicine given was not always recorded. Recording of how much was administered would help to make sure that too much was not taken within suitable timeframes.

People did not have a personal emergency evacuation plan (PEEP). These are important to ensure that people's evacuation needs are identified and they can be helped from the building safely in the event of a fire or other emergency. The main evacuation plan that was in place did not include the relevant information to ensure staff could support people safely. The plan stated the number of staff required to evacuate. For example, the people who needed two staff. However, there were people living over four floors and after 4pm there were only three staff on and only two staff between 8pm and 8am. The decrease in staffing levels was not reflected in the evacuation plan. Staffing levels especially at night would not be able to respond to the actions detailed in the evacuation plan, due to the layout of the home and only two members of staff on duty. This placed people at risk from failed emergency evacuations. This meant people were potentially at risk from harm from unsafe procedures.

The above issues were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care needs were not always met because there were not enough staff on duty. People, staff and visitors all said there were not enough staff. One person said, "The staffing levels are not good, sometimes there is only two staff because of sickness. I don't feel safe." Another person said, "There isn't enough staff, but the staff are brilliant, really good, it's not their fault."

Staff were rushed and working under pressure to support people to get up and ready for the day. Personal care was not always completed in the way people wanted. One person told us, "Staff are lovely but they have to rush, not enough time to give all the support I need." Some people had not been shaved and some people's clothes, following breakfast, were stained and not changed. Staff said, "Night staff get (name) up and we don't have time to change people until later." This person remained in same clothing all day, without any visits to the bathroom or relief of position. Four people who could not move independently sat in the dining room for breakfast and remained there all day in the same position. Not everybody had the support they wanted to go out to the shops or the bank. We saw staff explaining to two specific people that if the activity person had time she may be able to take them out later but this might not happen. Staffing levels were not adequate to meet people's needs and wishes.

This was supported by the care documentation we looked at, accident records and observations during our inspection. Care plans were not always specific about how many staff people needed to support them with certain tasks, such as getting up and going to bed, dressing, washing, bathing, support with continence and mobilising. Most care plans said people needed the support of one or two staff. Staff told us that four people on the lower ground floor needed two staff for all their personal needs which left one staff to work on the three other floors.

This was a breach of Regulation18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all staff had received training on safeguarding adults. Staff confirmed this and knew who to contact if they needed to report abuse. Staff were confident any abuse or poor care practice would be quickly spotted and addressed immediately by any of the staff team. Policies and procedures on safeguarding were available in the office for staff to refer to if they needed.

Policies and procedures on all health and safety related topics were held in a file in the staff office and were easily accessible to all staff. Staff told us they knew where to find the policies.

Records showed that all appropriate equipment had been regularly serviced, checked and maintained. Hoists, fire safety equipment, water safety, electricity and electrical equipment were included within a routine schedule of checks.

The provider had good recruitment procedures in place. The staff recruitment records we reviewed showed all of the relevant checks had been completed before staff began work. These included disclosure and barring service (DBS) checks, evidence of conduct in previous employment and proof of identity. A DBS check is completed before staff begin work to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. Staff were not allowed to start work until these checks had been completed. This helped to

Inadequate

Is the service safe?

ensure that staff employed by the service were safe to work with the people they cared for. Staff confirmed there was a robust interview process in place and that they had been required to provide all the relevant documentation before they started working for the provider.

Inadequate

Is the service effective?

Our findings

People spoke positively about the home. Comments included, "I'm looked after" and "The carers are very good." However, we found Arden House did not always provide care that was effective.

Information and care requirements were not always specific to individuals, making it difficult to know if their health care needs would be effectively managed. For example, there was no information provided to staff about how and when one person's catheter bag should be emptied, how the catheter tube should be positioned to prevent risk of skin damage or compression of the tube, which may prevent adequate drainage. The person had health problems that needed specific care but there was no guidance in the care plan to reflect the need for monitoring fluid intake and output. We saw that the person needed assisting with access to fluids; there was no information for staff about the colour of urine in the catheter bag which may indicate dehydration. Catheters can also make people susceptible to urinary tract infections (UTI), leading to a greater risk of falls and confusion. There was no information about any UTI signs or symptoms for staff to be aware of. Where people required support to look after the catheter and hygiene, there was no specific and individual guidance about how this should be done to prevent infection and odour.

Another person had a number of health problems that were recorded and whilst we saw preventative steps had been taken to prevent pressure damage the care plan had not been updated to reflect recent changes. Staff we spoke with were unaware of the recent deterioration. Appropriate steps, therefore, to effectively manage the individual's health needs had not been taken. The lack of individual health care information placed people at risk that their health care needs may not be effectively managed. Information available did not make use of potential signs of infection, which if known, may allow for early interventions and treatment.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS).

DoLS form part of the Mental Capacity Act (MCA) 2005. It aims to make sure that people in care settings are looked after in a way that does not inappropriately restrict their freedom, in terms of where they live and any restrictive practices in place intended to keep people safe. We saw that only one member of staff had received training about MCA and DoLS and that had been with their previous employment. We found mental capacity assessments did not always record the steps taken to reach a decision; and records did not set out the decision requiring assessment of people's mental capacity. For example, in relation to personal care and communication. Two people with specific mental health problems were isolating themselves in their bedroom and had refused assistance from staff in respect of skin integrity and health checks. The staff had accepted some behaviour that impacted on their health and welfare rather than assess their capacity to make this decision to refuse care. We were given examples of behaviours that challenged that had not been fully documented and did not meet with the principles of the MCA.

Sample checks of mental capacity assessments and discussion with staff did not show an embedded understanding or practices which met the principles of the MCA 2005. This is a breach of Regulation 11of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff said they had training to make sure they had the skills and knowledge to provide the support individuals needed. However, staff also told us they were behind in some areas and some staff had not received any training. We observed poor practice in moving and handling people, assisting people with personal care, infection control and in safe medicine administration practices.

We looked at training records for the six staff employed. Training is provided in the form of booklets, which staff complete and return to the provider. The training programme identified that staff had not all received essential training. Only two members of staff had received the theory of moving and handling training, and according to training records no staff had attended moving and handling practical sessions. Specialist training to meet people's individual needs, such as diabetes and epilepsy had not been provided. We saw care delivery for people who lived with dementia was not always stimulating and person focused and people with diabetes were not always

Inadequate

Is the service effective?

supported in a way that maintained their health. This impacted negatively on people's well-being. Therefore, we could not be confident that staff had the necessary skills and experience in order to meet people's needs.

We looked at the induction training for a new member of care staff; we also discussed the induction with the staff member. The staff member told us that due to the staff shortages the induction had been a 'non-starter really'. They confirmed that they had a shadow shift to meet the people and staff at Arden House, and that the induction had not been supported by them being signed off as competent. We saw despite their induction not being signed off as complete, the member of staff had supported people while unsupervised. We were also told that newly appointed staff shadowed other experienced members of staff until they and the manager felt they were competent in their role. However, this was not evidenced from the duty rota or from the induction programme which was unsigned by a senior member of staff. One staff member made contact with us following the inspection and told us, "I feel that I have lost my confidence, I feel unsupported and not fulfilling what I was trained to do." Another staff member said, "I struggle to do training due to the hours I work."

Staff supervision was not up to date for all staff. Supervision helps staff identify gaps in their knowledge, which was supported if necessary by additional training. Staff said "Supervision has not been happening." Staff records of supervision confirmed that staff supervision had not been undertaken in six months or more for most staff. The supervision records were poor in quality and not effective for its' purpose. Staff told us they felt unsupported at present due to staff changes and lack of leadership. This was reflected in the unsafe practices we observed. This placed people at risk from receiving inappropriate and unsafe care from staff who were not competent and trained.

Staff had not received appropriate training or supervision to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As a guide to maintaining people's health, people were weighed when they moved in to the home and then monthly. Any significant weight gains or losses were reported to the registered manager and GP referrals made. We saw some people were referred to dieticians and speech and language therapists for advice about nutrition and eating difficulties. Each person had a nutritional assessment, showing any concerns about weight and any specific dietary needs. Where needed, some people received fortified meals and supplement drinks. The cook regularly discussed meals and food with people, so that they were aware of people's preferences.

People and visitors spoke positively about the improvements in the food, telling us, "I really enjoy the food," "The cook can cook" and "The food is excellent, there is a very good choice and it tastes nice." People received a wide variety of homemade meals, fresh fruit and vegetables. Home baked cakes and desserts were also particular favourites. People were provided with menu choices and the cook catered for people's dietary needs. A menu planner showed lunch and supper time meals and choices of desserts and we heard staff reminding people what there was to eat. People told us breakfast was usually cereals or toast, and snacks were available at any time. Mid-morning and mid-afternoon drinks were served with a choice of biscuits. Drinks, both hot and cold were available at people's request. People had jugs of water and juice in their rooms. The food served was well presented, looked appetising and was plentiful. People were encouraged to eat independently and supported to eat when needed. Staff asked people if they enjoyed their meal and if they wanted any more. Drinks were provided during meals in accordance with people's choices.

Requires improvement

Is the service caring?

Our findings

People spoke positively about the home. Comments included, "I'm looked after." "The carers are very good." One person said, "I love everything about living here." One relative told us, "The staff are good, they care and are kind."

We identified concerns about how involved people were enabled to be, about the care and support they received. For example, care plans did not reflect that people were able to express their views and be actively involved in making and reviewing decisions about their care. Reviews were not up to date and two people did not have a care plan in place. People had not signed their care records to show that staff had discussed their planned care with them or that they had agreed to changes. Some people told us they did not know what their care plan was and were not aware if it had been discussed with them, but told us they were happy with the support they received. People felt happy they could discuss their care and support with staff if they felt they needed to. Some people told us they had done this, however, other people felt they had not had the opportunity or did not know that they could.

Some people depended on staff to support them with their continence and mobility needs. Three people were not offered a toilet visit or a change of position for up to seven hours. The care plan for two people stated the need to offer regular visits to the bathroom. In another it stated 'move regularly to encourage them to move." This did not happen during our inspection. We asked staff if this was normal practice and they told us, "We don't have time". People were not having their needs and preferences met effectively.

The provider had failed to support and enable people to understand their care and treatment choices and to support them to make decisions about their care. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were treated with dignity and respect. People confirmed staff made sure doors were closed when they helped them with personal care and screens were positioned to afford privacy if people needed support in a communal area. People were positive in their comments about the care staff. People told us, "Staff are helpful and caring," "They are all very nice, helpful people here. I have a good laugh with them all. Staff are friendly here," and "They've been awfully good to me here. They look after me."

We observed staff were kind, caring and patient in their approach with people and supported people in a kind way. People and staff told us mornings were rushed and there weren't enough staff. We saw that the staffing levels did impact on staff being able to spend time with people. We observed, however, people smiling and laughing during interactions with staff. The impact of inadequate staffing levels has been addressed under the safe question in this report.

Most staff knew people well and demonstrated a high regard for each person as an individual. Staff spoke with us about the people they cared for with genuine affection and were able to tell us about people's lives prior to living at the home; including what was important to people. During the inspection staff talked about people in a respectful way. The staff who were still getting to know people as they had not worked in Arden House very long said, "It's the residents that make the job worthwhile, they are really lovely."

Staff promoted people's independence, and allowed them to carry out tasks for themselves if they wished to do so. When people could manage some aspects of their personal care, staff prompted them to do this for themselves, helping people to maintain their independence as much as possible. One person told us, "I like being able to do things for myself. But if I do need help I will ask." Another person spoke about being able to go to bed when they wished and said, "I can get up at a reasonable time, which is not too early." We were also told, "I can go out and meet friends, we go out on trips sometimes."

People had been supported to personalise their room with their own keepsakes. One person said, "It feels nice to have some of my things nearby." This helped to demonstrate that staff listened to and respected people's wishes.

Relatives told us that they felt welcome at the home at any time. They said: "We are always welcomed with a smile," "They make us feel welcome and offer drinks" and "We are all welcome, it's an open door here and we come at all

Requires improvement

Is the service caring?

times". Relatives described the care as positive and felt staff genuinely cared about the people they supported. A relative told us they thought their family member looked "Well looked after."

Requires improvement

Is the service responsive?

Our findings

Some people told us, "We are very well cared for, best place to live," and "Really can't complain." Others told us that, "Staff don't have the time to do what I want, it's not their fault," and "I get done but I miss the little things like help with my nails and make up." Whilst some people told us they were happy with the standard of care provided and that it met their individual needs, our observations identified that staff were not always responsive to individual needs.

Whilst care plans contained more personal information about people, such as their preferred daily routines, what people could do for themselves and the support they needed from staff; information was inconsistent and out of date. Reviews of care plans were ineffective because they had not identified or rectified areas of inconsistency; therefore staff may not have accurate information to ensure that people's needs and preferences were clearly represented and supported. We found some care plans contained contradictory information about people. For example, the continence assessment in one care plan explained that the person was continent but in the daily notes it stated 'pads changed'. A further care plan for another person stated that they needed 'regular' repositioning to safeguard against damage to their skin, but there was no clear guidance or definition of 'regular,' and no evidence of this happening.

The home used a computerised care plan system which was also printed and kept in the staff office. There were various assessments including people's health, their dependency, mobility, risk of falls and fluid and nutrition needs. Care plans were six months behind in review and some pertinent information was not reflective of people's changed needs. We also found two people did not have a care plan in place. We found for one there was information from social services and a social service needs assessment but nothing else since their admission in 2014.

Wound care records were not all up to date. The records lacked detailed instructions for staff to enable them to monitor and redress wounds as required. One person had developed pressure damage and the day staff had not been made aware of this development. We were told staff were not sure if it was due to be redressed or of the status of the wounds. There was no reference of the wound being dressed in the daily notes or reflected in the care documentation. This person was frail and had other health conditions placing them at risk of pressure sores developing very quickly. This was addressed during our inspection by staff undertaking a full assessment and body map.

Care plans did not cross reference mobility difficulties with washing and bathing, for example, if people needed to use a bath hoist or shower chair. Most care plans did not detail the amount of support people needed with different tasks, for example, if people needed the support of one or two staff, but not explaining when or why support was provided safely and consistently. One person was very clear about how they wanted to be assisted but this was not incorporated in to their care plan. Where people had specific medical conditions, some general guidance was available in care plans, but it was not personal or tailored to individual needs. For example, catheter care plans told staff that they needed to follow infection control procedures, but did not say what they were; similarly there were no step by step instructions about how catheter care should be delivered or reference to people's preference of care. Where a person lived with epilepsy, their specific symptoms of an impending seizure such as aura or as a result of infection and seizure records were not maintained. The lack of information that was specific to people's individual needs meant that care was task based and not person centred.

Reviews of care plans were not effective, they did not identify inconsistencies in care or ensure care and treatment reflected individual needs and preferences. The provider had not ensured that the care and treatment was person centred to meet with people's needs and reflect their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to take part in activities inside and outside of the home. Activities included occasional outings, shopping trips, quizzes, bingo and ball games. People said they enjoyed the activities, but felt that more opportunity for quick visits to the nearby shops would be 'great'. One person told us, "There's only so much (name) can do, she can only push one of us, but we take turns." Another person told us "I can't grumble because it's wonderful here." We asked another person if there were any activities that appealed to them. They replied, "Oh yes." While care plans noted people's interests, they did not explore alternatives

Requires improvement

Is the service responsive?

for people to pursue. For example, a care plan noted a person could no longer read because of poor eyesight. However, no consideration was given to sourcing talking books or newspapers in large print. This is an area that requires improvement.

The manager told us they were not dealing with any complaints at the time of our inspection. People and visitors told us they did not have any complaints and did not wish to make any. They told us they knew the staff and provider by name and were confident that, if given cause to complain, it would be resolved quickly. The complaints procedure was displayed for people and visitors and was clear and accessible.

People, their relatives and visiting health care professionals had completed questionnaires to give their feedback about the service provided. Resident and relatives meetings also took place. Responses to questionnaires were positive, with people commenting favourably about the friendly atmosphere of the service and the kindness of staff. Where people had made requests or suggestions we saw these had been acted upon. For example, changes to menus and trips out.

Inadequate

Is the service well-led?

Our findings

People, friends and family described the staff of the home to be approachable, open and supportive. People told us; "Friendly and kind," and "Helpful." A relative said; "I think the manager leaving has left a gap, because it's been a little hard to find out things, but everyone tries hard." A staff member commented; "The acting manager is supportive, and I think everything is good."

The registered manager was currently on long term leave. The acting manager was very well thought of by both the staff and the people who live in Arden House. However, the acting manager had no experience of day-to-day care home management. The support and guidance from senior management was not in place to ensure the service was well-led and there had been no induction into the role.

The provider did not have appropriate systems in place to assess, monitor and mitigate the risks relating to people's health, safety and welfare. Areas of concern highlighted during the inspection had not been identified within any of the service's quality monitoring processes.

Leadership of the service had failed to ensure action was taken when needed. For example, risk assessments and care planning for people's specific health needs, the management had failed to ensure these were embedded as best practice in all applicable areas. Accidents and incidents were recorded, but lacked management oversight to ensure that they formed part of the quality assurance systems to identify trends and mitigate risks. Learning from incidents and accidents was not embedded into practice and did not link to risk assessment and care plan reviews.

The provider's audit systems had not identified people's risk assessments and care plans were not always accurate. A person's nutritional assessment stated they were not at nutritional risk and it also stated they were not eating poorly and did not lack appetite. This was despite the person having a very low body weight, the persons' own reports that their appetite was not good and care staff confirming that the person ate only small amounts. Additional risk factors due to the person living with a specific medical condition had not been included in their risk assessment. A different person's recently revised care plan stated they were 'immobile.' Both the electronic care plan and the care plan made reference to the person sitting out of bed at times during the day. There was no information on how the person was to be supported to get out of bed in either care plan. Care workers told us about different ways in which they supported the person to get out of bed. The provider's audits had not identified the person's care plans had not set out how the person and care workers' safety was ensured when supporting the person to get out of bed.

Medication audits had not identified the errors highlighted at our inspection. Audits for cleaning and for training and supervision of staff had not been undertaken recently. These shortfalls exposed people to unnecessary on-going risk as identified through this inspection report.

The service lacked appropriate management action plans to ensure continuous improvement and development and to demonstrate learning from incidents and accidents. The quality assurance framework was ineffective because the provider failed to have effective systems and processes to ensure they were able, at all times, to meet requirements in other parts of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff felt their suggestions were not listened to, for example, in relation to staffing levels. The staff meeting minutes identified that staff had raised the issue of staffing levels and staffing levels had not increased.

The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services and keep complete and accurate records of was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Daily handovers were held at the end of staff shifts and we attended two of them. The quality of the handover was poor and did not give the staff all the information they required to run the shift efficiently and safely. They were not informed of the status of wounds, blood sugar irregularities and about which people had not been drinking and eating enough. The management team told us that they had identified this as an area that required improvement and were dealing with this through meetings with staff, investigations and supervision. However, we saw that important specific details of people's health had not been handed over for staff to know, which had the potential to impact negatively on people's health and welfare.

Inadequate

Is the service well-led?

The provider used questionnaires to seek people's views on the quality of services provided. A range of people's views were sought, this included staff and people's relatives. All of the questionnaires we saw responded positively about the service. The manager also held meetings with staff. This included weekly evening meetings with the staff which enabled night staff to attend. For example we saw that the provider had discussed access to training with staff so the needs of the service and staff preferences could be taken into account. Staff told us the acting manager operated an 'open door' policy. They said they felt able to share any concerns they may have, in confidence with them.

Throughout the inspection, the acting manager and staff were open to different ideas when we raised matters. Their responses showed they were keen to develop the service, so they could meet people's needs. The acting manager also wished to ensure they were in a position to comply with our regulations. For example, we asked them about their awareness of the duty of candour which had come into effect in April 2015, and they were keen to find out more. By the end of the inspection, they had downloaded a copy of this part of the regulation and were working on developing a policy. We discussed with the acting manager and their deputy that they might find attending further training on their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards beneficial. They had started trying to access relevant training by the end of the inspection.

The provider's philosophy of care stated the service strived to 'preserve and maintain the dignity, individuality and privacy of residents within a warm and caring atmosphere.' In their statement of purpose they said their aim was to 'to build personal and open relationships with residents and their loved ones, in order to support each individual's right to comprehend the full benefits of the care structures we develop with you.' The staff we spoke with summed up their philosophy by stating "At the end of the day it's all about our residents." One person's relative said "It's a small home which is what we wanted."

Staff told us that they attended regular staff meetings and felt the culture within the home was supportive. Staff told us they felt confident about raising any issues of concern about care practices at the service, including using whistleblowing process if needed.

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 The provider had not ensured that service users received person centred care that reflected their individual needs and preferences. The provider had not ensured the enabling and supporting relevant persons to understand the care or treatment choices available to the service user and to discuss, with a competent health care professional or other competent person, the balance of risks and benefits involved in any particular course of treatment. Regulation 9 (1) (a) (b) (c) 3 (a) (h) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Where people did not have the capacity to consent, the registered person had not acted in accordance with legal requirements. Regulation 11 (1) (3) (4) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 The registered provider had not taken steps to ensure that care and treatment was provided in a safe way for service users including assessing risks to their health and safety and doing all that is reasonably practicable to mitigate any such risks. Regulation 12 (1) (2)(a) (b) (f) (g) (h)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to meet peoples needs. The registered person did not ensure persons employed in the provision of a regulated activity received appropriate training as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (1) (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

The provider had not maintained 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 and of decisions taken in relation to the care and treatment provided;

Systems or processes had not been established and operated effectively to assess and improve the quality and safety of the services provided, assess, monitor and mitigate risks and evaluate and improve practices.

Regulation 17 (1)(2)(a)(b)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
Warning notice