

Arbborough House Ltd

# Arbborough House Limited

## Inspection report

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### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

This inspection took place on 26 July 2016 and was unannounced.

Arbborough House is a care home that does not provide nursing care. It provides support for up to 14 older people, some of whom live with dementia. At the time of our inspection there were 11 people living at the home. Accommodation is over three floors and stair lifts were available for all except one, the lower floor.

Our last inspection at Arbborough House took place on 20 January 2015 and we found that improvements were required in the monitoring of the quality of the service provided at the home. We made a requirement for action and we received an action plan telling us that the improvements would be in place by October 2015.

At this inspection whilst we found that improvements had been made, we found not all actions had been taken by the provider to ensure the service was fully compliant with all the Regulations.

A registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Medicines were not managed safely because there was lack of proper recording of medicine administration and important information relating to some medicines was not complete.

People's care had been appropriately assessed and plans had been developed to ensure that staff met people's needs and reduced and identified risks. However, food and fluid charts, which although were in place did not always contain sufficient information to understand any relevant risks. We have made a recommendation about this.

People confirmed they felt safe and that staff involved them in making decisions and staff knew people well.

Observations demonstrated people's consent was sought before staff provided care. However, we also observed people having their medicines crushed and staff had not offered them the medicine beforehand to see if they would have it without it needing to be disguised in food.

People described staff as lovely and caring. Staff treated people with respect and recognised the importance of promoting independence, dignity and privacy.

Staff demonstrated a good understanding of safeguarding people at risk. They were confident any concerns raised would be acted upon by management and knew what action to take if they were not. However they

were unsure about the Mental Capacity Act and Deprivation of Liberty Safeguards.

Recruitment checks were carried out and the provider ensured there were enough staff on duty to meet people's needs. Staff received an induction when they first started work which helped them to understand their roles and responsibilities. They felt supported through supervision, appraisal and training.

People and their relatives knew how to make a complaint and these were managed in line with the provider's policy. Systems were in place to gather people's views and assess and monitor the quality of the service. However, this had not effectively identified and addressed the concerns around medicines administration.

We found one breach 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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement** ●

The service was not always safe.

Identified risks associated with people's care were assessed and plans were developed to mitigate such risks.

Medicines were not managed safely. For example staff did not record how much medicine they had given and not all staff signed to say they had administered a medicine.

Staff had a good understand of safeguarding. They knew what to look for and how to report both internally and externally.

Recruitment processes ensured staff were safe to work with people at risk and the provider ensured appropriate staffing levels to meet people's needs.

### Is the service effective?

**Requires Improvement** ●

The service was not always effective.

Staff were well supported to understand their roles and responsibilities thorough effective supervision, appraisal and training.

Whilst staff demonstrated they involved people in making decisions and respected the decisions they made, they did not have a good knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards.

People said they liked the meals. However, where concerns had been identified the food and fluid records did not show that people had had sufficient to meet their needs. We have made a recommendation about this.

Nutritional needs were met and they had access to healthcare professionals when they required this.

### Is the service caring?

**Good** ●

The service was caring.

Staff treated people with kindness and respect. They demonstrated a good understanding of the importance of promoting independence, dignity and respect.

### Is the service responsive?

Good ●

The service was responsive.

Staff knew people well and the planning of care was personalised and reflected people's needs.

A complaints procedure was in place and people knew how to use this. Where concerns had been raised the registered manager had implemented the provider's complaints procedure and people had been satisfied with the outcome.

### Is the service well-led?

Requires Improvement ●

The service was not always well led.

People's care plan records were accurate and complete and reflected their needs. However the food and fluid charts and medicine records did not reflect the needs of people.

Systems were in place which monitored the service and gathered people's feedback. However there were issues with medicines that had not been picked up as the audit for medicines took place monthly.

The manager was visible on the floor working with staff and staff were encouraged to share concerns and make suggestions.

# Arbborough House Limited

## **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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The inspection took place on 26 July 2016 and was unannounced.

The inspection was carried out by one inspector. Prior to the inspection we reviewed previous inspection reports and information we held about the service including notifications. A notification is information about important events which the service is required to tell us about by law. This information helped us to identify and address potential areas of concern.

During the inspection we spoke with three people who lived at Arbborough House and two relatives. To help us understand the experience of people who could not talk with us we spent time observing interactions between staff and people who lived in the home. We also spoke with the registered manager and three care staff, housekeeping staff and the cook. We looked at the care records for two people and sampled another one, and the medicines administration records for 11 people. We reviewed five staff files in relation to their recruitment, supervisions and appraisals, the staff training matrix and the staff duty rota for four weeks. We also looked at a range of records relating to the management of the service such as accidents, complaints, quality audits and policies and procedures.

# Is the service safe?

## Our findings

Although people were unable to tell us directly whether or not they felt safe, we observed through their interactions with staff that anxieties were well managed and showed people were comfortable and relaxed with staff. Few people were able to tell us verbally about their experiences, however one person said they liked it at the home. We saw one person being moved with the hoist, observing that staff were professional and well trained. One visitor told us, "My relative is looked after really well, things are great and I feel people are safe."

We looked at five staff files for recruitment and saw that the appropriate checks of suitability had been made with the exception of one of the five records. For example two references had been sought and received for all members of staff except one where there was only one reference. All other checks that are required by law to ensure that the persons being employed were of good character had been carried out. Where Criminal Records Bureau (CRB) and Disclosure and Barring Service (DBS) checks had shown areas of concern, the manager had risk assessed the suitability of the applicant to work at the home and had recorded this in a risk assessment.

We looked at how medicines were managed. Medicines were stored appropriately. Medicines were administered by staff who had received the appropriate training to do so. We saw that medicines were stored correctly. Storage was clean, tidy and secure so that medicines were fit for use. There were procedures in place for the ordering and safe disposal of medicines.

We looked at 11 records in the medicine administration records (MAR) folder for the dates of 4 July 2016 to the day of the inspection 26 July 2016. There was also a separate creams folder where staff signed to say when they had applied prescribed topical creams for people.

We saw that there were plans in place that outlined when to administer extra, or as required, medication. However, suitable care plans, risk assessments and records were not always in place in relation to the administration of some medicines.

For example, we found that where people had been prescribed a variable amount of a medicine such as one or two tablets or two (10ml) to four 5ml (20ml) spoonfuls of a liquid medicine, on the records we looked at staff had never recorded the amount they had given.

We saw a letter from the GP to say that one person's medicine may be mixed with their food. However, we observed a member of staff who was administering medicines crush another person's tablets and take them to the person. When we looked at their records there was no record of instruction from the GP permitting crushing. The MAR records stated that they could be given covertly if the person refused them. There was no evidence on the MAR records that the person had been offered the medicine first, but staff had crushed them anyway.

There was no information or protocols in the MAR records on the possible side effects of some medicines,

when it should be given and what to do in the event of any concerns. For example, people were being administered medicines for heart failure, bone disease and with regard to dementia, but there were no details held on file to help staff understand important side effects.

We saw 17 gaps in the records where there was no staff signature to show if someone had received a medicine. The manager identified this as being the responsibility of one member of staff and undertook to speak to them and look at their competency to administer medicines.

We saw that one person who had been admitted recently was prescribed two medicines that could not be taken at the same time. There was no information on why one of the medicines was prescribed. The prescriptions for the person showed they were to have three a week on a Monday. The inspection took place on a Tuesday and there was no indication in the records that it had been given. Staff had stored the medicine and were unsure about administering it so they had not. They had not taken any action regarding this medicine such as contacting the GP. This meant the person had not received their weekly medicine on time. This medicine is only given weekly to maintain a therapeutic level. The manager rang the GP whilst we were at the home; we have yet to receive an update on the outcome.

The poor record keeping, lack of signatures, not recording how much medicine was given and ensuring people had access to their prescribed medicines, together with the lack of information on medicines meant that medicines were not safely administered. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed there were sufficient staff on duty to provide care and support to meet people's needs. New staff had been appointed since our last inspection in January 2015. The new staff included senior care staff and care staff. Staff we spoke with told us they felt that there was enough staff. One care staff told us that the staff morale was good. We observed that call buzzers were answered promptly and care staff did not appear to be rushed in their duties.

During this inspection we looked at records of the accidents and incidents that had occurred since our last inspection. We saw that where necessary appropriate treatment had been sought and notifications to the appropriate authorities had been made. All the records we looked at showed appropriate action had been taken in response to incidents to promote the safety and wellbeing of people.

Appropriate individual and premises risk assessments were carried out to safeguard people and staff within the service, for example care plan and risk assessment audits. The provider had made adaptations to the service to ensure the safety of people. For example an extra fire door had been added on the lower floor. Plans were in place to ensure people's safety in the event of emergencies which might necessitate evacuation of the service.

Staff had a good understanding of safeguarding people at risk. They were able to identify the correct safeguarding and whistleblowing procedures to follow should they suspect abuse had taken place. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, anonymously if necessary. One member of staff said, "I would always tell my manager if I thought someone I was looking after was at risk. I'm sure they would do something but if they didn't, I'd let the local authority know". Another member of staff said, "I just wouldn't tolerate anything like that. I'd report anything straight away". Staff confirmed to us the manager operated an 'open door' policy and that they felt able to share any concerns they may have in confidence.



## Is the service effective?

### Our findings

Relatives told us their loved ones received the care and support that met their needs and that staff carried out their duties effectively. For example, "[name] can be difficult but the staff always manage to talk them out of their mood."

Induction training was provided for new staff and this involved them working alongside more experienced staff members. They did this for a period of time to help them develop the required level of skills and knowledge to support people safely. A new member of staff confirmed they had completed their induction training before they worked independently. They also explained they had begun working on the 'Skills for Care' Care Certificate to further support them in carrying out their role. The Care Certificate is an identified set of standards that care staff adhere to in their daily working life and gives people the confidence that staff have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff told us that the essential training they had completed such as moving and handling people and infection control was good and provided them with the necessary skills to undertake their role. They told us some of their training could be updated easily with eLearning or workbooks which were sent away for marking. Other training such as medicines involved an assessment of their competencies.

Training schedules showed what training needed to be completed. However staff had not completed training in regards to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). When we asked staff about this, they had a limited knowledge of what this meant in practice. This meant staff may not recognise how to apply the MCA and DoLS appropriately, potentially placing people at risk of being restricted without the appropriate authority or not being able to be supported to make choices.

Staff told us they handed over any information of concern about people to staff starting the next shift to ensure any risks associated with their care were managed.

New staff, as well as existing staff, sometimes had supervision meetings with the registered manager to discuss their ongoing work performance. These meetings provided staff with an opportunity to discuss personal development and training requirements. A staff member told us they discussed, "How I feel about the place, any problems, how things are going, any changes that need to be made." The registered manager told us she planned to hold supervision meetings more frequently which would enable staff training and support to be more effectively managed.

We asked the registered manager about their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission is required by law to monitor the operation of the MCA and DoLS and to report on what we find. The MCA ensures the rights of people who lack mental capacity are protected when making particular decisions. DoLS referrals are made when decisions about depriving people of their liberty are required, to make sure people get the care and treatment they need in the least restrictive way.

The registered manager was able to explain the principles of MCA which showed they had some understanding of the legislation. There had been six DoLS referrals made and she intended to make more referrals to the local DoLS team. The registered manager acknowledged that staff had a limited understanding about DoLS and when a referral should be made to enable decisions to be made in the person's best interests. The registered manager agreed this was an area where they and staff would benefit from further support and training and they would arrange this.

We saw people were involved in everyday decisions about their care such as where they sat, what they ate, and what drinks they would like. Some people were independent with some of their care so did not always require staff support.

People said the food was good but most people did not know what meals they would be receiving, as there was no menu board and people often forgot. Choices provided to people were limited in that there was only one main meal provided each day. Staff told us the main meal was something everyone liked and if anyone did not want this, they would provide them with an alternative choice. Comments from people about the food included, "Good, very good."

The cook told us that every meal was cooked fresh on the day it was to be eaten. They were reviewing the menus and were hoping to introduce pictorial menus soon. Breakfast menus had been created and staff would use these daily to see what people liked, it included cereals as well as a hot choice such as eggs and bacon. The cook told us they were aware of who had soft foods and the meals we saw that had been softened looked as pleasant as the other meals served.

Where people were not eating and drinking sufficiently to maintain their health, the registered manager had introduced food and fluid charts to monitor the amount of food and drink they had consumed. However, the food and fluid charts we looked at had not been completed sufficiently to establish whether the person had eaten and drunk enough each day. The food chart did not always show the amount of food the person had eaten as it just stated a percentage and did not indicate how large the meal was at the start. Although staff recorded how much people had had, the fluid charts did not have a daily target to indicate to staff how much fluid the person should have each day.

We recommend that the service seek and implement guidance from a reputable source on food and fluid charts to ensure they are using the most effective methods to meet people's needs.

People who needed assistance to mobilise were supported to the dining area to eat their lunch. The dining area had limited space for tables for everyone so some people remained in the lounge area and ate their lunch from small tables placed in front of them. Staff served everyone with the same meal and explained to people what was on their plate. Staff interacted with people politely and respectfully. They altered their approach and tone of voice in line with each person's communication and hearing abilities.

One person was reluctant to eat their meal when their relative arrived, and staff offered them encouragement. When the person became anxious staff reassured them their family member would wait until they had finished their meal.

We observed that a person in a reclining chair was assisted to eat their food at a pace in accordance with their needs. The staff member spoke quietly to the person explaining what the food was which the person responded well to.

Staff spoken with had a good understanding of people's health care needs. All the people we spoke with

told us if they needed a doctor the staff team would make an appointment for them. We saw that other health professionals visited the service to support people's needs when needed. This included physiotherapists, chiropodists and opticians.

## Is the service caring?

### Our findings

One person using the service told us, "The staff are good to me, lovely people". Other people indicated or told us staff were kind and they liked living in the home. One relative told us, "We can see by their behaviour how well [my family member] is well cared for". Another relative said, "From self-neglect at home to living here, they have gone from strength to strength,"

Staff were seen to be caring. Observations showed staff treated people with kindness and affection. During conversations with people, staff spoke respectfully and in a friendly way. They chose words that people would understand. Staff explained what they were doing and why. They used people's preferred form of address and got down to the same level as people and maintained eye contact. Staff spoke clearly and repeated things so people understood what was being said to them. They treated people with dignity and respect and people felt listened to. One person told us how staff always asked them how they were, what they wanted and checked with them that they were happy with the care they were getting. Staff responded in a caring way to difficult situations. For example, when a person became agitated, we saw staff sitting with them talking with them in a way which helped them to calm down. When another person became upset staff spoke reassuringly to the person and used appropriate touch to comfort them.

Staff demonstrated a good understanding of the need to respect people's dignity and privacy. For example, when a visiting professional arrived they encouraged and supported the person to another room for privacy. When assisting with meals or drinks staff supported with dignity and engaged with the person in the activity.

Staff recognised the importance of encouraging people's independence. One told us, "I don't interfere if I think someone can do something for themselves". We saw people were supported to maintain their independence inside the home.

People confirmed they were asked their views about the care they received and their relatives confirmed their views were sought. The registered manager told us they spoke with relatives as they needed to and the relatives we spoke with confirmed this. The manager was aware that people did not have daily information about their meals and was working with the chef on how to change this. We saw that staff asked people their opinion and choices on foods and favourite meals as part of the preparation of the new menus.

## Is the service responsive?

### Our findings

People and their relatives told us they felt welcomed into the home and were asked for their views about the care provided. A healthcare professional told us they felt the staff and service were person centred, understood people's needs and were responsive to changing needs. They said they made referrals at appropriate times and always acted upon advice they were given.

People's care had been appropriately assessed and plans had been developed to ensure that staff met people's needs consistently and reduced and identified risks. Staff had a good knowledge of person centred care and were able to tell us what this meant. They knew the people they cared for and the support they needed. Plans of care were personalised and reflected people's individual needs. For example, one person's plan for personal care detailed what they could do for themselves, the support they needed, what they liked to wear, and how they made choices.

There was a complaints procedure in place and on display in the hallway of the home. People knew who to speak to if they had any concerns or complaints. They told us they could talk to staff and felt listened to. The complaints policy included clear guidelines on how and when issues should be resolved. It also contained the contact details of relevant external agencies, such as the Local Government Ombudsman and the Care Quality Commission. We asked relatives whether they felt they could raise concerns if they had any. One said, "I've never had any concerns but if I had I can speak to any of the staff." Another told us if they had a problem they felt happy to raise it directly with the manager. This meant that people knew how to make complaint should they need to. No formal complaints had been made since our last inspection. The manager told us she preferred to deal with people's concerns as and when they arose.

Records we looked at during this inspection showed when changes had occurred in people's needs they had been recorded appropriately. They also showed that when incidents had happened people's records and risk assessments had been reviewed. We also saw that care plans were being reviewed and updated regularly.

We looked at the care records for two people. We saw that information for staff about how to support individuals was very detailed. We saw from the care records that people's health and support needs were mostly clearly documented in their care plans along with personal information and histories. However specific information about people's medicines was not fully recorded in some cases

We could see that people's families had been involved in gathering background information and life stories. Staff had a good understanding of people's backgrounds and lives and this helped them to support them socially and be more aware of things that might cause them anxiety.

We could see in people's care plans that there was effective working with other health care professionals and support agencies such as local GPs, community nurses, mental health teams and social services. We spoke with health care professionals who supported people who lived in the home. They told us that the staff were good at contacting them and asking for advice and support promptly and made appropriate

referrals where necessary.

## Is the service well-led?

### Our findings

Relatives told us that the home had a 'good ethos' of caring and they saw it working when they visited.

All the staff we spoke with told us they thought the home was well managed. They told us that they felt well supported by the manager and said that they enjoyed working in the home. One member of staff told us, "I love my job; this is a good home, all the staff are here to provide good care to people." Another said, "The staff team is stable now and feel the manager is very approachable."

We saw during our inspection that the manager was accessible to staff and spent a lot of time with the people who lived in the home and engaged in a positive and open way.

At the last inspection in January 2015 we found a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponded to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was ineffective monitoring of the quality and safety of the service. This was no longer a breach at this inspection but improvements still needed to be made.

At this inspection we found new systems and procedures had been implemented to record the quality and safety monitoring of the home. We saw new records for weekly, monthly and quarterly checks of the service. The registered manager submitted reports and audits to the provider who then came to the service and carried out some audits and signed off those of the manager. However, the audits had not identified that there were issues with the food and fluid charts.

There was process in place for the regular review of people's needs. Maintenance checks were being done regularly and we could see that any repairs or faults had been highlighted and acted upon. The manager had identified an ongoing improvement plan for the home and outside areas. There was a cleaning schedule and records relating to premises and equipment checks to make sure they were clean and fit for the people living there.

However we were concerned that the monthly audit for medicines had not yet taken place at the time of our inspection and we had identified several concerns in that area, some from the middle of the month which had occurred on medicine records. This meant that the manager was unable to then rectify the issues in a timely manner. We discussed this at the time with the manager and spoke about the timing of these audits. They said they would seek advice on how to alter this and look at alternatives.

There were processes in place for reporting incidents and we saw that these were being followed. There was regular monitoring of incidents, these were reviewed by the manager to identify any patterns that needed to be addressed.

Since our last inspection the manager had been notifying CQC of all incidents and events that were required under the regulations, for example Deprivation of Liberty Safeguards applications.

Staff told us the manager was open and approachable. They felt comfortable to talk to them and confident action would be taken if they had any concerns or suggestions. One care worker told us, "If I have a problem I go to the manager and they will sort it out if they can". The rota was planned to ensure that there was a senior member of staff on duty at all times. A health care professional told us that whilst they did not often engage with the registered manager, there was a clear hierarchy in the service and care staff were supported by senior staff. They felt staff understood their roles and responsibilities well.

Regular meetings between the registered manager and staff took place and were held every two months. The minutes contained a review of the minutes of the previous meeting and a plan to decide what action would be taken as a result of the current meeting, by when and by whom. The staff we spoke with felt the meetings were held in an open and honest manner in which they could share ideas and raise 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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment</p> <p>The registered person had not ensured people's medicines had been administered safely and that there was adequate information available to staff to mitigate any side effects. Regulation 12(1)(2)(g).</p>