Leonard Cheshire Disability

Arnold House - Care Home Physical Disabilities

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected this service on 19 and 22 February 2018. The inspection was unannounced.

We last inspected the home on 28 June 2016 to carry out a focused inspection due to a breach of the regulations related to medicines management as stock records did not tally with medicine receipt and administration records, and people's allergy status had not always been recorded or updated. Prior to the focused inspection, the last comprehensive inspection took place on 15 September 2015. The overall rating for the service prior to this inspection was Good.

Arnold House is a 'care home'. People in care homes receive accommodation and 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.

The service is registered to provide personal care for up to 23 people with a physical disability. At the time of the inspection there were 23 people living at the service of all ages.

The care home accommodates 21 people in one purpose built building. There is a bungalow situated in the garden which accommodates two people. This is viewed as 'move on' accommodation.

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

We found multiple concerns with medicines management at the service. Concerns ranged from medicines not being available for people as per their prescription, inaccurate recording of medicines administration and discrepancies when tallying medicine stocks versus records. This placed people at risk of unsafe care.

There were not always risk assessments in place to provide guidance to staff in their caring role, including key areas such as choking, bathing, and moving and handling risks. This increased the risk of accidents occurring and placed people at risk of harm.

We found that the number of staff rostered to work was not always reflected in the number of staff working. This impacted on the care provided to people. With the exception of one person, people were not restricted to leave the service. However, the staff shortages impacted on people having the opportunity to go out as many people required staff support to leave the building. We found there were insufficient staff to provide personalised care to people.

We did not find comprehensively completed care records in place that set out in detail people's likes and dislikes nor their needs or how these were to be met. The service could not evidence they provided person-

centred care.

We had mixed views from people living at the service regarding their experience of living there and the care provided by the staff. Whilst some people told us staff were caring and kind, other people told us some staff fell short in this area, and this impacted on the dignity and respect shown to them by the service.

We found that staff were able to tell us what they would do if they had safeguarding concerns, but refresher training was not taking place in line with the provider policy in key areas such as safeguarding and moving and handling. Supervision was not taking place as regularly as the provider policy stipulated. These failures to support staff appropriately increased the risk of unsafe care being provided to people.

The provider had quality assurance systems in place. However, these were largely ineffective in the areas of safe medicines management, or with ensuring people's risk assessments and care records provided staff with up-to-date information on how to care for people. Although the provider had identified these concerns in autumn 2017, there had been few improvements to the service in these areas at the time of our inspection.

We could see from records that staff recruitment was safe. References were in place and Disclosure and Barring Service certificate checks had taken place prior to people being employed. This meant staff were considered safe to work with vulnerable adults.

The provider had a complaints system in place and we could see they responded to complaints within their set timeframe.

We found the provider was in breach of five fundamental standards. These related to the safe care and treatment of people using the service, person-centred care, staffing, dignity and respect and governance of the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

You can see what action we told the provider to take at the back of the full version of the report. However, full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. There were multiple and serious concerns with medicines management. We found medicines not being available for people as per their prescription, inaccurate recording of medicines administration and discrepancies when tallying medicine stocks versus records.

Some relevant risks to people had not been assessed and we found a number were generic and lacked personalised detail and were out of date.

There were insufficient numbers of trained staff to meet people's individual care needs, which impacted on the care provided to people.

The service was clean and food was stored and labelled safely.

Recruitment of staff was safe.

Is the service effective?

Requires Improvement

The service was not always effective. Staff did not receive regular supervision and refresher training in key areas had not been undertaken in the last 12 months, which undermined their ability to support people appropriately.

Care records did not always evidence how people's health needs were met which placed people at risk of poor care. However, people told us they were supported with health appointments and a health care professional told us the service addressed people's health care needs.

Staff understood the importance of consent and people told us staff gained their permission before providing care.

People's choices for food were catered for.

Is the service caring?

Requires Improvement

The service was not always caring. People told us some staff were kind and others were less so. People told us they were not always shown dignity and respect.

As there were gaps in care records we could not always see how staff promoted people's independence.

Care records did not always set out people's preferences or daily routines, and did not always address people's cultural or religious needs.

Is the service responsive?

Requires Improvement

The service was not always responsive. There were some people without person-centred support plans in place and we found others' plans with either inaccurate information or gaps in them.

The provider did not have a system to evidence how they supported people in a person centred way to lead fulfilling varied lives.

There was a complaints process in place for people living at the service. However, there was not clear evidence the provider had always acted on issues raised by people living at the service.

Is the service well-led?

Inadequate

The service was not well-led. Although the provider had quality assurance processes in place we found they were ineffective at addressing key areas of concern they had identified in October and November 2017 including safe medicines management and lack of risk assessments.

Subsequent to the inspection the provider had taken remedial action to improve the quality of the care provided to people.

Arnold House - Care Home Physical Disabilities

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 19 and 22 February 2018, and was unannounced. The first day of the inspection was undertaken by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. They spoke with people using the service to ask them their views of the service. The second day of the inspection was undertaken by a pharmacist inspector.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection, we checked for any notifications the provider sent us and the information we held on our database about the service and the provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law.

The inspection site visit activity started on 19 February and ended 22 February 2018. It included a visit to the service to meet people living there, the staff working with them and to check records kept at the service.

On the first day of the inspection we talked with eight people who lived at the service, and one relative. Some of the people who live at the service have complex communication needs so we were unable to communicate with all the people living at the service as part of this inspection. We also spoke with the

registered manager, the deputy manager and four members of care staff. We checked five people's care records, accident and incident records, and records related to the management of the building. We checked five staff recruitment records and supervision and training records for the staff team. We checked medicines and complaints and quality assurance documents. We also observed lunch being provided and an activities session.

On the second day of the inspection a CQC pharmacist visited to check medicines management. This included looking at medicines storage, 17 medicines administration records, ordering of medicines, controlled drugs register and storage. They also checked medicine stocks versus records, and spoke with the registered manager and two team leaders.

Subsequent to the inspection we spoke with four relatives and one health professional responded to our request for feedback on the service.

We received additional information including additional quality assurance information, policies and staff rotas. We also spoke with the Quality Director, the Regional Manager, an additional interim manager and the Quality Assurance Manager.

Inadequate

Is the service safe?

Our findings

On the first day of the inspection, a staff member told us "We have had issues with medication. Someone came to check it, I don't know who. We have been putting it right." However, we found three medicine stocks did not tally with medicine administration records (MAR).

A pharmacist inspector undertook a detailed review of medicines on the second day of the inspection and found further serious issues with medicines management.

There was poor communication between the GP surgery, the pharmacy and the care home which contributed to serious concerns being identified with medicines management. These included problems with re-ordering of medicines which meant that people did not always receive their medicines as per prescription. Examples of these concerns included one person who did not receive an oral contraceptive tablet which was prescribed for associated health reasons, as opposed to preventing pregnancy, for the period from 27 November to 15 December 2017. This meant that people were placed at risk of unsafe care due to not getting medicines as prescribed to them.

Another person was on a blood thinning medicine and did not have a blood test to evaluate the dosage required although one was due on 3 January 2018. Although the service had attempted to get a blood test taken in the week prior to the inspection, this was not successful, and the staff were administering warfarin doses as per the last instruction from the clinic dated 22 December 2017. There was no medicines care plan or risk assessment in place for this high risk medicine. This placed this person at serious risk of harm, particularly if they had injured themselves in anyway.

Due to there not being medicine available, a third person missed medicines for seizures for three days and medicines for anxiety for four days in the four week period from December to January 2018. This placed this person at risk of serious harm.

Stock checks on three medicines did not reconcile with MAR which meant the service could not confirm people had had medicines as prescribed which placed them at risk of harm.

There were cases where the MAR had duplicate entries for the same medicine. Staff signed both entries for the same time period. We found one instance when the two records for the same medicine did not match, which meant it was not possible to tell how much medicine had been given to this person. This meant the service was not keeping accurate records of medicines given to people which placed them at risk. This also indicated staff were not following best practice in recording of medicines administration.

Handwritten entries on MAR had not been countersigned which is best practice when medicines are prescribed out of the usual four weekly cycle, for example, antibiotics. This is to ensure that two staff have checked the person has been prescribed the new medicine and it is accurately recorded on the MAR.

Protocols for 'as required' (PRN) medicines were not always in place. This meant staff were not always sure

when to give medicines. We also saw staff were not always following PRN protocols. For example, we saw one person had been offered an additional painkiller when the PRN protocol stipulated not to.

Medication competency checks were not up to date for five of the six staff who provided medicines to people. This was a requirement in the provider's medicines policy. This meant that staff were not up to date with safe medicines practices and this was evidenced by the issues raised above.

Additionally, cream charts did not indicate whether the cream should be used 'as required' or state the frequency of application. Body maps had not been completed, although one of the three cream charts checked stated where the cream should be applied. There were gaps in recording the application of cream which meant that people may not have received their creams as prescribed.

Storage arrangements for non-controlled medicines were appropriate. However, the controlled drugs cabinet was not in line with the regulations of the Misuse of Drugs and Misuse of Drugs (Safe Custody) (Amendment) Regulations 2007 because it was made out of wood and it is required to be made out of metal to ensure controlled drugs are securely stored. We also found expired medicines not removed from general medicines supplies. This potentially placed people at risk of being given out of date medicines.

As a result of the inspection the service sent seventeen statutory notifications to the local authority and CQC as potentially people have been placed at risk of abuse due to concerns they did not receive medicines as prescribed to them. At the time of writing this report the provider was still awaiting responses from people's GPs as to whether the issues with medicines would have impacted negatively on individuals' health.

The evidence above demonstrates failures to ensure the proper and safe management of medicines, which is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Subsequent to the inspection the clinical lead for the provider visited the service and reviewed the medicines management processes. This included reviewing the ordering cycles and reviewing key relationships with the local pharmacist and people's GP's. Medicine plans have subsequently been put in place for all the people living at the service and medicines training has taken place for staff.

Risk assessments were not consistently seen in the five care records we checked. Whilst we found some risk assessments were in place and up to date, there were a number of risk assessments which were either not in place or were generic in nature rather than person specific. In most cases they did not link to a plan of care for the person, therefore it was not clear how the information was used. For example, one person had a generic risk assessment for bathing/showering but no associated care plan so it was unclear how to support this person or what risks may be involved in offering this support. This person also had a generic risk assessment for bed rails which indicated they were at high risk, but there was no other documentation on how to reduce the identified risks. Similarly this person was considered at high risk of choking due to a generalised risk assessment dated December 2016 but there was no personalised risk assessment in place after this date.

We found a second person who was at high risk of choking without a personalised risk assessment in place. The risk assessment that was in place was generic and was dated December 2016. This person did not have a risk assessment for moving and handling that was personalised despite being a wheelchair user. This same person did not have a bathing or showering risk assessment. There was no support plan in place for this person so it was unclear how the service assessed and addressed any safety risks to them when being provided with care.

In another instance, despite detailed medical advice being given in a letter by a tissue viability nurse dated March 2017 regarding how to support a person with personal care, there was no risk assessment or detailed guidance in relation to skin integrity in place for staff. This person was also rated as at high risk of choking in a generic risk assessment dated December 2016 but there was no personalised risk assessment in place.

We found personal emergency evacuation plans (PEEP) in place but these did not state how many staff were required to support people in the event of an emergency.

The moving and handling risk assessment for one person was detailed as it related to transferring, personal care and other matters and was therefore informative. However, it was dated March 2016. As it had not been reviewed, it may not recognise any current and changed risks to this person's safety in respect of moving and handling care provided to them.

We noted one person fell on three occasions before there was a meeting with them and other people involved in this person's care to address the issues that had contributed to the fall. Whilst there was action agreed on 1 December 2017, on the day of the inspection the support plan still contained information which was out of date and which if staff followed could contribute to further falls taking place.

Overall, risk assessments were of a poor standard and did not inform the care provided to people. A number of people at the service had a high level of need and were unable to articulate their needs. Therefore, people's safety was not managed and monitored in an effective way which may have put them at risk from harm.

These concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were eight staff on the rota to work in the morning on the first day of the inspection and five staff in the afternoon. However, we found that there were only actually seven care staff working in the morning and six staff in the afternoon.

We asked people whether they thought there were enough staff to meet people's needs. We got mixed views. One person told us "daytime, yes but I don't think so at night." They added, "The buzzers go off a lot at night which makes me feel staff are not around and I wonder if they are short staffed?" Another person told us they did not think there were enough staff. We asked some people about their routines, and whether they were able to get up or go to bed when they wanted. One person said, "Not always. Sometimes they are short staffed so I have to go to bed early." Two other people told us they thought there were enough staff. One said, "I think so but I think other people would disagree." One other people, when asked if there were enough staff, told us, "Yes but more would be good."

We asked staff if they thought there were enough staff to meet people's needs. We were told that when shifts were covered as planned there were enough staff to cover the work. One staff member said, "When staffing is eight and five it's ok. We need this level of staffing because 19 people require two staff for hoisting." Another said, "When there is eight in the morning and five in the afternoon it is fine." However, staff also said that some shifts had less staff working than rostered and this was confirmed by checking records as was the case on the day of the inspection. We saw staff were very busy providing care to people in the morning.

We asked the registered manager how they managed staff shortages and were told that bank or agency staff were used. We noted that from 6 to 19 February 2018 there were six occasions when staffing levels dropped below that required and when neither bank nor agency staff worked these shifts. On 6 February 2018 the

morning shift was two staff short. These details were confirmed by the provider although no explanation was given as to why cover was not provided. This put people at risk of their care being affected by insufficient staffing levels.

These concerns were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Subsequent to the inspection the interim manager confirmed the service had increased staffing levels for the afternoon shift from five to six staff. The service has also developed an agency profile folder with details of agency staff and induction information for agency staff to familiarise themselves with the service.

The service had additional staff to carry out cleaning, kitchen, laundry and maintenance staff. There were also volunteers who supported staff with activities and lunch.

We asked people if they felt safe living at the service. People gave us mixed views. One person told us they felt "a little bit" safe. We asked for more information but this person would only say they were angry "with some of the staff". We asked another person if they felt safe living in the home they said, "No I don't". We asked why and were told "The staff." A third person told us, "Yes mostly." In contrast three other people told us they felt safe.

The provider had a safeguarding policy in place and we had received safeguarding referrals appropriately in the previous 12 months. Staff were knowledgeable about safeguarding, although records showed compliance with keeping safeguarding training up-to-date across the staff team was at 54%. Staff were able to describe the different types of abuse and reporting procedures within and outside of the service.
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Accident and incident forms were completed by the service and we saw that actions were recorded on the documents. However, we were not confident learning always took place, or was followed through.

For example, the registered manager carried out service level audits in November and December 2017 and January 2018. Some issues were identified and the registered manager sent an email to staff regarding medicines issues. However, they were not effectively acted on to improve medicines management by the time of the inspection.

At the provider level, medicines management had been identified as a serious concern in an internal audit on 31 October and 1 November 2017 but we found that there had been a lack of management oversight and action taken as a result of these concerns.

Records showed that pre-employment checks were carried out before staff started work. These included two written references, proof of identity as well as their employment history and a criminal records check. This showed that there was a system in place to ensure staff were suitable to work with people at the service.

People were protected by the prevention and control of infection. The kitchen was clean and we could see food was stored and labelled safely. The chef could show us recent records of when appliances were cleaned. An infection control audit in December 2017 had identified a number of areas that required improvement including areas in the kitchen such as fridges, freezers and food labelling. These improvements, along with new colour coded mops, foot operated bins and new systems for storing laundry had been implemented by the time of the inspection. The majority of family members told us the service was clean.

Records showed fire safety equipment had been serviced in September 2017, hoists had been serviced in November 2017 and there was an asbestos risk assessment plan in place due to asbestos in the locked basement. Fire drills had taken place in recent months to incorporate both day and night staff, and the fire brigade had assessed the service as having satisfactory arrangements in February 2018. The electrical system had been checked in the past five years and portable electrical equipment more recently. Safety checks for gas to the service had taken place in March 2017.

Requires Improvement

Is the service effective?

Our findings

We asked people if they thought staff had the skills and knowledge to look after them. One person told us, "Yes they are. They are very professional." Another person said, "Yes but they don't all have people skills." One relative questioned whether all the staff were clear about how they should communicate with people and also what the expectations were for staff, as in their view some staff fell short of their expectations.

Staff told us they had received training appropriate to their roles and they felt confident in moving and handling. However, records on staff training showed there was only 26% compliance with the refresher moving and handling practical course and 50% compliance with the refresher manual handling theory course. One staff member told us, "There has not been as much training recently, a lot is online at the moment." Another said, "Historically training has been face to face but it's changing, more will be online." Other key areas in which refresher training had not taken place included safeguarding adults training at 55% and health and safety awareness at 41%.

Subsequent to the inspection five training days were booked for staff to undergo refresher moving and handling training.

New staff undertook a mixture of training and shadowing as part of their induction. New care staff were also expected to undertake the Care Certificate, training which sets out and assesses the competency of care staff against the national standards for providing care. Due to changes in personnel at the service the provider was not able to confirm if these had taken place for new staff in the last 12 months.

The provider policy regarding developmental supervision stipulated a minimum of four supervision sessions per year, one of which would be an annual performance review. Some staff said they felt supported but this was not consistent. One staff member said, "I don't have regular supervision or an appraisal. The last one was with the previous manager about two years ago." Another told us their supervision had been cancelled twice recently. The supervision matrix for 2017 showed that supervision did not take place in line with the provider's policy and some staff had not had any supervision at all during 2017, although we could see there had been a number of supervisions for some staff in November 2017. The Quality Assurance Manager told us three appraisals were completed between January to December 2017 and 38 appraisals were outstanding for the last 12 months.

During the inspection there were training staff who had come to offer support to the service. We asked them what the key performance indicators were for staff training. They told us 80% minimum but preferably nearer to 90%. They told us they reviewed the figures for services monthly but were unable to explain why the levels in some key areas were so low at this service.

Refresher training and supervision provide an opportunity for staff skills and knowledge to be improved and reflected upon by the staff member and their manager. Lack of refresher training and supervision meant the provider was not following their own policy in this regard and therefore could not satisfy itself that staff were competently providing care to people.

The above evidence demonstrates a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted there was 90% compliance with the communication course, and in excess of 80% with the courses in decision making/capacity; equality and diversity; infection control, and nutrition and health.

There were nutritional assessments for two people whose care records we checked. One indicated that a person had received input from the speech and language therapy team due to concerns in relation to choking. People's weight was recorded monthly and seen to be stable for those people checked. The information regarding people's eating and drinking was very variable. For example, whilst one person's support plan provided detail on how to support this person with eating and drinking for another person there was no support plan in place despite this person being identified as at risk of choking. Overall, it was therefore not possible to be confident that people's nutritional needs were well managed although we did not identify specific concerns. This could impact on people who were unable to articulate their needs.

We asked people if they enjoyed the food. One person told us the food was "very, very good." This person also told us they were able to help themselves to food and had access to the kitchen as and when they needed. Another person told us the food "was very good. It's nice"." Asked if there were choices this person told us, "Yes always" and they were able to get drinks and snacks when they chose. Another person said, "I am fussy so I have ready meals. I buy them from [shop name]." A third person told us, "Usually there is two choices of lunch but if you want something different they will get it for you if you ask before 9.30am."

We saw there was a menu available. One person told us, "The food's very good, but the menu is very tedious. It's very plain. I like a bit of spice and flavour. It's on a 28-day cycle. There could be more variety. I have mentioned it at meetings." Subsequent to the inspection the provider told us there was a meeting booked for the chef and people living at the service to discuss future menu options.

On the first day of the inspection some staff removed plates from people without asking if they had enough or would like more food, and after the main lunch period we saw one person was seen to struggle to eat their lunch in the dining room on their own for ten minutes without a staff presence. The person's relative arrived and provided support. This issue had previously been raised with the service by a family member.

We noted the menu in the dining room was quite high on the wall and it would be difficult for people in wheelchairs to read it. One person told us, "One resident asked for it to be on the tables but it hasn't been done yet."

The above evidence demonstrates a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found care records did not always include a log of health care visits therefore it was not possible to confirm that people were supported to access appointments with health care professionals when required. There was some evidence of health care appointments such as opticians, and speech and language therapist. The audit of 14 February 2018 by the provider had highlighted that no care records had a general health plan on them and only two people had a health plan front sheet summarising people's health needs. It was not easy therefore to see at a glance what people's health conditions were or how these were safely managed. A health professional told us most of the care staff, team leaders and management team were committed to working in partnership with them and often sent information regarding the outcome of hospital visits which was helpful in determining the best management plan. They also told us staff were usually effective in managing individual people's needs. When any deterioration in health was noted staff

were usually quick to make contact with the relevant health professional.

Subsequent to the inspection the provider informed us that 12 hospital passports had been completed. These are booklets containing key information for health staff for people who may find it difficult to communicate their needs or health conditions to facilitate improved health outcomes. The provider also told us 10 general health action plans have been completed.

We asked people if they accessed health appointments including dentist or optician. People told us of regular appointments. One person said, "I haven't been to the dentist since I've been here but I have been referred to the [health] team. I am waiting for an appointment". Another person said, "Yes I have the optician if I need them and a regular dental check-up. I have to go to the hospital regularly to see the physiotherapist and the [specialist health professional]."

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).

At the time of the inspection the registered manager told us only one application for DoLS was in the process of being considered by the local authority.

Staff understood the importance of gaining consent, but care records did not demonstrate that people's consent had been sought or that their capacity had been assessed in relation to aspects of their care. Staff told us most people had capacity and were given choices. For example, one member of staff told us, "People get good care. They are offered a bath or shower every day. There is lots of choice such as what to wear. For people who are non- verbal we hold the clothes up."

We asked people if their permission was sought before providing care. People told us, "Yes they ask me if I want any help. They don't take anything for granted. I'm quite vocal and can speak up if I need to but not everybody here is in that position." Another person said, "Yes they do. They ask first." We were also told, "Yes they always ask me first."

The environment was suitable for the people who lived there. People's rooms were on the ground floor of the main building or were in the bungalow and there were bathing facilities with ceiling track hoists for people to use. The building décor was dated with paint peeling off the exterior woodwork and marks on the walls.

There was a large garden with a large accessible patio. The deputy manager told us they hoped to make the whole garden accessible, although there were no specific dates or plans to confirm this was committed to by the organisation.

Requires Improvement

Is the service caring?

Our findings

People had mixed views regarding the service and whether staff were kind and caring. This likely reflected the variety of people who worked in the staff team and their differing approaches. For example, one person told us, "With this place, you can't expect 100% perfection. With some staff, I feel the 'wow' factor is missing. Some staff have the 'wow' factor like [names six staff members]. They are very good. I feel sometimes that the other staff can't be bothered."

Another person told us, "The staff are always in a hurry," particularly when they were assisting with supporting them to eat. A third person told us, "I tell them [staff] some things but they don't know all about my life. They don't ask." We were also told by one relative that their family member was asked abruptly, "What do you want?" when using the call bell as opposed to 'how can I help you?' A second relative told us they thought some staff were always kind and caring and others were not.

We asked people if they were afforded dignity and respect. People had varied experiences. One person told us "Staff are not respectful." Another person told us that staff were sometimes reluctant to support them to the toilet as they frequently needed this facility due to a health condition. We asked this person how they knew staff were reluctant to assist them. They said that a staff member told them "You have just been to the toilet, you don't need to go again." This impacted on their dignity and did not show respect.

Two people told us they thought the buzzers were turned off at night without being answered. Another person told us they had to wait a long time for their buzzer to be answered and that the delay in responding at night to buzzers impacted on their dignity.

We asked people on the day of the inspection if they had raised these issues with the management, and were told they either had and in their view nothing had changed or people felt uncomfortable and anxious about raising this issue so had chosen not to do so.

We saw a mixture of interactions on the day of the inspection. We saw some staff were kind and caring in the way they spoke with and assisted people. However, we also saw less caring interactions. For example, at lunchtime we saw some staff were talking to each other across the room and not to the people they were supporting. One person asked for a drink and was given juice without being asked what they would like. We spoke with one person after lunch to ask their views of the service. They had food left around their mouth after being supported by staff to eat, which did not show them dignity.

These concerns were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the issue of the buzzers with the interim manager who told us they had held two meetings since the inspection with people living at the service and the issue of buzzers not being answered had not been raised. However, they were looking into the sound level of the buzzers at night and would ask people's views about this issue at the next residents meeting.

In contrast when we asked another person if staff were kind we were told "yes", and that staff listened to them and that "they look after me so well." A fifth person told us staff were caring and that "they treat me very well." A sixth person said of staff, "Yes they are lovely. They listen to me. If I'm worried, I always speak to them or the manager." Two other relatives told us staff were kind and caring. Other people told us they were treated with dignity and respect, with staff always knocking before entering their room.

In summary we got very mixed views from people and their relatives regarding staff attitudes and the care provided to them. Some people also differentiated between different staff members, and told us who in their view, was kind and caring and respectful and who was not.

We could see from one audit undertaken by the registered manager that they had discussed with staff their communication with people living at the service. When we asked what this referred to, the registered manager told us they were some areas in which they felt the staff could communicate in a better way with people, but they did not provide further information.

We asked people if they were involved in their care. People who were able to articulate themselves told us, "Yes". We asked people if they were asked to sign their care plans and some people said yes. Some people told us they could not physically sign but had been involved in discussions regarding their care. Of the care plans we saw these were not routinely signed by people nor was it recorded that people had been unable to sign documents but had been involved in decisions.

We saw some support plans provided guidance on how to communicate with people. For example, "'[Person's name] likes people to speak to them directly; allow time for [person] to get across what they are saying/requesting." However, as other support plans were less detailed it was not always possible to know how to best communicate with individuals. Some support plans had detailed information regarding people's past but others did not have support plans in place or these sections were not completed. It was mixed as to whether people's cultural and religious needs were noted on care records.

Completed support plans were not in place for everyone living at the service, and the quality of information was variable. It was not clear from care records how much people's independence was promoted. Some people were clearly able to articulate to staff how they wanted care provided and when, but others were not. Care records did not always set out in each area what a person could do and how staff could support them to improve areas of independence.

We asked people if Arnold House felt like home. Again people expressed mixed views of the service. One person told us, "No". Another person said, "Well it's not, but it's what I have to adapt to." A third person said, "You can live your own life here. It's a home from home. It's my home". One person confirmed they could have visitors when they wanted.

There were three meetings for people living at the service in the previous 12 months and we could see that pertinent issues were raised including opportunities to go out and menu choices. Clearly there were some ways in which people's views were able to be given, at these meetings and when involved in care planning. However, following discussions with people on the day of the inspection we were also of the view that there were issues people were not happy with, or that had been raised in their view but not addressed. This meant the service was not dynamic in involving people in the way it was run, or in gaining people's views of the care provided.

As one person told us, "The only thing here is it's institutionalised." We asked for more detail and were told, "You end up fitting in with the surroundings. For example, if I want to play scrabble, I can but only on certain

days." Another person told us, "I feel sorry for the people who are unable to speak up or can't understand."

Requires Improvement

Is the service responsive?

Our findings

Of the person centred support plans (PCPs) we found two out of five that were detailed and covered main areas of support including how to communicate, food drink diet and mealtime routines, movement and mobility, and managing finances. One was dated December 2016 and had a written note on each page that it had been reviewed in January 2018. The other person centred plan was dated December 2017. Whilst the second one was detailed it was not up to date as we found information relating to this person's night routines that was out of date following a series of falls. Were a staff member to have followed the support plan in this area they would have placed the person at risk of reaching and falling out of bed.

A third PCP lacked any detailed information and was dated December 2016, but had been signed as reviewed in June 2017. It contained inaccurate information as it referred to a wound on a person's knee when in fact wounds were on the person's feet. A 'minimal moving and handling of people' form had been completed for this person dated January 2017 and reviewed in June 2017 but it referred in two areas to another person by name so it was unclear who this information related to.

The fourth PCP, whilst containing some information on the person's needs, had no pen portrait or life history. There was no evidence of person-centred care nor how to support the person in their life goals. This person had a Waterlow skin integrity assessment which had last been completed on 16 April 2017 and noted the person was at high risk of skin breakdown. However, there was no support plan for skin care and the risk information had not been updated. There was also no nutritional assessment in place although this person was weighed monthly.

The fifth person's care records we looked at didn't have a support plan in place at all. A member of staff had written on a person-centred checklist responses to specific questions which was not dated or signed. There was no information in this person's care records to explain what this person's needs were or how to meet them, despite them always using a wheelchair, being rated as at high risk of choking, and needed a bed rails risk assessment. These records did not guide staff on how to support this person.

We saw from an audit by the Quality Improvement Manager on 14 February 2018 that six people did not have a PCP. However, subsequent discussions with senior managers confirmed of the 15 other people the provider believed a PCP to be in place, they were "unable to confirm the PCPs are complete in full" and "extra development is required on existing plans" due to key areas not being completed.

In summary there were significant gaps in a number of the care records which meant that staff would not be aware of people's needs or their personal preferences or routines. This meant the service was unable to evidence that person-centred care was planned for or provided. One staff member told us, "Staff don't always read people's care plans but they are shown what to do."

On the care records we viewed there was no information to show the level of hours of support required for each person, or their daily routines, despite there being a significantly different number of hours being commissioned either by statutory organisations or paid for privately. Hours commissioned ranged from 13.5

hours to 82.75 hours a week.

The provider had a tool for calculating the hours required when commissioning the service with numerous categories included, for example, care, leisure or education when assessing a person prior to them entering the service. However, at a service level this did not translate into what support hours should be provided and for what purpose. We discussed this with a member of the senior management team who told us the provider did not routinely show how support was provided for individuals at a local level. There was a wide variation in assessed hours for residents but it was not clear from the support plans how support was provided in a personalised way that reflected these assessed hours. There was also limited evidence to show how residents' goals and outcomes were identified nor how support was organised to help residents achieve these.

We could not see from care records details of activity plans for people. One for example stated Monday to Friday 'activities' morning and afternoon with weekday evenings watching TV or listening to music. We were aware that one person was studying for a high level national course through distance learning. However, despite there being younger people at the service, there was little emphasis on opportunities for personal development or training in the care records we viewed. This was confirmed by one relative we spoke with.

The activities co-ordinator had left their post in August 2017. Whilst this role was not filled by a staff member at the time of the inspection, this post had been recruited to at the time of writing this report.

A volunteer was taking on this role on the day of the inspection. We observed one activity session and asked to see the schedule of activities. We were told there was no schedule but they tried "to do something different every day." We were told by staff that this was usually, "Scrabble Mondays and Thursdays and bingo Tuesday and Fridays". We were told there was input from an arts project who work in care homes approximately once a week and also a music group on a regular basis. We asked people their view of the activities. We were told "They do the same thing every week. They could do more". Another person told us, "Yes it's alright." When we asked what they liked doing they said, "I don't mind. Anything."

Staff told us in their view people needed to go out more. One staff member said, "People should be going out more. We have three vans." Another said, "People could go out more. There are only two drivers." We asked people if they went out of the service much. One person told us, "Yes if there's enough staff and a driver but I'm not allowed out on my own." This was clarified by the service to mean this person could not physically go out on their own.

A second person said, "I want to go out more. I asked and they said 'no'." The person was unclear why. A third person told us they did not get involved in activities "because I am studying so spend half my day on the computer." We asked a fourth person if they could leave the premises, they told us, "Yes it's not a prison. I can go out in the garden when I want." A fifth person said of going out, "More [staff] would be good so that I could go out. I have only been out twice last year. I miss going into London but I can't go because there aren't enough staff to take me." This person acknowledged they sometimes went to the pub for lunch locally.

We asked the provider for information regarding two people and how often they had been out in December 2017 and January 2018. We could see that one person had been out four times in December mostly to the local shops or for lunch, and the other person had been out five times in December and January 2018, mostly to pubs for lunch. This information had been evidenced by the charge to their account for using the transport as opposed to being part of a support or activities plan. It was not clear how people pursuing activities or hobbies outside of the service was monitored by the service.

We asked relatives their view of how often people were taken out of the service. One family member told us, "They used to take them out more often, but not now." They were of the view there was not enough staff to take people out regularly. This was confirmed by another relative who told us the service rarely took their family member out, rather family members had to take on this role.

The above evidence demonstrates the service was not able to show they were providing person-centred care that met people's needs and reflected their individual preferences.

The above evidence demonstrates a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found some examples of person-centred care. The bungalow was occupied by people who were more independent and so they could set their own schedules more easily. From talking with people who were able to articulate themselves, some people clearly discussed with staff their preferences for care. One person, when asked if they were able to get up and go to bed when they chose, told us, "Yes. I go when I'm ready." Another person said, "Yes. I tell the staff what I want and they listen." Some information on PCP's was person-centred. For example, one person liked to get up between 4-6am and their support plan detailed the types of snacks they liked to have at bedtime. Another PCP highlighted a person had greater intensity of spasms in the morning prior to having their medicines and that care must be exercised during this period.

Subsequent to the inspection the provider undertook to update all care records. At the time of writing this report they had not provided specific information on how many had been put in place or reviewed for accuracy.

The registered manager said there was a key worker system in place. This meant that support staff were linked to particular people who would then understand people's needs and work with them to develop their person-centred plan, to advocate on their behalf and ensure they were aware of how to make complaints. However, we found the key worker documents viewed simply indicated tasks carried out with people, for example, playing games, going shopping or helping them tidy their room. Although these tasks and the time spent may have been valuable to the people being supported, they were not evidence of a key working system in place at the service.

The service had a complaints policy. The file for 2017 contained a mixture of complaints and safeguarding. It was not clear if some had started as complaints and resulted in a safeguarding investigation. Although we saw that complaints were resolved it was not evident that feedback was used to improve the quality of care. One member of staff said, "We are told about them, we discuss it in meetings and handovers. I am not sure about lessons learnt."

We asked people if they knew how to make a complaint. Most people who were able to articulate their needs told us they did. One person said "I don't feel I need to use the complaints procedure. I just tell them."

Another person was less complimentary and said "no because they don't listen and nothing changes. I have the phone number and address for CQC and I would use that". Another person told us they did not think they would be listened to. One family member told us they did not always feel the issues they raised were responded to effectively. Two other relatives had not made a complaint but felt confident issues would be addressed by the service.

We saw from the minutes of residents' meetings that people were reminded of the complaints procedure and how to make their views known. However, from the discussions we had on the day of the inspection

there was a view held by some people that their opinions were not valued or issues raised by them were not always addressed. Three compliments were held of file but these were not dated and two had been written by the Manager to provide evidence of feedback from people.

Inadequate

Is the service well-led?

Our findings

We found serious concerns with the management of the service, at both service and provider level.

The provider had routine internal audit processes which were designed to quality assure the standard of the service. However, the quality of the service had deteriorated to such a level that the provider using their own quality assurance tools on 31 October and 1 November 2017 gave the service a rating of inadequate overall, with a rating of inadequate in both safe and well led domains. This prompted an action plan to be established which was developed by the provider's Quality Improvement Team in conjunction with the Regional Manager.

Key areas of concern in the safe domain related to poor medicines management, for example, unsafe storage and out of date medicines; recording of medicines administration as signatures were missing from MAR charts and out of date competency checks for staff administering medicines. The audit also identified the lack of risk assessments in place for key areas such as nutrition, skin integrity, choking, epilepsy and mobility and manual handling.

The provider sent us information detailing the input and support by senior staff following the audit of 31 October and 1 November 2017. Despite 21 visits by senior staff from the Quality Improvement Team, the Regional Manager, Health Professional Trainer and the Quality Director, at our visits we found there remained serious issues related to medicines management and recording, and insufficiently detailed care records to provide guidance to staff. We also found there was no system to record which risk assessments were in place for individuals in key areas such as choking and manual handling. At the time of the inspection, only one out of six staff who administered medicines had undertaken a medicines competency assessment. This meant the interventions by the provider as a result of the audit were not effective at achieving sufficient improvements in the period from 1 November 2017 to 22 February 2018.

The provider's action plan had been updated on several occasions, on 5 and 26 January and following a visit to the service on 14 February 2018. However, the plan did not always reflect actual work completed as it was updated on occasions without any reference to source documents. For example, on the action plans dated 5 and 26 January under the outcome 'For support plans to be tidy and contain accurate information that is easy to follow when providing support' this was noted as completed, with the note 'All PCP's have been put into new folders with dividers. This has made the PCP documentation clear and easy to follow'. We did not find this to be the case at our inspection and subsequent to the inspection the senior managers could not confirm all support plans were in place with all relevant sections completed to guide staff when providing care.

The action plan dated 26 January 2018 also noted as an action required 'To ensure that there is enough medicine stock available for people. If medicines stocks are low they need to be ordered and received in a timely manner so that there are no missed medication doses. To ensure that at the start of the monthly ordering cycle there is enough medicine ordered for the 28 days'. This was noted as 'Not started' and remained a serious concern at our inspection on 19 and 22 February 2018. Under 'Staff competency in giving

medicines' the plan stated 'For all Team Leaders and staff that administer medicines to complete their annual medicines competency training.' This was noted as being 'In progress' despite being identified as an action required since the 1 November 2017 audit. The 5 January 2018 action plan had noted only one staff member still required a competency assessment for medicines administration, whereas we found only one out of six competency assessments had taken place by the time of the inspection. This showed us that there was no prioritisation of tasks on the action plan based on a safety and risk based assessment, so people were at risk due to medicines not being available and being administered by staff, the majority of whom had not been assessed as competent to do so within the previous 12 months.

The action plans dated 5 and 26 January 2018 also contained contradictory information. For example, under the health and safety section the outcome 'For residents to be kept safe according to their health plan', there was an action of 'For all residents to have up to date risk assessments in place with regard to eating and drinking, choking, nutritional needs, moving and handling, and epilepsy'. The 5 January action plan noted this as being 'In Progress' whereas the 26 January 2018 action plan noted this action as 'To be started'. We found gaps in risk assessments to provide guidance in key areas such as choking and moving and handling risks during our inspection, and a subsequent discussion with senior managers highlighted to us there was no system for recording which risk assessments had been completed for individuals. This illustrated a lack of senior management oversight and management of the action plans, the requirement to improve the service and ultimately the standard of the service being provided.

Notes from a visit to the service by senior managers including the Quality Director on 30 January 2018 noted 'Went through all PCP plans and updated SID [internal system for care documents]' and 'It was evident from this visit the Service is progressing well, however with CQC imminent there is a certain time pressure to get everything done to ensure compliance.' These notes do not accurately reflect the situation on 30 January 2018 in relation to care records. This illustrated to us a lack of rigour in quality assurance processes.

On 14 February 2018 the Quality Improvement Manager undertook a review of PCPs, and associated health documentation and found there were no 'health plans' on files, 10 people did not have a one-page profile and there were eleven PCP review sheets to be completed. It has since been acknowledged by the provider that the quality of the PCPs varies greatly, some with no information in key areas. The audit on 14 February 2018 was the first thorough audit of care records, three and a half months after the original audit which found the service to be inadequate overall, despite this issue being highlighted on 1 November 2017.

This was evidence that despite the systems being in place to prompt quality improvement there was no priority or urgency given to establishing care records to set out to staff how to ensure people were safely cared for, and that up until a review of actual care records on 14 February 2018 there was ineffective scrutiny and action taken by the provider to improve the quality of care at the service.

Despite medicines management being noted as a serious concern in October and November 2017, there was minimal effective intervention by senior managers to support the service until our inspection. Various managers had noted actions were not completed in November, December and January but there was no follow-up response. Senior manager held differing views as to who was responsible for ordering of medicines at the service, but this was not explored further and clarified until the provider's Head of Clinical Excellence visited the service on 23 February 2018 following our inspection.

In this way the governance systems were not effectively operating to assess, monitor and improve the quality of the care, and risks to people were not mitigated. The provider's response lacked a co-ordinated approach to the issues identified in the October and November 2017 audit and so continued to put people at risk of inadequate care.

Other areas in which the service was not well led included: low levels of supervision and training for staff in key areas including manual handling; ineffective systems for monitoring staffing levels on a daily basis; lack of effective audits by the registered manager at service level for monthly returns as these did not require evidence of checking any source documents so did not always accurately reflect the situation at the service. For example we noted a monthly audit by the registered manager addressed the issue of "Do customers feel safe?" and the audits we saw for November 2017, January and February 2018 had been completed with "Yes" as a response. We asked the registered manager how they satisfied themselves this was the case and they said they asked a few residents who lived at the service but did not keep a track of who they spoke with.

We found daily check list documentation which required staff to indicate that water jugs were replenished, beds were made and the toilet or bed pan were cleaned were routinely not completed and regularly not signed by the staff member. Instead some areas of the record were ticked. This meant that we were unable to see if these tasks had been completed for people.

The Quality Assurance Manager confirmed that despite provider quality assurance requirements from April 2017 that call bell response times above 10 and 15 minutes were monitored on a monthly basis, this audit had only taken place on one occasion in January 2018 at which there was only one event of a call bell ringing for more than 12 minutes.

Staff and residents' meetings took place on a regular basis. Despite this, some people told us they did not feel listened to, and their concerns were not acted upon. This meant that some people felt powerless within their own home, and there was little evidence they were actively involved in how the service was run.

There were four staff team meetings in 2017 with one meeting for night staff in August 2017. However, there were no team meetings following the internal audit in October and November 2017 until after our inspection on 22 February 2018. Similarly, whilst there were three meeting for residents in 2017 there were no meetings following the internal audit in the autumn of 2017. This missed opportunities for either staff or residents to be engaged fully in the process of addressing the concerns raised within the audit and being part of the solution to improve care at the service. Following the inspection in February 2018 there have been meetings with staff, people living at the service and their relatives regarding the improvement plan and the issues raised by the inspection.

These concerns were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the registered manager had taken some actions to address concerns. For example, they had written a memo to staff following issues with medicines reminding them of their responsibilities with completing MAR and recording accurately creams applied and warfarin dosages given. They had also carried out a night time visit to quality assess the service in February 2018 and told us they had been addressing issues of communication with staff to remind staff of how to appropriately interact with people living at the service. However, neither had been effective in achieving improvements.

We asked people's views of the service and whether it was well led. We received mixed responses from people living there. One person told us, "Common sense is lacking a lot". Two people told us they would not recommend the home to other people.

Two people told us they would recommend the home to others. Two other people were cautious in their recommendation telling us "yes probably" they would recommend the service and another answered "it's ok" when asked if they thought the service was well run. We asked relatives their view of how the service was

run. One family member told us, "There is not a good culture." Another two family members said they thought their relative was happy there and they were happy with the service. The fourth and five relatives we spoke with following the inspection told us they had had some concerns regarding the way the service was led previously, but were heartened by the changes proposed by the provider at a meeting in March 2018, following the inspection.

Other actions the provider had taken subsequent to the inspection included additional management support at the service; remedial action regarding medicines management; an audit of health and safety at the service; brief management 'flash' meetings daily to aid communication with fortnightly management meetings starting from mid-March 2018. The provider had also involved another professional from within the organisation to support people living at the service in giving their views and addressing issues of concern raised by them.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and treatment of people using the service did not meet their needs and reflect their preferences. Regulation 9 (1)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not always ensure people were treated with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service did not ensure there were sufficient numbers of suitably competent, skilled and experienced staff to meet the needs of people living at the service. The provider did not ensure there was appropriate support, training, professional development, supervision and appraisal to enable staff to carry out the duties they are employed to perform. Regulation 18 (1)(2)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered people did not ensure that care and treatment of people using the service is provided in a safe way. This included through: - assessing the risks to people's health and safety and doing all that is reasonably practicable to mitigate and such risks; and - the proper and safe management of medicines. Regulation 12 (1)(2)(a)(b)(g)

The enforcement action we took:

WN will be issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not effectively operated to ensure compliance with the regulations. This included failures to: • assess, monitor and improve the quality and safety of the services provided; and • assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service and others. •seek and act on feedback from relevant persons on the service provided in the carrying on of the regulated activity. Regulation 17 (1)(2)(a)(b)(e)

The enforcement action we took:

WN will be issued