Wellington Healthcare (Arden) Ltd

Arden Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 7 and 12 November 2018. The first day was unannounced.

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

At the time of the inspection there were 37 people living at the home.

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

This was the first comprehensive inspection we had undertaken at Arden Court. This was because the provider, Wellington Healthcare (Arden) Ltd re-registered with CQC in April 2018 and any previous inspection ratings were not retained. This inspection was also carried out in response to information of concern we had received about the care being provided at the home.

At this inspection we identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to safe care and treatment and good governance (two parts of this regulation). You can see what action we have asked the home to take at the end of this report.

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

Medication was not always stored, recorded, administered and disposed of safely.

From checking records maintained within the home, it was not always clear if people were receiving foods of the correct consistency, which could place people at risk of choking and aspiration.

People's pressure relieving equipment (to keep their skin safe) was not always being used correctly. This included pressure relieving mattresses being operated at the wrong settings.

Accurate and contemporaneous records were not always maintained by staff. This made it difficult to establish if people's care needs were being met.

Quality monitoring systems needed to be improved to ensure the concerns found during this inspection

were identified and acted upon in a timely way through the homes own internal auditing systems.

The premises were being well maintained, with regular servicing checks of equipment and the building carried out. The home was clean and tidy throughout, with infection control procedures followed as required.

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

We found staff received sufficient training, supervision and induction to support them in their role. The staff we spoke with told us they were happy with the training they received and felt supported to undertake their work.

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

Appropriate systems were in place regarding Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA).

People told us they enjoyed the food and we saw people being supported to eat and drink, throughout the day.

We received positive feedback from people we spoke with about the care provided at the home. People said they felt treated with dignity and we observed staff treating people with respect during the inspection.

Each person living at the home had their own care plan in place which provided an overview of their care requirements and any associated risks. The home had recently started to use electronic care plans and staff used hand held devices to record people's information

There were a range of different activities available to participate in and people told us there was enough to keep them occupied during the day.

We found complaints were responded to appropriately, with compliments also collated where people had expressed their satisfaction about the care provided.

Staff meetings took place, giving staff the opportunity to discuss their work and raise any concerns about practices within the home. We observed a staff handover taking place, where an update was provided about people's care needs from that shift.

Staff spoke positively about management at the home and said the registered manager was supportive and approachable.

Policies and procedures were in place and were being reviewed regularly to ensure the information was still current.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Not all aspects of the service were safe.

Medication was not always administered safely.

From checking records maintained within the home, it was not always clear if people were receiving foods of the correct consistency, which could place people at risk of choking.

People's pressure relieving equipment (to keep their skin safe) was not always being used correctly.

Is the service effective?

Good

The service was effective.

Appropriate systems were in place regarding DoLS and the MCA.

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

We observed staff seeking consent from people throughout the inspection.

Is the service caring?

Good

The service was caring.

People who lived at the home made positive comments about the care being provided.

People were treated with dignity and respect.

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

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

Accurate and contemporaneous records were not always maintained by staff.

Complaints were responded to appropriately.

Activities were available to people to participate in if they wished to.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led.

Quality monitoring systems needed to be improved to ensure the concerns found during this inspection were identified and acted upon in a timely way.

Staff told us they enjoyed their roles and liked working at Arden Court.

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

Arden Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. The inspection was undertaken because we had not inspected Arden Court since the re-registration with CQC in November 2017.

This inspection took place on 07 and 12 November 2018. The first day was unannounced, however we informed staff we would be returning for a second day to complete the inspection and announced this in advance. The first day of the inspection was carried out by one adult social care inspector and a pharmacist inspector from CQC, a nursing care specialist advisor (SPA) and an expert by experience. An expert by experience is someone who has personal experience of caring for people in this type of service. The second day of the inspection was carried out by one adult social care inspector only.

Prior to the inspection we reviewed all of the information we held about the home in the form of notifications, previous inspection reports, expected/unexpected deaths and safeguarding incidents. We also contacted stakeholders from Salford City Council to establish if they had any information to share with us and used their feedback to inform our inspection planning.

During the inspection we spoke with a wide range of people, including the registered manager, area manager, 14 people who lived at the home, four visiting relatives, eight care staff and two registered general nurses (RGN's).

Records looked at during the inspection included 10 care plans, five staff personnel/recruitment files, 18 Medication Administration Records (MAR), training records, building/maintenance checks and any relevant quality assurance documentation. This helped inform our inspection judgements.

Requires Improvement

Is the service safe?

Our findings

Prior to our inspection we had received information of concern about how people received their medication. At this inspection our pharmacist inspector looked at medicines and medicines administration records (MARS) for 18 people and found concerns about the way medicines were managed for all those people.

On the first day of our inspection, the morning medicines round took until 11:30am to complete and the lunch time medicines round was started less than two hours later this meant that there may not have been enough time between rounds to leave a safe interval between doses. Some people were prescribed Paracetamol or medicines containing Paracetamol which must be given with a minimum of four hours between doses. Records were not always made about the time each dose was given so it was impossible to tell if each dose had been given safely.

Some people were prescribed pain relieving patches which must be applied every three days at the same time of day to ensure continuous pain relief. We looked at the records about the administration of these patches for three people. Records showed that the people did not always have their patches applied at the correct times. For example, one person had their patch applied nine hours late. We also saw that one person missed having their patch applied on two occasions and another person on three occasions.

The registered manager told us that steps had been taken to ensure patches were not missed by making sure they were applied first thing in the morning. However, the records showed that the patches were not always applied at this time. If patches are not applied at the correct times, people risk experiencing unnecessary pain. We also saw that one person's old patch was "missing" and was not found on their body when staff came to replace it. This meant the person may have suffered unnecessary pain for several hours. No records were made to check their patch was on their body each day.

One person was prescribed insulin and the records about the administration of this person's insulin did not demonstrate it was being given as prescribed.
Some people were prescribed thickener to be added to their fluids to prevent them from choking. The staff making drinks had information on their hand-held computers to tell them how thick to make each person's drinks. However, the records made about the use of thickener did not show how thick each drink was made and only half the records made showed that they had thickened people's drinks. If people's drinks are not thickened properly they are at risk of choking.

On the day of the inspection we saw that thickeners were not always stored safely. We saw that a tin of thickener was in the dining room area and other tins were stored just inside the kitchen and the kitchen door had been left open and unsupervised.

We looked at the information recorded to support the administration of medicines prescribed "as required" and with a choice of dose. We saw that no information was available to guide nurses which dose to administer when there was a choice. We looked at 17 medicines to be given when required and found 15 of them did not have a protocol to support their safe and consistent administration. The medicines prescribed

in this way included those prescribed for seizures, sickness and anxiety.

During the inspection one person had just begun to be given some "when required" end of life medicines. This administration was supported by the hospital palliative care team and two of the nurses in the home had been trained by the team. However, there was no personalised protocol to in place support the safe administration of these medicines. The nurses told us that they would ensure one was put in place to make sure that nurses on duty overnight knew how to access the support they needed to administer these medicines safely.

We looked at records about moisturising and barrier creams applied by the care staff for three people. The records about the administration of creams for two people clearly showed creams were being applied as needed. There were no records made about the application for creams for the third person, which meant their skin may not be being cared for properly. The creams were not safely stored in people's bedrooms, despite specific care plans being in place about their safe storage. Creams must be kept securely and out of view so they are not misused. The creams in people's bedrooms were all on clear view next to their televisions.

Other medicines were not safely stored. Medicines which were no longer prescribed were stored alongside current medicines which meant that they could be given accidentally. Waste and unwanted medicines were not stored safely locked away as recommended in the NICE (National Institute for Clinical Excellence) guide lines. We examined the records about waste medicines and found that the could not always evidence that all unwanted medicines had been disposed of safely.

We looked at how people were protected from the risks of choking and aspiration and found concerns about how this was managed for three people living at the home. We found each of these people had been assessed by speech and language therapy (SALT) as required a fork mashable diet. However, when we reviewed these people's food intake charts we found they had eaten foods which could place them at risk of harm. These included pork pies, toast, chicken nuggets, chicken wings, hash browns and doughnuts. These items can place people at risk of choking if they have been assessed as required a fork mashable diet.

One of the people in question had capacity to make the choice they wanted to eat toast (which is not fork mashable without the crust) and staff had appropriately referred them to SALT so a further assessment could take place. We found staff had continued to provide this person with toast whilst the assessment was pending however and a 'Feed at risk' agreement had not been implemented with involvement from the person's GP, SALT and family which could have placed them at risk. We raised these concerns with the registered manager who told us this was a recording error and that the foods would not have been served in these consistencies and that crusts for example, would have been removed from these foods.

We looked at how people were protected from the risk of skin breakdown. We saw people had specific skin integrity care plans in place and risk assessments in place, which provided staff with an overview of the care people required. Many people living at the home also needed to be re-positioned in bed to help keep their skin safe and we saw records demonstrated this was done regularly by staff. We saw that in three people's bedrooms, pressure relieving mattresses were in use. However, we saw these were not being maintained at the correct settings meaning they would not be providing people with the correct level of pressure relief. We raised this with one of the nurses and were told they could have been altered by the maintenance man. However, staff were not checking these consistently to ensure they were working properly.

The concerns relating to medication, choking/aspiration and skin integrity meant there had been a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to safe

care and treatment.

People living at the home said they felt safe. One person said, "I definitely feel safe and content, as I like it here. I am very happy." A relative also added, "My husband is in a safe place. I couldn't have asked for anything more."

We checked to see there were sufficient numbers of staff working at the home to care for people safely and viewed a sample of the home's staffing rotas. The staffing ratio on shift consisted of a nurse and three care assistants at night and two nurses and nine care assistants during the day. In addition, there were also staff who worked in the kitchen and domestic staff who undertook cleaning duties. The home also had an activity co-ordinator and administrative staff. This was to provide care and support to 37 people. Certain people spent their time being cared for in bed. Others spent the day in the dining area and we observed staff checking on people in their rooms to see if there was anything they needed and bringing them drinks. We saw call bells (used by people in their bedrooms) being answered promptly by staff and we did not observe people waiting unreasonable lengths of time for assistance.

We looked at how the service managed risk. Each person had a series of risk assessments which contained information to manage any risks posed to them. Risk assessments in place covered areas such as waterlow (for people's skin), mobility, bed rails and nutrition. People's care plans also contained detailed information about how risks could be mitigated. For example, where people were at risk of falls and needed to use specific equipment, such as walking frames, we saw this was always available. (for them during the inspection).

Appropriate systems were in place to monitor accidents and incidents. These were investigated and preventative measures put in place to keep people safe and mitigate any further risk. Trends analysis was completed to monitor any re-occurring events, such as repeated falls. Personal emergency evacuation plans (PEEPs) had been completed for each person and provided emergency services and staff with an overview of how people needed to evacuate the building safely.

Staff recruitment was safe. We looked at five staff recruitment files and noted they contained documents and checks such as photographic identification (ID), application forms, references, interview questions/responses and job offer letters. Disclosure and Barring Service (DBS) checks were also undertaken to ensure that new applicants did not have any criminal convictions that could prevent them from working in a care setting with vulnerable people. We noted that all of these checks had been carried out in advance of staff commencing employment.

There were systems in place to safeguard people from abuse. These included having a safeguarding policy and procedure for staff to refer to if they encountered any allegations of abuse. The training matrix showed staff had received training relating to safeguarding and staff spoken with demonstrated a thorough understanding of how to recognise signs of abuse and report their concerns. Staff told us they were aware of whistleblowing (used to report any bad practice within the home) procedures and said they would not hesitate to use them.

The premises and equipment were well maintained and we saw certificates and relevant documentation of any work that had been completed. These included checks of electrical installation, fire alarms, legionella, portable appliances, hoists/slings and fire equipment. Any remedial work or recommendations had been followed up on to ensure the premises were safe to be used by people living at the home.

We looked at the systems in place with regards to infection control. We observed domestic staff undertaking

various cleaning tasks the morning of our inspection and noted that the home smelt fresh with no odours present. We checked in bedrooms, toilets, bathrooms and communal areas and found they were clean and tidy and staff wore appropriate personal protective equipment (PPE) to reduce the risk of any infections being spread.

Good

Is the service effective?

Our findings

People living at the home told us they felt staff had the correct skills to provide effective care. One person said, "A number of staff are being shown the rope by the girls as they have just started. So, they are being trained on the job as well to make sure they know what they are doing."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found DoLS applications were made where people had been assessed as lacking the capacity to consent to the care and treatment they received. A central 'tracker' was also used to monitor applications and they were due to expire.

Where people living at the home had potential restrictive measures in place and lacked capacity, such as the use of bed rails and lap belts to help prevent falls from bed and wheel chairs, decision specific assessments were carried out to establish if people were able to understand their use. People's families who acted as their lasting power of attorney were involved in people's care as required. Lasting power of attorney means that friends or family members take responsibility for providing consent to people's care and treatment if they lack capacity. During the inspection we observed staff seeking consent from people prior to providing any assistance with tasks such as entering people's bedrooms and asking people if they would like to wear an apron at meal times to protect their clothing if they spilled their food.

We looked at how people's nutrition and hydration needs were being met. We saw people had nutrition care plans and risk assessments in place providing an overview of their dietary needs. People's body weight was kept under review, with some people needing to be weighed on either a weekly or monthly basis. Nutritional assessments were completed and provided an overview of the level of risk presented to people regarding their nutritional status. We saw the home responded appropriately where people had lost weight and provided people with prescribed drink supplements to help them either maintain or gain weight. These were clearly documented on people's MAR charts when they had been given. Referrals were made to the dietician service where people were identified as losing weight.

Records relating to advice from other health care professionals such as dieticians, was not always clearly documented within people's food charts. We have reported on this further within the responsive section of this report relating to record keeping.

We observed the lunch time meal to look at how people were supported to eat and drink. We saw people's independence was promoted at meal times, with people being encouraged to eat their own meals if they

were able to. Tables were set with condiments in advance of the meal, with staff available to assist people as required.

Newly recruited staff followed a formal induction programme and were required to undertake a range of mandatory training when they commenced employment. Staff also told us they were introduced to other people and were given the opportunity to 'shadow' existing and experienced members of staff to gain an understanding of the role. The care certificate was also completed for staff who had not worked in a care setting previously. The care certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It's made up of the 15 minimum standards that should be covered if staff are 'new to care' and forms part of the internal staff induction.

We looked at the training staff were provided with to support them in their roles, with both practical and computer based training available. The current training matrix showed staff had received training in areas such as moving and handling, safety, safeguarding, infection control, first aid, COSHH (Control of Substances Hazardous to Health), health and safety, medication and MCA/DoLS. Each member of staff we spoke with told us they were satisfied with the level of training available at the home.

Staff received supervision to support them in their role and we saw records of this documented. Regular supervision meant staff were supported to discuss any concerns regarding staff or people who used the service, their own development needs and encouraged to make suggestions for continual improvement. Staff appraisals were also carried out where staff had worked at the home for longer than a 12 months period. This enabled staff to receive-feedback on their performance during the year and evaluate their own performance and how they felt they were progressing.

People were supported to maintain good health. Staff at the home worked closely with other health care professionals and we saw referrals were made to services such as the falls prevention team, dieticians and podiatry service, if there were concerns about people's health or safety.

Good

Is the service caring?

Our findings

We asked people living at Arden Court for their views and opinions of the care they received and if they felt staff were kind and caring towards them. One person said, "I have been here 18 months now. I am very comfortable here. All the girls are very nice to me." Another person said, "There are good staff here. One or two staff will help to get me into a shower and they are very nice with me when assisting me." Another person added, "I like it here. People here are very good, nice and kind." A visiting relative also told us, "Mum has been here since January. Care is good and the staff are excellent. Absolutely tops. Some nurses are very good."

People who lived at the home and relatives told us staff were caring. One person said, "Staff are fantastic. Can't do enough for you. Just go to the manager, she listens to you. All the nurses and carers are very good. They are understanding, kind and polite. They are always popping in to check if I am all right. Care is 100%. Very gentle with me, couldn't ask for anything better."

During the inspection we observed staff interacting with people in a kind and friendly way. We observed staff sitting with people in communal areas and pleasantly speaking with them which people seemed to enjoy. People were dressed appropriately and we did not see anybody looking unclean or unkempt, with staff maintaining records of when people had received a bath, shower and full body wash. In one person's care plan it stated how staff needed to make sure they were dressed smartly and we observed them wearing trousers with a matching striped top.

During the inspection we observed staff treating people with dignity and giving them privacy if they needed it. People told us they felt well treated and were never made to feel uncomfortable or embarrassed. We observed staff knocking on people's doors before entry and then closing it behind them when delivering tasks such as personal care. We also saw people's window curtains were closed overnight so that people could not see into their bedroom from outside. A dignity notice board was on display on the ground floor and this detailed the main principles staff should bear in mind when delivering care. One member of staff was a dignity champion and their responsibility was to make sure these principles were upheld.

People's independence was promoted by staff and we saw people being able to eat their own meals and mobilise using equipment such as wheelchairs without the assistance of staff. People were able to make choices about how they spent their day, whether this be in the lounge area, or the comfort of their own bedroom.

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. Signage was clear and of a suitable size with good contrast between the text and the background to allow them to be read more easily.

There were systems in place to facilitate communication between staff and people who lived at the home. People's care plans provided an overview of their communication requirements and if they needed any

specialist equipment such as glasses or hearing aids. In one person's communication care plan, it stated they had poor eye sight and were nearly blind in one eye. Staff needed to make sure the person's glasses were in reach for them at all times. However, we observed this person in bed, where they were cared for and their glasses were on a cabinet at the far side of the room, out of reach. They also wore bilateral hearing aids and needed to be worn throughout the day. Again, we saw these were not being worn and were also at the other end of the room, out of reach. We raised the issue with a member of staff, who then promptly supported the person to put them (glasses and hearing aids) both on.

People's equality, diversity and human rights were respected and recorded as part of the care planning process. At the time of the inspection, there was nobody living at the home who had any specific cultural requirements. People of all faiths were welcome at the home and we were told their religious beliefs would be taken into account as required. This information was also captured within people's care plans.

Requires Improvement

Is the service responsive?

Our findings

People living at the home told us they received a service that was responsive to their needs. One person said, "All of my needs are met. I have no complaints or suggestions that could make it any better."

We checked to see if accurate and contemporaneous records were being maintained by staff. One person had been seen by the dietician service in August 2018, with an action plan then implemented for staff to follow. One of the actions was for them to be given full fat milk in between meals to help them gain weight. This was not being documented on the person's food charts however as being either offered, or refused by staff.

The home used an electronic care planning system which detailed information about people's assessed needs and the care and support they needed from staff. Staff also used separate hand-held devices to record when certain aspects of people's care had been attended to. We found these accurate records were not always being maintained. For example, the charts indicated people's nails and teeth were not always being cleaned and that bed rails were not always being checked to ensure they were in good working order.

Not all people had an oral care, care plan in place to inform staff about the assistance they may need to clean their teeth. Staff were not always clearly recording on the system if people's care had been delivered by either one or two members of staff. This was because both staff were not signing when interventions had been carried out.

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

Before people moved into the home, an assessment of their needs had been carried out. This enabled staff to establish the care and support people needed. Each person living at the home had their own electronic care plan in place, covering areas such as mobility, nutrition, hygiene, skin integrity, continence and sleeping. During the inspection we looked at 10 people's care plans, which provided a detailed overview of the care staff needed to deliver to people. These care plans were reviewed each month to ensure the information was still an accurate reflection of people's care needs. Personal information of importance to people had been gathered and captured. This person-centred information included their parent's background, schools attended, memorable places, work and hobbies/interests.

We looked at the activities available within the home to ensure people were kept stimulated and had enough to do. The home employed a full-time activities coordinator and activities were available for people either as a group, or in one to one sessions. Activities available within the home included external entertainers visiting the home, arts and crafts sessions with pupils a local school, quiz afternoons, film afternoons, reminiscence, cake decorating, play your cards right and ball games. Events throughout the year were also celebrated such as valentine's day, Halloween and Christmas parties. Childhood memories were

on display in corridor areas and pictures of memorable parts of Eccles (where the home is located) were displayed which people could relate to. Several people living at the home had also been involved in a pen pal scheme and written and received letters from other residents living at another care home in Salford. One person told us this was something they enjoyed doing, as they done this when they were younger and we saw some of the letters were on display in their bedroom.

There were systems in place to involve and seek/respond to feedback from people living at the home, relatives and also staff, in the form of satisfaction surveys and residents/relative meetings. This gave people the opportunity to raise any concerns about the service, or provide feedback about things that were working well so the home could continually improve. A notice board titled 'You said, we did' was displayed on the ground floor of the home, informing people of things done following on from feedback.

We looked at the systems in place to investigate and respond to complaints. A central log of any complaints made was held within the home, including details about who had raised the complaint, what the issue was, details about the investigation and the outcome. We saw that where any complaints had been made, a response had been provided with any actions to be taken. A complaints policy was in place, which explained the process people needed to follow which was also displayed on the wall near to the entrance of the home. Compliments were also collated where people had expressed their satisfaction about the care provided at the home.

We looked at the systems in place regarding end of life care. People had end of life care plans in place, capturing information about people's preferences in the event of death such as people to inform, funeral arrangements and if they wished to be buried, or cremated. Anticipatory medicines (used when people are approaching end of life) were in stock and ready to be used by staff when required. DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) forms were completed and took into people's preferences about allowing a natural death to occur.

People living at the home were supported to maintain relationships as much as possible, with no restrictions on visiting times and we saw people's relatives visiting throughout the day.

Requires Improvement

Is the service well-led?

Our findings

There was a new registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, 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.

Arden Court is owned by Wellington Healthcare (Arden) Ltd, with a head office based in Southport. A staffing structure was in place and the work of the registered manager and staff was overseen by a provider representative, who visited the home to see how things were going and carry out audits to ensure standards were being maintained. The registered manager was further supported by nurses and care assistants, some of whom had worked at the home for a number of years and displayed a detailed knowledge of people's care needs. The home were also in the process of recruiting a deputy manager at the time of the inspection. The home also employed maintenance, domestic and kitchen staff who carried out their duties around the home as required.

The staff we spoke with during the inspection told us there was a good culture amongst staff. We observed staff working well together and assisting people with their care such as assisting people at meal times and helping people in their bedrooms. Staff told us they were happy working at the home and felt well supported in their roles.

We received lots of positive feedback about management and leadership within the service. The feedback we received, without exception was that the registered manager was approachable, supportive and responsive to any issues that were raised. One member of staff said, "If we have any concerns then they get sorted out." Another member of staff said, "Yes I think management is good and I feel supported to do my job."

We looked at the systems in place to monitor the quality of service being provided to ensure good governance. A range of internal audits were in place that were completed, covering areas such as weight loss, pressure sores, infection control, falls, medication and staff competency, care plans and hand hygiene. Checks of night staff were also undertaken to ensure high standards were being maintained. Whilst these checks were in place, overall quality monitoring systems needed to be improved to ensure the concerns found during this inspection were identified and acted upon in a timely way. For example, regarding the concerns found during the inspection relating to medication, pressure care, choking/aspiration and record keeping.

These issues meant there had been a breach of regulation 17 (part 2, a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to good governance. This was because there had been a failure to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.

Team meetings (for both day, night, domestic and kitchen staff) were held, giving staff the opportunity to

raise any concerns effecting their work and receive feedback about aspects of their work. The registered manager told us they had introduced a system called the 'Proud jar' and this was used to collate any special achievements from staff and boost morale within the home. Staff handovers also took place between day and night staff to ensure any concerns, or changes to people's care needs could be communicated effectively and we observed these taking place during the inspection.

The home had policies and procedures in place which covered all aspects of the service. These were developed and updated by the provider. Staff were aware of where these documents were kept and how to access them should they require any advice, or support.

Confidential information was stored safely, with information such as staff recruitment and supervision/appraisal documentation held securely. People's care plan information was stored on an electronic care planning system which was password protected to ensure access could be restricted.

Registered care providers must submit statutory notifications to CQC when certain incidents such as safeguarding concerns, serious injuries and expected/unexpected deaths occur. This enables CQC to follow these up accordingly and make further enquiries if needed. We found the registered manager submitted notifications to CQC as required.

The ratings of previous CQC inspection must be displayed within the home and on any corresponding websites operated by the provider. This is to enable people using the service and their relatives to know the standards of care being provided. We will review this at our next visit, due to the fact this was the first inspection of the service since the provider re-registered with CQC in April 2018.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Appropriate systems were not in place to ensure people received safe care and treatment.

The enforcement action we took:

We issued a warning notice regarding this regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Appropriate systems were not in place to ensure good governance.

The enforcement action we took:

We issued a warning notice regarding this regulation.