Banyan Residential Care Limited

Arbory Residential Home

Inspection report

London Road
Andover Down
Andover
Hampshire
SP11 6LR

Tel: 01264363363
Website: www.arbory.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 26th February 2018 and 5th March 2018 and was unannounced.
The Arbory Residential Home 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.
The Arbory Residential Home accommodates up to 60 people who are living with dementia. Accommodation is in two adjoining buildings, the Court, a purpose built three storey extension and the Lodge, an adapted building over two floors both were accessible with stairs and passenger lifts. There are extensive accessible grounds and gardens. When we inspected 58 people were living at the service.
There was a registered manager in post. A registered manager 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.
People were kept safe from harm and staff were trained in safeguarding and knew how to report concerns. Risks were assessed and actions taken to minimise residual risks without impacting on people's rights.
There were sufficient trained staff deployed to support people and provide high quality care. Recruitment practices were robust and appropriate checks and training were in place before staff commenced in post.
People were supported to maintain their health and well-being and their nutritional needs were met.
People were given choices and control over their lives. The service complied with the principles of the Mental Capacity Act and Deprivation of Liberty Safeguarding. Controls in place were in the best interest of people and were the least restrictive option.
Positive working practices were in place with other professionals such as district nurses, community psychiatric nurses and GP's. A multi-disciplinary approach was taken when risk assessing and care planning.
Medicines were safely managed. Staff were trained in giving medicines and were checked for competence before administering them unsupervised.
There were activities to involve and entertain people both within the home and the local community that were appropriate to their needs.
People received person-centred care that was delivered with kindness and compassion. Staff were caring and empathetic towards people. Behaviours were managed as 'fear behaviours' and staff changed their approach to support people.
There was a positive and inclusive culture in the service. The service's ethos was to provide a home, not a care home and people were friends and not patients. This was embedded in and evident in staff practice.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Previous concerns about risk assessments had been addressed and there were detailed and regularly reviewed risk assessments reducing the risk of harm to people and staff.

There were sufficient, well trained staff deployed to effectively meet the needs of people and to offer support on a 1-1 basis. Staff recruitment practices were safe and relevant checks were completed before staff commenced in post.

Medicines were managed safely. Medicine cabinets were secure, clean and uncluttered. Care plans were in place and people told us they received medicines as prescribed.

There was an infection control champion who raised awareness of infection control and ensured staff were aware of good practice guidelines.

Is the service effective?

Good

The service was effective. Staff were trained to provide effective, compassionate and person-centred care. Staff received regular training and supervision and were aware of current best practice guidelines.

Nutrition and hydration were monitored and there was access to snacks and drinks at all times. People and staff had meals together and support was given in a respectful way. Mealtimes were a social event which encouraged people to eat.

There was good access to healthcare and the service worked in partnership with district nurses in providing end of life care. Weights were monitored using the MUST tool.

A pressure care champion had been appointed and had promoted good practice in the prevention and management of pressure sores.

The service was suitably adapted to meet people's needs. All areas, including the gardens were accessible and people were able to move around the service as they wished.

Is the service caring?

Good

The service was caring. People, their relatives and visiting professionals told us that staff were caring and treated people with dignity and respect.

People were involved in developing their care plans. Staff knew people well and provided care that reflected their preferences, likes and dislikes.

Staff were unhurried when providing care and were encouraged to spend quality time with people chatting and reassuring them.

Is the service responsive?

Good

The service was responsive. People had clear care plans that were regularly reviewed and adjusted to meet their changing needs..

People and their relatives were involved in developing their care plans.

People participated in a varied range of activities relevant to their interests.

Information on how to make a complaint was available and complaints were responded to in a timely and thorough manner.

Partnership working with district nurses provided people with a dignified end of life. If there were no relatives, staff would sit with people and no-one was alone at the end of their life.

Is the service well-led?

Good

The service was well-led. There was an open culture and the management team were accessible to people and staff.

There was a strong registered manager who led by example and ensured the services values were embedded in staff practice.

Staff told us they were supported and encouraged to make suggestions to improve the service.

There were quality assurance systems in place and questionnaires completed by people and their relatives provided positive feedback.

There was a commitment to 'make each day the best it could be' and to provide excellent dementia care.

The registered manager shared his expertise with staff, relatives and the community through information sessions.	

Arbory Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 26th February 2018 and 5th March 2018 and was unannounced. The inspection team consisted of one inspection manager, one inspector and two experts-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.

Before our inspection we reviewed previous inspection reports and the notifications we had received from the service. A notification tells us information about important events that the registered manager is required to tell us about. We requested feedback about the service from local health and social care professionals. The provider had also completed a Provider Information Return. This is information supplied to us by the service at once annually which provides key information about what they do well and any forthcoming improvements. We used this information to help us decided what areas to focus on during our inspection.

During our inspection we spoke with the registered manager, the deputy manager, one senior support worker, one support worker, the head of housekeeping, seven relatives and 14 people living at the service.

We pathway tracked three people using the service. Pathway tracking follows a person's experience of the service and gets their views on the care and treatment. We looked at staff files, training records, recruitment files, duty rotas, supervision records and reviewed the services policies and procedures. We observed care being delivered in communal areas and interactions between staff and people at the service.

We previously inspected this service on 20th January 2016 when we noted that risk assessments needed to be improved. Overall in 2016, the service was rated as good.

Good

Is the service safe?

Our findings

People and their relatives told us the service was safe. One person told us "I've never felt not safe here, the staff are lovely, I've never had any problems". A relative told us "she's definitely safe here. She's been here a number of years now….and she's absolutely fine". Another relative told us "I have no worries about (person)'s care. All the staff are lovely".

Our last inspection had identified that risk assessments needed to be more robust and provide more detailed guidance on how staff should respond to behaviour which others might find challenging. This inspection found that improvements had been made. The risk assessments viewed were person centred, detailed regularly reviewed and supported staff to deliver safe care. For example, people had risk assessments of moving and handling, falls, the use of bed rails and medicines.

Where risks had been identified, assessments from professionals had been undertaken to inform people's care plans. For example, the speech and language therapist had provided guidance about how to manage problems with swallowing and the use of drink thickeners. This information was available to all staff either via a handheld device or through a computer. This ensured all staff were working from current risk assessments and care plans. This also gave the registered manager instant information on a daily basis assisting with managing existing risks and new risks.

People were protected from abuse by staff who had good knowledge of safeguarding, how to identify possible abuse and how to report it. Staff completed safeguarding training and the registered manager alerted the local authority and completed notifications if abuse was suspected.

There were sufficient staff to meet people's needs. A total of 14 support staff were deployed over the two buildings each day. In addition two activities officers, senior support workers, domestic staff and a catering team were also deployed. We observed people being supported by staff when they needed it and noted there were staff in communal areas at all times. Rota's provided evidence that staffing levels were maintained at this level.

Medicines were managed safely. Medicines care plans detailed how people liked to take their medicines and person centred protocols in place describing how and when people might need their 'as required' or PRN medicines.

Medicines storage was clean and uncluttered and temperatures of the medicines cabinet and room were taken and monitored daily. Medicine administration records or MAR's were completed and no errors were seen. There was a clear process to follow in the event an error occurred. Stock checked was correct and items for disposal were labelled. We noted that disposal records were not easily read due to being carbon copies. we suggested taking a photocopy of the original record before it was removed by the chemist so a clear record was retained in the service.

Supplies of personal protective equipment (PPE) including gloves and aprons were available. Staff were

observed using appropriate PPE when supporting people. Staff were trained in infection control procedures and the home was clean in appearance and there were no unpleasant odours during our inspection. There was an infection control champion in place who completed an audit and ensured staff were working according to current best practice.

Recruitment practices were safe. We checked the files of three staff members recruited since our last inspection. Necessary checks, including receiving two references and a Disclosure and Barring Service (DBS) check before people started in their post had taken place. The DBS check highlights potential issues around criminal convictions and shows if someone is barred from working with vulnerable people. This ensures that people employed at the service are suitable to work there.

Good

Is the service effective?

Our findings

People told us that the food served was appetising and high quality. A relative told us that her family member had begun to eat more when they moved to the home. "The dining room is cosy, like a homely café. They actively encourage people to eat and eating communally really helps".

Meals and drinks were prepared to people's preferences and needs. A choice of meals was offered, sample plates were shown of the food if people did not recognise a verbal choice. There were two main choices and a vegetarian option available at each meal. Food was available when people wanted it, alternatives to the menu were prepared if someone had an allergy or did not like what was available. Plates of finger food were also offered if people were reluctant to eat meals, and snacks and drinks were always available. Pureed foods were presented using moulds of food types to make them familiar and more appealing. A staff member told us "The moulded, pureed food looks aesthetically pleasing and has made a huge difference, people now eat really well". Nutritional risks were managed, for example, where necessary records were kept of food and fluid intake.

Assistive technology was in use, motion sensor beams alerted staff to people moving who were at risk of falling as an alternative to sensor mats which had proved ineffective in the home. There was a nurse call system, mainly used by staff members that was discreet and not disruptive to people as it alerted using pagers rather than an audible alarm.

Staff members had regular supervisions and participated in an in-depth induction when they commenced their employment. For example, staff completed one day learning about the philosophy of care at the service and one day learning about dementia as part of their induction alongside mandatory training. A new online training system had been introduced providing mandatory training, the Care Certificate and a range of other training courses that staff could choose to complete.

The registered manager facilitated an annual training day focussing on dementia awareness for members of the community. Over 30 people attended the last event. A relative told us "It was the best three and a half hours ever spent, even how to approach family members etc. He says you have to go to their level". Trying to understand how someone with dementia saw things was a theme the relative found useful.

Staff communication was effective. A daily meeting 'huddle' kept senior staff members informed about the events of the previous 24 hours and plans for the next 24 hours. Information about people's health, pressure sores and expected visitors such as an advocate were discussed and planned actions agreed.

The premises were mainly in good decorative order. People were encouraged to personalise their rooms with items from home to create a feeling of familiarity. There was a wall mounted memory box outside each bedroom holding photos and mementos that held meaning for the person and helped them recognise their room.

There were a number of seating areas people used to entertain visitors or spend time alone. There were

also communal lounges and dining areas where activities took place in both buildings. There were many pictures on walls which were chosen both because they were eye catching and may be a 'landmark' for people and for their use in reminiscence activities. Old movie posters, advertising and vintage images were on display. There were also objects left about the home to act as triggers for peoples memories.

Staff were seen to offer people's choices and seek their consent before providing care. 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. Staff showed a good awareness of the principles of the MCA 2005. Capacity assessments were completed and when needed best interest decisions had been made.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS applications had been made appropriately and for a number of different reasons.

People had good access to health professionals. When people were admitted to hospital, they were sent with a 'hospital pack' of important information to enable continuity of care.

Good

Is the service caring?

Our findings

One person told us, "The care is outstanding, they take time with me". A relative said, "She is definitely cared for here and very respected. They know her well – what she likes and so on." A GP told us "staff seem to know the residents well and treat them with courtesy and kindness, and are responsive to their needs." We were told by a healthcare professional "There is a distinctly family atmosphere in the residential home and staff emphasise their individualised and often informal care."

Information about people's lives before they moved to the care home was available in the care record. Their personal preferences were reflected in person-centred care plans, how they wished to be supported and how best to communicate with them.

Staff were attentive and reassuring when providing care. For example, a person was being lifted in a hoist by two support workers; they explained every move and kept close eye contact. The person was smiling and engaged during the process. Staff praised his efforts and were kind and caring. The person commented "That's typical, that's how they are – all the time". At lunchtime we saw staff and people seated together enjoying their meals. People were given the support they needed in a discreet way and care was not hurried.

Staff respected that the care home was people's own home. For example, people were not referred to as residents but staff referred to them as 'friends'. Staff also considered that they were guests in people's homes rather than at work. They chatted with people and were person-centred not task focussed. All staff members were employed first and foremost as carers, whether they were support workers, domestic staff or management, if someone needed care and support this would be the priority. One staff member who was not a support worker told us that they would "Stop, sit and talk to friends, as if they ignored them and said it wasn't their job, the friend may become angry or frustrated". The atmosphere was warm and welcoming during our inspection.

Staff spoke with people as they moved about the service. They were familiar with people and asked how they were and if they needed anything. Conversations were meaningful as staff had good knowledge of people. In activity sessions there were happy and fun interactions and a familiarity which was professional but put people at ease.

We observed staff interacting with people in a friendly and caring way. First names were used and staff were able to support people who were becoming upset using their in depth knowledge of them. A person who had an office based career joined some meetings and made notes giving them pleasure and a sense of worth.

Staff were caring and thoughtful. For example, behaviours that challenge were referred to as 'fear behaviour's' and when seen, staff would consider what they may have done to cause the behaviours and what actions could they take to reduce them. Behaviours were not seen as a challenge, just a person responding in fear when they felt upset or threatened.

People and their relatives were able to be involved in the day-to-day running of the service. Residents meetings were held regularly and people were supported to be involved.

People's dignity and privacy was maintained. Staff described how they would ensure doors and curtains were closed when providing personal car cover the person as much as possible.

People were able to move freely between the two main units, they were not restricted to the floor or building they resided in. This enabled interactions with different people and staff, enhancing the experiences of people living at the service.

The provider had employed a culturally diverse workforce helping to ensure that people's cultural needs were met. For example, a person for whom English was not their first language had thrived when a staff member had spoken to them in their own language. There was access to ministers from different churches and regular opportunities to join in communion services.

Good

Is the service responsive?

Our findings

People were assessed before they came to live at the service to ensure their needs could be met. The care they received from the service was person-centred and responsive to their individual needs. The service's policy on care planning stated 'Planning care is user-centred. A plan of care will never be made without the active participation of the person to whom they relate, or where necessary their representative.' Information in care plans about people was from families or individuals and provided staff with their view of what they needed.

A healthcare professional told us that they worked in partnership with staff to assess and devise care plans for people as well as working together to set up behaviour plans. Care plans were clear and available to the staff that needed them and covered a broad range of areas including healthcare, personal care, mobility, medicines and nutrition.

Care plans were reviewed regularly and changes were communicated to staff through the electronic care records. Both full care plans and care plan summaries were available to staff through their hand held devices. Senior support workers several times a day to ensure care tasks had been completed and records updated appropriately.

Activities were available to people throughout the day. We saw people joining in with a quiz, singing and having one-to-one time with staff members. The activities coordinator arranged for each month to have a specific theme and held regular special events such as a haunted house experience, visits from a farm with animals, and alpacas who visited each floor of the service. Some events were opened to friends, families and the community.

The service provided items that people could use for reminiscence activities such as a silver cross pram. A car had been sourced for residents to sit in to stimulate memories. In the grounds there were chickens, an aviary, allotment beds and, in the summer, an ice cream stand.

Activities on a day to day basis included baking, arts and crafts, exercise and armchair Zumba, a community focussed day when people from the community such as school children visited and entertainers such as a musician or a singer performed on Fridays. A recent addition was a music therapist who was working with people in later stages of dementia.

The activities staff also used sessions to encourage people to eat and drink. Towards the end of the morning session, conversations were guided towards food topics, engaging people in conversations about their own food preferences so they began to think about their forthcoming meal.

Information was provided for people in ways that were appropriate to them. There were signs around the premises to support people to find bathrooms and toilets however the registered manager told us that they did not use a great deal of signs and symbols as the people living in the home had not responded well to them. They told us that due to being in later stages of dementia people did not recognise signs and there

had been limited benefits to using them.

There was a complaints policy and procedure available to people and visitors. During our inspection the service dealt with a complaint. Their response was appropriate, prompt and resulted in a change to service policy which was immediately communicated to staff. The complainant was very satisfied with the actions taken by the service.

The service does not provide nursing care but works in partnership with community health professionals to provide end of life care. Placements for people are considered to be permanent so end of life care plans were considered with most people and their families from admission. People were not alone at the end of their life, staff members sat with people who would otherwise be alone. Anticipatory medicines were held for people approaching the end of their life. Relatives were supported throughout their family members end of life care and also after they had died. A memorial garden commemorated people and staff were supported during and after the loss of a person.

Good

Is the service well-led?

Our findings

The mission statement of the service was, 'To improve the life experiences of all those around us'. The registered manager told us "We use the term friends here as opposed to residents, we create a family philosophy, we don't wear uniforms, team members share food together and the atmosphere is relaxed." The service had a homely feel, meal times were social events and people and staff enjoyed informal but appropriate familiarity.

People and staff were familiar with the management team and directors of the service. There was an 'open door' approach and management were usually available to people. All feedback about the registered manager was positive, a staff member told us "The manager is the most approachable person I've ever known. I'd never worry about approaching him, he'd always listen". A relative told us, "I've always been impressed by the manager and their knowledge of dementia so I'm happy for (person) to be here." The manager and director were familiar with everyone using the service and spoke to them and their relatives using first names and were aware of the person's condition and well-being at that time.

A quality assurance questionnaire completed by people and their relatives in January 2018 generated outstanding or good feedback about the care provided. People and their relatives were also able to provided feedback at the monthly resident meetings. Staff and senior staff had designated meetings and were able to discuss issues, concerns and ideas for improvement with management at their supervision meetings or on a more ad hoc basis.

Service quality was monitored using audits including reviewing accidents and incidents, care delivery and medicines. Policies and procedures were also reviewed annually or as required. The service was receptive to learning from experiences and had recently updated procedures as a result of such learning.

Staff members were encouraged to complete online training courses which could contribute to qualifications in future. Qualification training was offered to staff and they received extensive dementia training from the registered manager. Staff, relatives and community members had participated in virtual dementia training and the service ran community sessions to raise awareness of dementia and how best to support people living with the condition.

Staff have recently been appointed as champions for the service. Senior staff members have been tasked with championing moving and handling, pressure care, medicines, infection control, safeguarding, dementia, end of life care, nutrition and hydration and health and safety. The pressure care champion told us they had been supported to learn about pressure care, to forge strong links with district nurses and GP surgeries and set up systems to aid in monitoring and treating sores. There were three recent ulcers, all of which had either healed fully or made significant progress due to the champion who was good motivator for the team and extremely enthusiastic in their role. The champion role was promoted by the registered manager who was keen to develop the skills and knowledge of the team and enhance the service provided.

The service has positive community links. Local schools were involved in art projects in the services garden

and volunteers from the community supported the service. Plans are in place to run partnership events with a dementia group and the registered manager had spoken at national conferences on dementia. These initiatives will broaden the experiences of people living in the home and ensure that the registered manager remains current in their knowledge.