PureCare Care Homes Limited

Arden House

Inspection report

73 Arden Street
Gillingham
Kent
ME7 1HS

Tel: 01634280703

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was carried out on 27 March 2018. The inspection was announced.

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

Arden House accommodates up to three people who are experiencing mental health difficulties. Arden House is a small terraced house. There were two people living at the service when we inspected.

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. The registered manager was off sick. The provider had appropriate management support in place to cover. An acting manager had been put in place who was supported by a registered manager from one of the provider's other services.

Risks had not always been appropriately assessed and mitigated to ensure people were safe.

Medicines had not always been managed safely. Records had not always evidenced that people had received their medicines as prescribed.

Effective systems were not in place to enable the provider to assess, monitor and improve the quality and safety of the service. Although policies and procedures had been reviewed and updated they did not always relate to the most up to date regulation and guidance.

People were very happy with their care and support. Staff had built up good relationships with people.

Health and social care professionals were complimentary about the service people received.

There were enough staff deployed to meet people's needs. The provider operated safe and robust recruitment and selection procedures to make sure staff were suitable and safe to work with people.

Staff knew what they should do to identify and raise safeguarding concerns.

The service was clean, tidy and equipment had been properly checked.

People were encouraged to make their own choices about everyday matters.

People's care plans clearly detailed their care and support needs. People were fully involved with the care

planning process including identifying triggers, signs and actions to address their mental health needs.

People were encouraged and supported to engage with activities that met their needs. People accessed their local community independently and with the staff.

People had choices of food at each meal time. People purchased their own food and were given a weekly allowance for this. Some people prepared and cooked their meals independently and some people had support and encouragement to prepare and cook meals. People were supported and encouraged to have a varied and healthy diet.

People were supported and helped to maintain their health and to access health services when they needed them.

Staff were cheerful, kind and patient in their approach and had a good rapport with people. The atmosphere in the service was calm and relaxed. Staff treated people with dignity and respect. The service was small and homely.

People were supported to maintain their relationships with people who mattered to them.

People knew who to talk to if they were unhappy about the service. There had been no complaints about the service.

People told us that the service was well run. Staff were positive about the support they received from the management team. They felt they could raise concerns and they would be listened to.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks had not been appropriately assessed and mitigated to ensure people were safe.

Medicines were not always managed safely.

There were enough staff deployed to meet people's needs. The provider had followed safe recruitment practices.

Staff knew what they should do to identify and raise safeguarding concerns.

The service was clean, tidy and equipment had been properly checked.

Is the service effective?

Good

The service was effective.

Before people moved to the service their needs were assessed. People were encouraged to discuss their sexuality or lifestyle preferences as well as their rights, consent and capacity.

People had choices of food at each meal time which met their likes, needs and expectations. People were supported to be as independent as possible with preparing and cooking their meals.

Staff had a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People were supported to make choices about all elements of their lives.

Staff had received training relevant to their roles. Staff had received supervision and good support from the management team. Staff had a good understanding of the Mental Health Act 1983. Staff supported people effectively in understanding and complying with any conditions of Community Treatment Orders which enabled them to live at the service.

People received medical assistance from healthcare professionals when they needed it.

The service worked in partnership with health and social care professionals to ensure that care and support was consistent.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect. People had good relationships with staff and enjoyed their company.

People were involved with their care. Peoples care and treatment was person centred.

People were able to contact their relatives and friends when they wanted to and were supported to maintain contact with their relatives.

Is the service responsive?

Good

The service was responsive.

People were provided with the care they needed, based on a care plan about them. People had been involved in developing and reviewing their care plan.

People could take part in activities and socialise according to their lifestyle choices.

People knew how to raise concerns and complaints. The complaints policy was prominently displayed in the home.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems to monitor the quality of the service were not always effective. Policies and procedures required updating.

The management team had reported incidents to CQC.

Staff were aware of the whistleblowing procedures and were confident that poor practice would be reported appropriately.

Staff were positive about the support they received from the management team.

Arden House

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 27 March 2018. It was announced. We gave the service 48 hours' notice of the inspection visit because the location was a small care home for younger adults who are often out during the day. We needed to be sure that they would be in.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications about important events that had taken place in the service, which the provider is required to tell us by law. We used all this information to plan our inspection.

We observed staff interactions with people and observed care and support in communal areas. We spoke with two people about the care and support they received. We spoke with three staff, which included a support worker, the acting manager and the covering manager who was the registered manager from another local service owned by the provider.

We requested information by email from local authority care managers and commissioners who were health and social care professionals involved in the service. We also contacted Healthwatch to obtain feedback about their experience of the service. There is a local Healthwatch in every area of England. They are independent organisations who listen to people's views and share them with those with the power to make local services better.

We looked at the provider's records. These included both people's care records, which included care plans, health records, risk assessments, daily care records and medicines records. We looked at three staff files, a sample of audits, satisfaction surveys, staff rotas, and policies and procedures.

We asked the management team to send additional information after the inspection visit, including staff training records, policies, and the quality assurance records. The information we requested was sent to us in a timely manner.

The service had been registered with us since 08 March 2017. This was the first inspection carried out on the service to check that it was safe, effective, caring, responsive and well led.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the service. One person told us, "I do feel safe here with the support from the staff." We observed staff supporting people to maintain their safety. For example, staff gave advice about how to keep important documents such as a birth certificate safe. A staff member explained how they kept people safe by talking with people about how to stay safe when going out at night with friends. They gave examples of explaining the risks of leaving a group of friends, drinking too much and the dangers of leaving bags and drinks unattended.

There were systems in place to monitor and collate incident and accident data to make sure that responses were effective and to see if any changes could be made to prevent incidents happening again. Incident records related to incidents where a person had self harmed. The records showed that the management team had investigated and reviewed the incidents, reported these on to health care professionals and in some cases had put in place actions to keep people safe. However, it was not evident that lessons had been learnt from all incidents that had occurred. A person had used sharp items that they had come into contact with to self-harm, whilst action had been taken to reduce the risks within the house, the garden had not been considered. During the inspection we found a number of dangerous and hazardous items in the garden which people had access to. We reported this to the management team and asked them to take immediate action to ensure people were safe. They arranged for the items to be moved on that day and agreed that they needed to update their risk assessments and daily checks to maintain people's safety.

Whilst the management team and staff on duty during the inspection explained how they kept people safe by carrying out tasks in a certain way, there was a lack of documentation to evidence the reasons why tasks were done in this way. The management team had changed how one person had their medicines. The risk assessment had not been amended and reviewed and it detailed that the person liked to have their medicines in their room. Practice had changed and the person now had their medicines administered in the kitchen and staff carried out a check in their mouth to ensure they had taken their medicines as prescribed. This meant that there was a danger that staff may not know about the revised medicines procedures to keep the person safe, which increased the likelihood of the person becoming harmed through deterioration in their mental health. We reported this to the management team. The day after the inspection the medicines risk assessment was reviewed and updated to make it clearer.

Staff told us about the risks of one person using a hot water bottle which had been discussed within a handover meeting. Whilst the discussion at the handover meeting had been documented a risk assessment had not been completed to explore ways in which the staff could support the person to maintain their safety.

The failure to take appropriate actions to mitigate risks to people's health and welfare is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Risks to people's individual health and wellbeing were assessed. Each person's care plan contained individual risk assessments including assessments of people's mental health care needs, accessing the

community, managing finances and pets. Community psychiatric nurses (CPN's) were involved in planning and reviewing people's mental wellbeing. Staff signed support plans and risks assessments to acknowledge they understood them. When we spoke to staff they confirmed they understood potential risks and how these were minimised. Risks were discussed, communicated within the team and recorded at shift handover meetings.

Medicines were not always managed safely. People's records contained up to date information about their medical history. However, people's records did not always detail how, when and why they needed the as and when required (PRN) medicines prescribed to them. One person had been prescribed Co-Codamol pain relief and suppositories. There were no PRN protocols in place to detail how and when to use these medicines. This meant that staff administering these medicines may not have all the information they need to identify why the person takes that particular medicine.

People's medicines administration records (MAR) showed they had mostly had their medicines as prescribed by their GP and mental health specialists. However, the MAR for the previous month contained gaps. One person was prescribed Alimemazine 10mg to be taken at night. These had not been signed for on 22 March 2018. There was no explanation why and the MAR had not been completed with a key to indicate why they had not been signed for. One person's MAR contained hand written entries which had not been signed in appropriately. The MAR showed that Clindamycin, Co-Codamol and Glycerol suppositories had been added to the MAR. However, the amount received, the route and who signed in the medicines had not been recorded. One hand written entry for A-Z multivitamins had been signed in by a staff member and the amount received had been recorded. However, the administration route had not been documented. Hand written entries had not been checked for accuracy by a second staff member. The National Institute of Clinical Excellence (NICE) have produced guidance 'managing medicines in care homes'. Practice observed and records seen evidenced that the provider was not following NICE guidance. The provider's medicines policy dated December 2017 contained minimal information for staff and had had not incorporated all of the required information specified within the NICE guidance to ensure people were supported to have their medicines in a safe way.

The failure to manage medicines safely was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People were protected from abuse or harm. Six out of nine staff had received training in safeguarding adults. This helped staff to stay alert to signs of abuse or harm and the appropriate action that should be taken to safeguard people. We spoke with one of the three staff members who had not had the training; they knew how to keep people safe and how they should report safeguarding concerns. Staff were aware of the company's policies and procedures and felt that they would be supported to follow them. Staff also had access to the updated local authority safeguarding policy, protocol and procedure dated September 2017. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. Staff told us that they felt confident in whistleblowing (telling someone) if they had any concerns about people's care.

We checked that the provider was following safe recruitment practice. The provider had carried out sufficient checks to explore staff members' employment history to ensure they were suitable to work around people who needed safeguarding from harm. References had been received by the provider for all new employees. Records showed that staff were vetted through the Disclosure and Barring Service (DBS) before they started work and records were kept of these checks in staff files. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Photographs were in place for all staff members.

There were enough staff to support people. Staff rotas showed the management team took account of the level of care and support people required each day, in the service and community, to plan the numbers of staff needed to support them safely. We observed when people were in the service, staff were visibly present and providing appropriate support and assistance when this was needed. We observed that the service was calm. Staff were not rushed and took things at people's individual pace.

The service was clean and tidy, and it smelt fresh. The service was small and homely. Staff encouraged people to carry out cleaning tasks in their own rooms and staff undertook communal cleaning tasks. Staff had access to appropriate personal protective equipment such as gloves and aprons to minimise the risk of cross infection. Daily cleaning schedules were in place and were signed as completed. Staff completed daily actions to minimise the risk of infections such as using wipes to clean high contact areas on a daily basis and using antibacterial cleaner on door handles and switches. People were supported to be as independent as possible. There was a washing machine and tumble drier in place for people to use. A first aid kit was in place in the kitchen.

Each person had a personal emergency evacuation plan (PEEP) in place which detailed how staff should help them evacuate in the event of a fire. Fire alarms had been regularly tested. Fire drill records had been carried out, the last one took place in December 2017. The building had undergone necessary checks and was well maintained. Closed circuit television (CCTV) was in place in communal areas of the service so that staff could monitor people's safety on each of the three floors whilst maintaining people's privacy. Gas and electrical installations were documented and up to date as were portable electrical appliances, fire alarm systems, water hygiene checks and water temperature checks. Records evidenced that staff had recorded high water temperatures on a number of occasions without recording what action had been taken to address the risk of scalding. We spoke to the acting manager about this who notified the provider's handyperson immediately.

Good

Is the service effective?

Our findings

People told us they received effective care and support from the staff team. One person told us, "If I need to see the GP or someone else the staff support me to do so. I can see them anytime I need to do so. Sometimes staff encourage me to go when I don't want to. When I don't feel well because I have not eaten they will encourage me to eat or make me something I will eat like toast".

People were supported to maintain good health. People's health and wellbeing was consistently monitored and reviewed in partnership with external health services. The staff and management team contacted other services that might be able to support them with meeting people's health needs. This included the local GP, the community nursing teams, occupational therapist, and the community mental health team. Staff ensured people attended scheduled appointments and check-ups with their GP or consultant overseeing their specialist health needs. People had also been supported with appointments to psychiatrists, care programme approach (CPA) meetings, mental health team, blood tests, dentist, opticians and advice had been sought from paramedics when required. Where people had required hospital admission, they had been involved in the discussions and decisions about this. People had been involved in their health care needs and had supported staff to understand about their mental health needs by compiling a detailed plan of what may trigger a decline in mental health, signs and symptoms of this and what staff should do. Records showed the outcomes and any actions that were needed by Arden house staff to support people with these effectively. A health care professional told us, 'The GP has raised that my service user needs to think more about her exercise and diet. The staff have spoken with her to see how they can support her with this. She thought about attending [popular slimming group] and they volunteered to go with her.'

People were clearly enabled to be the decision makers in their own lives. We observed people making decisions about what they would like to do, eat, drink and wear. People's bedrooms had been decorated and furnished by them. One person said, "I designed my own room and chose the decoration" and "I go out when I want to. I have staff support when I need it and when I want to go out I go out." People had signed consent forms for certain areas of their care and support. Consent had been obtained when people were well for action required if and when they became unwell. For example, one person had consented to a bedroom check to enable staff to remove dangerous items which could be used to cause the person harm.

There was an initial assessment process in place for people before they moved into the service. The assessment checked the care and support needs of each person so the management team could make sure staff had the skills to care for the person appropriately. At the assessment stage people were encouraged to discuss their sexuality or lifestyle preferences as well as their rights, consent and capacity. A staff member shared how each person's individuality was welcomed. They said people with different sexuality and preferences had "Not been treated in any different way" and people were made to feel welcome. The staff member also shared that the staff team were a diverse group of staff in relation to sexuality, religion and culture. The provider also assessed people's dependency levels to capture the levels of staff care required while at the same time supporting people to maintain their independence. The provider's processes involved people and their family members in the assessment process when this was appropriate.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA 2005. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA 2005, and whether any conditions on authorisations to deprive a person of their liberty were in place.

People had capacity to make their own decisions about their lives. The management team informed us that no one was subject to an order depriving them of their liberty. We observed that people could freely go out when they wanted to. Staff told us they would carry out a MCA assessment if anyone was lacking in capacity to make a decision. Staff were aware that people's capacity may fluctuate if their mental health deteriorated as well as understanding people had a right to make unwise choices. One staff member told us, "If the person I support wants to make an unwise choice I will explain the pros and cons of that choice but they have the right to make the decision."

People were supported to be as independent as possible with shopping for food and drink, preparing and cooking meals. Staff took an active role in cooking if people were unwell. However, when people were well staff supported people to prepare and cook through prompts and encouragement. People had their own cupboards in the kitchen. Sometimes people chose to share their foods such as an evening meal and this was then reciprocated. A staff member told us, "I encourage people to cook for themselves and eat; if they are not going to cook then I will cook for them or support them to cook. The person I support already chooses to eat healthily so I have not had to support them to do so." A healthcare professional told us, 'The staff and residents often cook together as well as shop together. Meals are planned together in advance and are treated as a social occasion (for those who want this). My service user has particularly commented on this and how much she enjoys this time of the day.' The acting manager told us, "Service users are supported to go shopping, before they go they sit down and do a menu plan and then a shopping list. There are no diet restrictions; no food is required to meet specific religious, cultural or medical needs. We try and offer drinks during day, and offer juice or water with medicines. People have not been weighed recently; we have just implemented monthly weighing. We have bought scales and this is about to start."

New staff completed an induction which included reading the service's policies and shadowing an experienced staff member to gain more understanding and knowledge about their role. Staff were supported to gain qualifications and carry out training to help them develop. The acting manager was about to start a management qualification to support them in their role. Three staff had completed work related qualifications and four staff were in the process of completing a work related qualification.

Training records showed that all staff had attended training in fire safety and mental health, eight staff had completed medicines training, seven staff had attended basic health and safety training, first aid, infection control and basic food hygiene. Further training was planned for staff to improve their knowledge in different subjects. For example, Mental Capacity Act 2005, DoLS, mental health awareness and safeguarding training was planned for 12 April 2018. A staff member told us, "I enjoyed the training and found it really useful. We get handouts from the training so that we can go back and re-cover things afterwards. The training has helped me feel more confident."

Staff told us they had received regular supervision. The acting manager received their supervision from the registered manager at one of the provider's other local services. The acting manager detailed how they

worked in the evening to enable night staff to have a formal supervision within their working hours. One staff member said, "I feel like my manager listens to me."

The design and layout of the building met people's needs. People knew where their rooms were and where to find communal areas such as the kitchen, lounge and toilets.

Staff worked together to ensure that people received a consistent and person-centred support when they moved from or were referred to the service. One person had been staying at the service three days a week to enable staff to carry out assessments and check their suitability to move out of a secure long stay service. The service worked with a range of health and social care professionals in relation to this. One health care professional told us, 'My service user has only been there for a very short period of time but they have managed the transition from overnight stays to permanent residence very well.' The staff and management team supported the person to prepare and attend a tribunal meeting and provided feedback to professionals. On the day of the inspection the person was given permission by the tribunal to move into the service on a permanent basis. The staff made the person feel very welcome when they returned from the tribunal hearing. Staff offered congratulations and reassurance. One staff member was heard telling the person, "This is your new journey now". The person told us, "I am so glad my tribunal is over. I'm so excited, I've been discharged."

Where people were subject to Community Treatment Orders (CTO) the management team ensured this was communicated to all staff to ensure that they were fully informed about any restrictions that were in place. A CTO allows a person who has been detained in hospital (under the Mental Health Act 1983) for treatment to leave hospital and get treatment in the community. Staff supported people to comply with and meet the terms of their CTO. Staff also reminded and supported people to understand the terms of their CTO.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring. Comments included, "I really like it here, it's really homely"; "The staff are really good fun and really helpful. I don't feel restricted here at all. I feel respected as an individual. The staff understand me, they always have time for me and time to stop and talk" and "I have built up really good relationships with all the staff here (including the manager). They always stay and talk and listen to me."

We observed positive interactions between people and staff. People were at ease and comfortable in each staff member's presence. Staff were kind, considerate and respectful. Staff made time to chat with people about their day. People sought out staff and conversation was natural and flowing. When one person went out with their relatives they went round the staff to affectionately say goodbye. The staff wished them a good time.

A health and social care professional told us, 'My service user has really struggled in the past with making trusting relationships. The staff have recognised this and afforded her the opportunity to build these relationships over time. I have witnessed them being very encouraging and supportive.'

Staff had a good understanding of treating people with respect and dignity. They also understood what privacy and dignity meant in relation to supporting people with their care. People were able to independently manage their own personal hygiene as well as getting dressed and undressed. One staff member explained, "Sometimes if the person I support is dressed inappropriately for the weather, I will prompt them to change. I leave her to dress alone as she does not need support." Staff knocked on doors and checked with people to make sure they could go in. Staff were mindful of people's privacy and confidentiality. Conversations of a sensitive nature were held in private.

Staff were mindful about people's preferences for waking and ensured that they didn't make too much noise in the service when people were asleep.

When talking about their roles and duties, staff told us they enjoyed their jobs. Staff spoke about people in a respectful manner when we asked questions about people's care and support and needs. One staff member told us, "It's like being part of a family, there have to be boundaries but it can also be relaxed".

People's bedrooms were decorated to their own tastes. Each person's room was personalised with photographs, pictures and their own choice of furniture. One person had been supported to keep pets such as rabbits. They told us, "My rabbits keep me occupied. Sometimes I don't want to get out of bed but they give me a reason to do so. I have something to care for and be responsible for and that helps a lot."

There was a relaxed and homely atmosphere. There was lots of laughter and friendly chatter. People had free movement around the service and could choose where to sit and spend their recreational time. People were able to spend time the way they wanted. People chose to spend time in the communal lounge, dining room, the garden or their bedrooms.

People told us that staff listened to them and they felt in control. One person told us, "I am involved in planning my own support; I get input and feel like they listen to me" and "The staff have asked me how I feel about other people moving in. It's good that someone else is moving in, it's massive." The acting manager told us that as there were now two people living at the service, the staff would support them both to have a regular house meeting to enable them to share feedback and discuss ideas and improvements.

People were supported and encouraged to be as independent as possible in all aspects of their lives. Staff helped people maintain their routines and understand what was going to happen next. People were not hurried or rushed in any way.

Advocacy information was available for people and their relatives if they needed to be supported with this type of service. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

People were supported to engage with people that mattered to them such as friends and family members. People were supported to make contact with their relatives on a regular basis. One person told us, "The service supports me to go away with my family. I am able to go abroad because I have telephone support from people [staff] here. The support is essential. I am able to go because I know if things went wrong I could get away. I could telephone the staff and they would help me to get home."

Good

Is the service responsive?

Our findings

People told us that staff were responsive to their needs. We observed that staff were good at judging people's mood and were able to provide reassurance, encouragement and support when it was required. For example, one person became overexcited, stressed and unsure of what to do. Staff sat with the person and talked with them calmly. The staff member supported the person to calm down. The person appeared calmer after engaging with staff. Another person was concerned about some of the choices they have made in the past. Staff were supportive and empathetic.

Care and support plans were in place to clearly detail people's support needs. These were personalised, each person had been involved with developing their care and support plan and had written a 'My road to recovery' plan which detailed what triggered a relapse in their mental health, what self-help measures they use to manage this, what other people and staff can do to help and what are the early warning signs. These 'My road to recovery' plans were created with people as part of the admission process to enable staff to understand each person's needs. The plans were regularly reviewed. One person's plan showed this had been reviewed a number of times in a short period as they had identified with staff what additional support they needed when they began to show warning signs that their mental health was declining. Support plans evidencing core support times had been developed, reviewed and amended as people had settled in and their needs had changed. The acting manager had explored one person's needs further and had developed a prevention plan with the person to help to support to keep the person well. This had been developed on 14 March 2018. People told us they were fully involved in their care planning.

The person who had only just moved into the service had a care and support plan in place. This included key information such as details about their diagnosis, personal and life story, religions preferences, information on what tasks support is needed for, medicines information, likes and dislikes, information about triggers, warning signs and support. The management team were working with the person to develop further risk assessments and support plans.

One person had identified their wishes and preferences in relation to the end of their life. They had documented whether they preferred a burial or cremation, what music they might like played and what they would like people to wear.

People were supported to be active members of their community. Records evidenced that people utilised the local shops and café's frequently. Staff encouraged people to take up activities to provide physical and mental stimulation and worked with health and social care professionals to provide a consistent approach to activities. Activities included support to do daily household tasks and support to utilise a weekly budget allowance for food shopping. One person was keen to start swimming. They told us, "I would like to go swimming more. Some staff won't go because I want them to go in the water with me but [staff member] will. If I want to go they look on the rota and let me know when someone will come with me." The acting manager explained that the particular staff member had been scheduled on the staffing rota at least three days per week to enable the person to carry out their wishes in relation to activities, the staff were also exploring college courses to enable the person to develop their hobbies further. Another person was keen to

sign up to volunteer at a local charity shop. The staff were encouraging and supportive of the idea and offered to help arrange a placement. One person had been supported by staff to apply for a local leisure pass and a bus pass as well as the electoral role.

People knew how to complain. Complaints information was displayed in the service. Complaints records showed that there had been no complaints about the service. One person told us, "I know how to complain if I want to but I love it here. I did complain about the sofa and I think that they are replacing it. They will need to replace it if there are more people here."

Requires Improvement

Is the service well-led?

Our findings

People told us that the service was well managed. One person said, "I think the service is excellent, if it was up to me I'd say they were outstanding. They do a really good job supporting me."

A health and social care professional told us the service was well managed. They said, 'From the moment I first looked round at Arden House, I was impressed with the service they were providing. Working with women who have often experienced traumatic histories and require a lot of support and encouragement is not easy but the staff appear very committed to working with this particular client group. In my experience they are always approachable and friendly. Residents feel at ease in the home and able to talk to staff about any issues. The staff provide lots of support in and out of the home and are mainly to be found in the communal areas, not just in the staff office. The home has a lovely feel to it and I cannot praise the staff enough for the support they have given to my service user who is finally able to live in the community after nearly 15 years of institutional care.'

Audits and checks were carried out by the management team. These included monthly health and safety checks, checks on equipment, infection control, fire, medicines checks, finance audits, staff files and training. We found that there was no action column within some of the audits so it was unclear what had been done. For example, the first aid box had been audited but it was not clear if items had been replaced or needed to be replaced. The management team had arranged a pharmacist to carry out an independent check of the medicines storage, practice and records. The management team had reviewed one person's care plan every six weeks. Now there were more people living at the service, the management team planned to audit and check care plans and risk assessments on a regular basis. The management team had carried out informal observations of care and support and informal feedback had been given.

Despite the quality monitoring systems in place further improvements were required to drive the service forward to ensure people were receiving safe care. Quality assurance processes had not been successful in recognising the issues we identified in this inspection; such as risks to people and staff and medicines concerns.

Staff had access to a range of policies and procedures to enable them to carry out their roles safely. The policies and procedures had been updated and reviewed by the management team, however some policies and procedures related to old regulations and legislation that had been superseded.

We recommend that the provider reviews quality assurance systems and processes to ensure that systems and processes effectively monitor and improve the quality of services provided.

Staff were aware of the whistleblowing procedures and voiced confidence that poor practice would be reported. Staff told us that they had confidence in the registered manager taking appropriate action such as informing the local authority and CQC. Effective procedures were in place to keep people safe from abuse and mistreatment. The provider's whistleblowing procedure listed the details of who staff should call if they wanted to report poor practice.

The provider's statement of purpose detailed 'Arden House is a 24 hour supported residential environment for people with mental health problems where the focus is firmly on rehabilitation through the teaching and reinforcement of life skills. Arden House provides people with security, stability, structure and boundaries, all within a therapeutic environment. People are always prompted, encouraged and supported with day-to-day activities such as medication, personal hygiene, eating healthily, managing money, cleaning and social interaction. People are encouraged to access meaningful activities in the local community. In this way, people can develop a network of people around them so when they move on from Arden House they will still have support and encouragement'. The aims of the service at Arden House had clearly been communicated to all staff, they were all working to ensure people were effectively supported with all aspects of their lives.

Staff told us communication was good. The acting manager told us that communication included team emails to ensure that all staff received the same message to ensure consistency. Staff recorded key information on handover sheets too. A health and social care professional told us, 'I think the communication is excellent, be that by telephone, email or face to face. They are always approachable and helpful.'

Management worked with the commissioners of the service to review people's needs to ensure the service continued to be able to care for them effectively. Referrals had been made to health professionals for advice and training and staff followed recognised practice for delivering community mental health services.

Staff meetings had not taken place as frequently as the management team would have liked. The acting manager had addressed this and had scheduled a staff meeting for the 28 March 2018. The previous meeting had taken place on 21 July 2017. The acting manager had a monthly meeting with other local registered managers employed by the provider. This enabled the management team to discuss each service, offer support and advice and gain information from the provider to ensure that services were consistently operating. The acting manager shared that the management team had spoken about additional equality and diversity training for all staff within the organisation to ensure that staff had an increased awareness of supporting people who are lesbian, gay, bisexual and transgender (LGBT).

Staff felt well supported by the management team. One staff member told us, "The manager is very approachable, I know that I can go to them and they will take issues I raise seriously." It was evident that the acting manager had consistent support in their role from the registered manager from the provider's other local service. The registered manager from the service had clearly been involved with supporting people and the staff in the service, they supported one person to their tribunal appointment.

People were given the opportunity to provide feedback about the service through completion of surveys and through regular meetings with staff. These meetings were called collator meetings, people had these on a monthly basis and their feedback was recorded and acted on. We viewed completed surveys, feedback was entirely positive. Comments included; 'You let me have pets and treat me as an individual' and 'feels like my personal rights are respected and are done well.'

Relatives and health and social care professionals been sent surveys to gain their feedback about the service their family member or person they worked with received. The management team had not yet had any replies.

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries, Deprivation of Liberty Safeguards (DoLS) authorisations and deaths. The management team and the provider had notified CQC about important events such as serious injuries and safeguarding concerns that

had occurred.

The provider had put in place appropriate management arrangements to cover the absence of the registered manager. A health and social care professional told us, 'The current manager is on long term sick leave at the moment. Senior management acted immediately by employing a temporary manager as well as the senior manager spending lots of time at the house to offer on-going support.'

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to take appropriate actions to mitigate risks to people's health and welfare. The provider had failed to manage medicines safely. Regulation 12 (1)(2)