Montesano Care Ltd

Arlington House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:

Arlington House is a residential care home providing personal care to a maximum of 33 people in an adapted building combining four terraced houses over three floors. At the time of the inspection 25 people were living at the home. The people living there are older people with a range of health and mental health needs including people living with dementia.

People's experience of using this service:

• People were not always protected from abuse. The action staff may need to take to identify and raise safeguarding concerns had not always been taken and was not consistently understood.
• People and their relatives told us they felt safe. A relative told us, "My relative is safe because it's secure. I feel confident with the people looking after them. I also feel if they have concerns they get the doctor in."
• People's access to timely care and support, and access to meaningful activities that reflected their diverse needs was not always supported by a sufficiently deployed staffing. The provider had implemented changes that required further time, guidance and training for staff before they could be introduced and the impact on people's day to day experiences minimised.
• There were proactive quality assurance processes in place to drive improvements to the service. A relative told us, "The home is definitely getting better, you can see the improvements. They're doing a grand job." These improvements needed further embedding to robustly address inherited environmental and restrictive practice in relation to the use of CCTV as identified at the inspection.

• We have made a recommendation that the service seek suitable guidance on the use of CCTV.
• There was no registered manager at the time of the inspection. The provider had put measures in place to support the day to day management of the home.
• The provider needed to make further improvements to their oversight of the governance of the service to ensure the changes they were making continued to support safe practices in relation to recruitment, medicines administration and care planning for people with diverse needs.
• People were cared for in a clean and hygienic environment. The provider had worked hard at resolving inherited environmental health issues. A health professional told us, "The environment is improving, it was tired before, now it's really improving."
• Systems were in place for the recording of incidents and accidents. They were monitored and analysed over time to look for any emerging trends and themes.
• People's needs, choices and preferences were known by staff and their care plans were personalised.
• People were comfortable with staff and were cared for in a safe, friendly and calm manner. Staff and managers were approachable and knew people well.
• People were being supported to make decisions in their best interests. The registered manager and staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

• People and relatives were encouraged to express their views. Staff were asked for their opinions on the service and felt supported within their roles.
• People were supported to maintain a healthy nutritious diet and had access healthcare services and professionals as and when needed.
• The provider and care manager were keen to develop team work, reflective practice and training in relation to dementia and end of life care.
• The physical environment was under a continual cycle of refurbishment with a clear focus to improve people's day to day experiences at the heart of the home's value base.

Rating at last inspection:

This was the first inspection of Arlington House since Montesano Care Ltd became the provider of the service and registered it with the Care Quality Commission on 4 June 2018.

Why we inspected:

This was a scheduled comprehensive inspection based on our methodology to inspect newly registered services within a year of registration. At this inspection we identified areas that required improvement, including breaches of regulation.

Follow up:

We will be in contact with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Arlington House

Detailed findings

Background to this inspection

The inspection:

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:

The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert at this inspection had experience of caring for older people who lived with dementia.

Service and service type:

Arlington House is a 'care home' that provides personal care for a maximum of 33 people. Many people were living with complex mental health needs including dementia. 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.

A registered manager was not 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 and associated Regulations about how the service is run. Day to day management of the service was carried out by the provider and a care manager, who was giving further consideration to registering with the CQC.

Notice of inspection:

We carried out this unannounced inspection on 2 and 4 April 2019.

What we did:

What we did before the inspection:

• We reviewed notifications we had received from the home about significant events. Notifications are information that provider is required by law to tell us about.
• We looked at information sent to us from other stakeholders including, one local authority quality monitoring team and members of the public.

What we did during the inspection:

On this occasion, the provider was in the process of completing a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. During the inspection we observed the support that people received, spoke with people and staff to check that the care detailed matched the experiences of the people.

This included:
• Notifications we received from the service
• Two staff recruitment files
• Training records
• Six people's care records
• Records of accidents, incidents and complaints
• Audits and quality assurance reports
• We spoke with 10 people using the service and four relatives
• We spoke with a health care professional with the specialist community in-reach dementia team
• We spoke with members of staff, including the care manager, the provider and five care staff.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Systems and processes to safeguard people from the risk of abuse

- The provider had not consistently made the local authority aware of safeguarding incidents in line with their safeguarding policies to ensure people were protected from potential abuse and that they were thoroughly investigated.
- There were two occasions where incidences had occurred which had not been reported to the local authority or the Care Quality Commission (CQC). One incident related to the loss of money from a person's room and another related to one person being struck by another person.
- The provider had sought to reduce the likelihood of further incidents on each occasion but failed to identify and escalate the concerns as safeguarding incidents.
- The provider had a safeguarding procedure to follow, staff had been trained but were not always able to confidently describe the signs of abuse and how to report incidents to safeguarding authorities.
- People and relatives told us they felt safe. One person told us, "I feel safe because I'm looked after and checked up on. They're good at making sure I'm ok, they check on me at night as well."
- We shared our concerns with the care manager and provider that the incidents described could meet the threshold for safeguarding enquiries. In response to our feedback they completed safeguarding alerts in relation to the two concerns.
- People had been at risk of potential abuse due to shortfalls in staff training and understanding of safeguarding. In addition, the home had not identified or escalated the concerns to safeguarding authorities in a timely way to ensure people were fully protected and further risks of harm mitigated.
- Failure to ensure people were protected from potential abuse placed them at risk of harm and was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment

- Feedback from staff indicated they felt the service did not always have enough staff and our own observations supported this. When staff were sick or on annual leave as on the day of the inspection existing staff would be contacted to cover shifts and agency staff were used to ensure cover.
- Staffing levels were based on a dependency tool that noted the number of people and their care needs to calculate how many staff were required. The tool did not recognise the impact of the building lay out, the use of unfamiliar agency staff and people's behavioural support needs. For example, people who required encouragement to eat, socialise or be independent during meal times were left as staff focused on people with higher needs and tasks including; transferring people, bringing meals through and supporting people who required direct support with eating.

● On the first day of the inspection, we observed people who could be at risk of falling due to unsteadiness, moving around the building and in the lounge without staff present. A volunteer visitor present in the lounge was observed encouraging people to remain seated to reduce the risk of them falling.
● The provider was aware of the impact of using agency staff and was proactive using known agency carers while they recruited to a number of vacancies including; a new deputy manager, three senior staff and three carers.
● Staff told us they felt people were safe but noted that an increased use of agency made it harder to delegate and carry out tasks which took time away from spending time with people.
● People and relatives told us staff responded in a timely way when they needed support or used a call bell.
● We discussed our observations with the care manager and provider and our concerns that the deployment of staff during mealtimes had reduced people's opportunity to have their needs met fully and may have been placed at risk of falling due to staff not being present in communal lounge areas. They told us that staff should always have a sight of people in communal spaces and acknowledged the current building layout presented challenges which they were looking to address through developing an open plan dining area and reviewing staffing levels.

● Failure to ensure there were sufficient numbers of staff suitably deployed to ensure people's support and care needs were met consistently and safely was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● Staff files included application forms and written references from previous employers to ensure staff were suitable to employ. Checks had been made with the Disclosure and Barring Service (DBS) for new staff. The DBS is a national agency that keeps records of criminal convictions.
● Recruitment processes were followed to ensure that staff were safe to work with people but evidence of this was not consistently available. The provider was not able to provide copies of the evidence they had seen in relation to references and employment history of one staff member. They confirmed they would access a replacement reference, and this would be put in place.

Using medicines safely

● People were supported to take their medicines safely. One person told us, "My tablets and medicines are all sorted out for me."
● Staff gave medicines respectfully having gained consent and ensuring people were comfortable in how they were taking them.
● The home had medicines policies and systems of audit completed by the provider and independent pharmacist. This ensured staff had clear guidance on how to safely store, audit, record, administer and dispose of medicines.
● Staff that administered medicines were knowledgeable about people's medicines. They were trained and assessed as competent to do so. For example, they had a good understanding that people with degenerative conditions required medicines to be given at specific times. This ensured the impact of their symptoms were reduced throughout their day.
● Medicines administration records were completed, and people received their medicines as they were prescribed.

Preventing and controlling infection

● An independent infection and pest control audit and risk assessment had been conducted by professional bodies and the provider had sought guidance from the local authority's environmental health professionals, in relation to inherited concerns relating to the fabric and furnishings of the building.

● This highlighted that some mattresses, beds and areas of the building required on going attention. The provider had replaced and refurbished a number of items and areas of the building. Weekly infection control audits were in place and evidenced the progress and activities taking place to continually address the inherited issues.
● Systems ensured that the cleanliness of the home was monitored by the care manager and home had increased the number of housekeeping staff to ensure cleaning took place daily.
● Risks associated with infection control were managed throughout the home including the kitchen by the safe use of protective equipment such as staff wearing disposable gloves and aprons appropriately.
● Staff had completed infection control training and the home including furnishings and bedding was seen to be clean and smelt fresh.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

● Risks to people were assessed and managed for people's safety. For example, people at risk of malnutrition, had eating and drinking checklists, their weight was monitored monthly and there was nutritional support guidance provided for staff, so they could ensure the person ate a suitable diet and maintained a healthy weight.
● Each person's care plan included a range of risk assessments that guided staff on the level of risk, how it may occur, and how they could minimise the risk to people. For example, staff told us that one person was particularly unsteady and at increased risk of falling when they had just been sleeping. We observed, experienced staff ensuring newer staff ensured the person transferred safely and that they accessed adequate time to sleep when tired
● Personal Emergency Evacuation Plans were in place to ensure people would receive the right support in the event of a fire.
● Staff told us they understood the importance of protecting people and their colleagues from all types of discrimination and this was recognised in Arlington House's mission statement.
● Where accidents and incidents had occurred, the provider had investigated the root cause and implemented changes to reduce the likelihood of a reoccurrence based on any lessons learnt. For example, in relation to repeated falls, the falls team have been referred to and equipment accessed. One relative told us, "They give my relative emotional support and have brought in new equipment to use when she's transferring. Before they were anxious and scared to try and weight bare, but now with the stand aid she's much happier."

Requires Improvement

Is the service effective?

Our findings

Effective – this means that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.
Ensuring consent to care and treatment in line with law and guidance

● The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● Staff understood the importance of people's legal right to be enabled to make decisions where they could and followed the principles of the MCA. For example, in relation to how they supported people to make decisions about food and clothing. One staff member told us, "I offer choices by talking the options through, double checking people's answers and physically showing the options available."
● However, the provider had not ensured when gaining consent from people and their relatives about the ongoing use of the inherited CCTV cameras in communal spaces that this was the least restrictive option to ensure people's safety and the security of the building. Signed consent was gained, but there was no guidance or risk assessment in relation to the necessity or use of the equipment or evidence that they had considered other less restrictive options to promote people's rights. We recommend that the service seek suitable guidance in relation to the use of CCTV within a residential setting.
● Where people were found to lack capacity, there was guidance available to staff through completed care plans and best interest considerations were given in relation to specific decisions. For example, one person had a short term DoLS authorisation in place as they were initially not comfortable with moving into a home from the community. The DoLS assessor and legally authorised relatives had reviewed the decision for the person to remain at the home, noted the service was meeting their needs and that they benefited from the social interactions available.

Staff support: induction, training, skills and experience

● Established staff received training and were knowledgeable and competent in what was required when looking after people and we observed them giving guidance to new staff during the care shift. One person

told us, "Most of the staff know how to help me, not the new ones. Most of them are good." One staff member told us, "We have loads to do, but we do it. There is an impact on people with less familiar staff as they need more reassurance, but we support people the same, their health and personal care needs are met."

● Some staff we spoke with lacked an understanding of best practice in relation to safeguarding but knew who they would speak to if they had concerns.

● A number of staff were new or had not accessed refresher training in topics that the provider considered important for their role including; safeguarding, Mental Capacity Act and safer people handling. However, the care manager was aware of the gaps in people's training and had arranged future training accordingly.

● Staff including agency staff received inductions, training and shadowed experienced staff who could show them how to support people's needs.

● The care manager completed competency check on staff including; medicines checks before agency staff supported people with medicines to ensure they were safe to work with people.

● The care manager was keen to access more practical dementia and mental health awareness training and had run sessions in team meetings. One staff member told us they had found this useful and said "I didn't know about the different types of dementia before. I know more now how to approach people." They then gave an example of how they reassured one person when they were confused about their partner not being at the home.

● Staff received regular supervision and appraisal from their line manager and new staff could complete the Care Certificate. The Care Certificate is a set of standards for health and social care professionals that ensure workers have safe introductory skills and knowledge.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● The care manager carried out assessments of people's care and support needs before they began using the service to confirm if the person's needs could be met.

● The pre-admission assessments were being developed further with support from the community in-reach dementia team to provide a better understanding of people's mental health diagnosis and a more detailed care plan for each person.

● People and their relatives told us they were involved in assessments and reviews of care plans and staff told us they had clear guidance to help them understand how people needed their care and support to be provided.

● Protected characteristics under the Equality Act, such as ethnicity, sexuality and gender identity were not always considered as part of the assessment process. We discussed this with the care manager and provider who told us, they would not discriminate when arranging care planning. In response they are reviewing their pre – admission and care planning be more inclusive using equalities resources from a reputable source.

Adapting service, design, decoration to meet people's needs.

● The service was being refurbished at the time of this inspection. A health professional told us, "The environment is improving, it was tired before, now it's really improving." One area was 'themed' as a bar with nostalgic reference which we were told supported people living with dementia to orientate themselves around the premises.

● There were further plans to replace windows, heating systems and furniture and to provide a larger accessible kitchen dining area to promote the dining experience and independence as well as more visual references throughout the building so that people could orientate themselves.

● People's bedrooms that were most recently refurbished had been fitted with remote call bells. Most rooms were ensuite and there were stair lifts and accessible bathrooms.

● Staff used technology including the internet and emails to review people's needs and care plans had been transferred to an electronic system that was available for staff to access guidance about people's needs and record the support they had delivered including tools that monitored their health and wellbeing.

Supporting people to eat and drink enough to maintain a balanced diet

● People's nutritional needs were met. At least two choices were provided at mealtimes and people were able to eat at their own pace and enjoyed friendly interactions with each other.
● Healthy food and snacks were available in people's rooms and provided throughout the day to reduce the risk of malnutrition and ensure people had their choices met. One person told us, "The food is quite nice." A relative told us, "My relative is a keen eater and they really like the food." Another relative told us, "They always give my relative alternatives."
● People we spoke with were happy with the choice of meals offered at the service. There was a varied menu and specialist diets were catered for. For example, one person told us, "They know I don't swallow well so they make sure my meals are mashed up for me." Guidance identified the consistency of food the person required and how staff should support them while eating to minimise the risk of choking.
● The chef knew people's preferences and planned for their dietary needs such as diabetes, high calorific diets. Records confirmed people had maintained or gained weight in line with their needs.
● The care manager told us that they were working with the chef at developing menus more regularly with people using the service.

Supporting people to live healthier lives, access healthcare services and support; staff working with other agencies to provide consistent, effective, timely care

● People were supported by staff to maintain good health and had access to GPs, dentist's opticians and chiropodists when needed.
● People's health concerns were responded to in a timely way. A relative told us, "I feel confident with the people looking after my relative. I feel if they have concerns about their health they get the GP in."
● A health professional spoke about how proactive the home was in linking people in with the correct services to address their health needs. For example, they worked closely with GPs and community pharmacists to ensure people were accessing the correct dementia medicines for their diagnosis.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

At this inspection people were receiving a caring service. People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People were comfortable in the company of staff who spoke warmly about them and there was a relaxed atmosphere in the home.
- People and their relatives told us that they were treated well by kind caring staff. One person told us, "I feel they care." A relative told us, "The staff know us and our relative really well."
- A health care professional told us, "The care manager and provider want to create something different for people who have less loved ones about them. They want to make a difference in people's lives."
- We saw positive interactions and appropriate communication between people living with dementia and staff. Staff were attentive and patient when people became distressed and spoke with them with respect taking time to find out what they wanted to do or needed. A health care professional told us, "Staff are always calm and welcoming and give you a smile."
- People's individuality and diversity were respected and promoted. A relative who's loved one had lived at the service before the new provider told us, "Before they would talk over my relative's head, but not anymore, my relative is really happy."
- Religious beliefs, important relationships and how people chose to express them were detailed in care planning and activities provided. For example, one person enjoyed going on outings with their cousin and was supported to visit relatives locally.
- People were encouraged to have their own possessions in their rooms, including pictures and furniture.

Supporting people to express their views and be involved in making decisions about their care

- People at the home lived with dementia. People were not always able to verbally tell staff their needs and preferences.
- People were supported to communicate their needs and their care plans provided guidance for staff. For example, staff described how they provided individualised choice by offering different objects including items of clothing, simplifying language and giving people time to process what had been said and to respond.
- People and their relatives told us they were in free to move around the home and do what they wanted with their time. One person told us they preferred to stay in their room and that "My family comes to see me, and I can have visitors whenever I want."
- The care manager was aware of how to access relevant advocacy services so that people could be actively involved when making decisions about their care and treatment if they did not have a relative who was authorised to do so. An advocate is someone who can offer support for people who lack capacity to make

specific important decisions; including making decisions about where they live.

Respecting and promoting people's privacy, dignity and independence

● People's personal information was respected throughout the day. Care plans and electronic records were kept securely in offices or password protected on computers or tablets.
● People's privacy and dignity was protected, and we saw staff knocking on doors before entering and talking with people in a respectful manner. One person told us "They're very good they always knock." Throughout the inspection staff explained to people what they were needing to support them with and closed doors when they were providing personal care.
● Staff listened to people and encouraged them to make choices and be as independent as possible for example when transferring from chairs they reminded them where to place their feet and hands to ensure they kept their balance.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● People and relatives told us there were a range of activities that people enjoyed. A relative told us, "They used to do painting and all kind of things." Another relative told us that the service had regular access to a rickshaw ride along the sea front which their relative enjoyed. However, many activities described were supported by the activities coordinator who had left recently and had not been replaced. Throughout the inspection there were no focussed group or individual activities for people who would require encouragement to socialise or take part in an interest, hobby or sensory activity.
● Staff knew people well and anticipated their emotional needs but told us that they felt rushed and didn't have enough quality time with people since the activity's coordinator had left to provide activities and promote their social wellbeing and reduce isolation.

● The care manager told us that they were looking to develop staff skills to work with people in a more holistic way where direct care and activities would be provided by the same staff. This they told us would ensure people had access to meaningful activities and promote their social wellbeing. However, the structures were not fully in place to embed and facilitate this approach. For example, staffing levels were not suitably deployed and training and guidance in relation to engaging people with dementia and mental health needs in activities had not been consolidated.

● The community in-reach dementia team were supporting the home to improve how it supported people's dementia needs. They told us the provider was proactive and open to improving the service but had inherited a home supporting a range of people with complex dementia needs. They told us, "The challenge for the provider is how they manage the impact of the changes on people and staff."
● We discussed our observations with the provider and our concerns that the change in activities coordination had reduced people's opportunity to access meaningful activities and have their social needs consistently met. They told us that they would review staffing levels and consider an activities role further.
● Failure to ensure there were sufficient numbers of staff suitably deployed to ensure people's support and care needs were met consistently and safely was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care plans were personalised detailing life histories including people's achievements both personal and in their working life. A relative told us, "The staff know us, and they know our relative really well." Information was gathered prior to admission from people, their relatives, health professionals who knew them well.
● Relatives told us they were involved in the review and planning of people's care, when they had the legal authorisation to do so.
● People were given information in a way they could understand in line with the Accessible Information

Standard. People's care plans identified, recorded and highlighted people's communication and specialist health needs including; diabetes and sensory issues. For example, one person's care plan detailed the type of glasses they had and further information about how cataracts affected their eyesight.

Improving care quality in response to complaints or concerns

● People and relatives were confident that complaints were taken seriously and were happy to raise concerns they had with the provider and care manager. One person told us, "I tell staff if I'm not happy." A relative told us, "I send emails to the provider all the time, I contact them when I'm happy as well, If I do have a concern its dealt with straight away." Another relative told us, I deal mostly with the care manager. I trust them. They seem to have my relative's best interests at heart. They seem to be on the ball."
● The provider told us, that in response to people feeling either too hot, or too cold they had reviewed the suitability of the heating system at the service and were gaining quotes to replace the buildings inherited one boiler heating system with a two-boiler system with more hot water capacity.
● A satisfaction survey had been recently shared with people and relatives to provide an opportunity to feedback about the quality of the service provision. The initial survey outcomes were positive.

End of life care and support

● When needed the service provided end of life care for people.
● The care manager was establishing links with relevant health professionals and with the local hospice to develop advanced care planning at the service. For example, they were looking at developing community networks so that where people chose to remain at the home as part of their advanced care planning they could do so and experience a comfortable pain free end of life where their last wishes were respected.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Quality assurance is about improving service standards and ensuring that services are delivered consistently and according to legislation. The care manager and provider had developed their systems and processes and had made many improvements identifying themes for development with the support of a consultant. The care manager told us, "This is our baby we want it to be the best it can be, we know we have a lot to do, we inherited a lot to sort out and it takes time."
- Despite the improvements identified, the governance framework needed further embedding and had not ensured the delivery of high quality and safe care. For example, ensuring recruitment processes and the recording of prescribed topical creams, as required medicines were suitably documented and recorded on care files and the new electronic care planning tool.
- Environmental risks had been identified but not consistently prioritised or managed to mitigate the risks to individual's comfort. The service had worked proactively to improve the environmental health concerns inherited when taking on the building but had not always prioritised their refurbishment in response to their audit findings. For example, although the effected rooms received deep cleans in response to audits, the schedule of refurbishment prioritised rooms that were not in use to limit the disruption to people.
- There was no registered manager as required. The previous registered manager had de-registered on 21 September 2018. A registered manager's application had been in progress with the CQC until 26 March 2019 when that manager left the service. The provider had put measures in place to support the management of the home in their absence and the care manager was overseeing day to day management.
- Staff were well supported and felt they all worked as a team. One staff member told us, there were clear lines of responsibility through their roles and embedded practices.
- Daily meetings, team meetings and management schedules underpinned the day to day service delivery tasks, ensuring individual support needs were planned for and met. For example, health and social activities were noted on the rota and shared at handover meetings

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- People and their relatives spoke positively of the provider, the care manager, their staff team and how responsive and approachable they were. One person told us, "I've met the provider they come in quite a lot and ask me if I'm ok." A relative told us, I know who the owner is, and the care manager is brilliant, my relative loves them." Another relative told us, "The home is definitely getting better, you can see the

improvements. They're doing a grand job." A health care professional told us, "The provider is passionate and has a vision to improve the service, they want the best for people."

● Up to date sector information was made available for staff including details of managing specific health conditions including tissue viability to ensure they understood and had knowledge of people's needs.

● The care manager understood their responsibilities in relation to the provider's registration with the Care Quality Commission (CQC). The home had submitted notifications to us, in a timely way of important events that happened in the service including; DoLS authorisations, police incidents and deaths.

● The care manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guideline's providers must follow if things go wrong with care and treatment.

● There was a clear focus on developing team work, reflective practice and training in relation to the physical environment, dementia and end of life care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider was encouraging an open and transparent culture where staff could be listened to and could share their views on how the home could improve. One staff member told us, "The provider is approachable and always able to talk, they ask about the best way of approaching my role and we share ideas."

● People and relatives were encouraged to complete surveys, attend regular meetings and provide feedback and make suggestions for improvements in the home. For example, menus, staff changes, and the refurbishment of the house were discussed in resident's meetings. One relative told us, "The provider is very approachable, anything I ask for is done straight away. I can't complain about anything."

● People's diverse cultures were considered and promoted. The provider designed activities to support people to celebrate their own identity and experience others. For example, they celebrated Burn's Night, celebrated Valentine's day and invited relatives to Christmas carols and Easter events.

Continuous learning and improving care; Working in partnership with others

● The provider and care manager were continually looking to improve the culture of the home. They attended local authority care home forums and were actively developing community health partnerships. For example, they were promoting better practice through the community in-reach dementia team providing regular guidance, case studies and training for staff. A health care professional told us, "The provider knows this will take time. They will need to skill up staff and the layout of the building does not help."

● Arlington House was also establishing partnership working with a local hospice to develop the services awareness of end of life care and advance care planning and to provide links for people who may wish to remain in their home or use a hospice as part of their care.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were placed at risk of potential abuse due as the home had not identified or escalated safeguarding concerns in a timely way to ensure people were fully protected and further risks of harm mitigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not always ensured that staff were deployed in such a way that met people's preferences and care and support needs