Derby City Council

Arboretum House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We undertook this unannounced focused inspection visit on 25 August 2016 to check that the provider had addressed the breach in regulation identified at our last unannounced comprehensive inspection visit on 4 & 5 November 2015. At our last visit we identified that the provider had not notified us of the outcome of referrals which they made to the supervisory body for authority to deprive a person of their liberty. We issued a requirement notice as the provider was in breach of the regulation regarding notifications of other incidents. We also found improvements were needed in medicines management, some staff raised concerns about staffing levels and there was no registered manager in post.

After the last comprehensive inspection visit, the provider did not write to us to say what they would do to meet legal requirements in relation to the breach.

This report covers our findings in relation to the breach and other areas that required improvements at our last inspection visit. It also covers related information gathered as part of this inspection visit. You can read the report from our last comprehensive inspection visit, by selecting the 'all reports' link for Arboretum, House on our website at www.cqc.org.uk

Arboretum House is a care home which provides residential care for up to 38 people. The home specialises in caring for older people, including those with physical disabilities. At the time of this inspection there were 17 people in residence. Since the last inspection the provider was providing care to a younger adult. The provider told us they would change their registration details with us to reflect these changes. Since the last inspection visit the ground floor was being used by the provider in providing day care provision for younger adults. This provision was for people with profound and multiple learning difficulties and not part of the care provided by Arboretum House.

There was a registered manager in post, who registered with CQC on 5 September 2016.This 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.

When people lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At our last inspection visit we had not received the relevant notifications. At this inspection visit we found another person had an authorised application in place to deprive them of their liberty but we had not been notified of this. The manager completed the relevant notification at the inspection visit and sent it to us.

At this inspection visit, we saw that improvements had been made to how people's medicines were managed. This included the introduction of new medicines administration procedures.

There were enough staff on duty to meet people's needs. A staffing tool had been implemented to determine staffing levels at the service. People and most staff we spoke with told us staffing levels had improved.

People told us they were happy with the staff team. The staff provided effective care and understood the importance of offering people choice. The acting manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005.

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.

There were sufficient staff to support people and recruitment procedures ensured the staff employed were suitable to support people. Medicines were managed safely.

Is the service effective?

Good

The service was effective.

The provider and staff were aware of how to protect the rights of people who needed support to make decisions.

Is the service well-led?

Good

The service was well-led.

The service had a registered manager. The provider was aware of their legal obligations in reporting any changes, events or incidents that they must tell us about.

Arboretum 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 was 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 visit took place on 25 August 2016 and was unannounced. This inspection was done to check that improvements to meet legal requirements planned by the provider after our inspection visit of 4 and 5 November 2015 had been made. The inspection was carried out by one inspector. We inspected the service against three of the five questions we ask about services: is the service safe? Is the service effective? And, is the service well-led? This is because the service was not meeting some legal requirements.

We reviewed the notifications we had been sent. Notifications are changes, events or incidents that providers must tell us about.

We used a variety of methods to inspect the service. We spoke with two people using the service, one person's relative, the acting manager, assistant manager, senior care team leader and two care staff. We observed people being supported in communal areas. We also looked at one person's care records. We looked at the systems the provider had in place to support people who lacked capacity, medicines management and notifiable information and incidents.

Good

Is the service safe?

Our findings

At our last inspection visit in November 2015, we saw medicines were not managed safely. The medication trolley was left unattended with the doors unlocked. A similar incident was noted at a quality review by the local authority during February 2015. This showed people who were unauthorised to access medicines such as people using the service and visitors could access medications inappropriately and put themselves at risk.

At this inspection visit we saw the medicines administration procedures had changed. Staff told us the medicines trolley was no longer wheeled into communal area's and was kept in the medicines room.

We saw the senior care team leader administer medicines at lunchtime. People's medicines were prepared in the medicines room, each time the staff member left the room they locked the room and took the keys with them. They observed each person take their medicines before they returned to the medicines room to complete the records before they prepared, another person's medicines. This ensured unauthorised people did not have access to medicines.

At the previous inspection visit some staff felt more staff were needed particularly in the morning. People at this inspection visit told us they felt safe at Arboretum House. One person stated, "I have never witnessed staff being unkind to anyone." People and a relative we spoke with told us they felt there were enough staff on duty. Since the last inspection visit, the manager told us staffing levels were determined by using an 'analysis tool'. This electronic tool was completed by management or senior staff on a daily basis. People's needs were entered on to this system which then calculated the staffing levels required. The manager told us if staff were not available due to unforeseen circumstances or were on holiday these shifts were either covered by the existing staff team, or care staff from other services within the provider group or regular agency staff. This was confirmed by staff we spoke with.

Staff told us in recent months a number of staff had left, which meant they were short staffed. One member of staff said, "The morale has been low due to staff and management changes. But things have improved now." Another member of staff told us, "There have been a lot of agency staff, however lately there has been more consistency as we tend to get agency staff who have been to the service before." We discussed this with the manager who confirmed there were three care staff vacancies, one post had been recruited into and the other two positions were advertised. The manager told us they did their best to ensure when using agency staff they received staff who had worked at the service before. This showed steps were taken to provide continuity of care.

Good

Is the service effective?

Our findings

At the last inspection visit in November 2016, we saw Deprivation of Liberty Safeguards (DoLS) authorisations could not be located. When people lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. The application procedures for this in care homes and hospitals are called the DoLS. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the mental capacity act 2005 (MCA). The 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.

At this inspection we saw the authorisation documents for a person who recently placed on a DoLS.

At the last inspection people's records showed that mental capacity assessments had not been completed by the provider when a person was thought to lack capacity. At this inspection we saw in one person's care records a report from an external professional which stated the person lacked capacity. However there was no information in place regarding the person's mental capacity. We discussed this with the manager who told us if they had concerns about a person's capacity to make decisions, this information would be shared with the social work team immediately. They said the social work team would be responsible for completing mental capacity assessments. The manager told us they would update this person's records to reflect how they were supported to make decisions. We spoke with staff who knew about people's individual capacity to make decisions and understood their responsibilities for supporting people to make their own decisions.

We spent time with people in the communal areas. We saw staff gained people's verbal consent before supporting them whenever this was possible. Where people were unable to give their consent, staff explained what they were doing during any support given.

At the last inspection visit a person told us they had not consented to moving to the home. The systems in place regarding consent were not clear when people moved into the service. The acting manager told us following the last inspection, when people moved to the service they were asked if they consented to the move. One person's file showed us they were unable to give consent to their stay, their family member had consented to the stay alongside other professionals who were involved in the person's care. Records showed this person was also supported by an advocate. Advocacy is about enabling people who have difficulty speaking out to speak up and make their own, informed, independent choices about decisions that affect their lives.

We found the staff and management worked with health and social care professionals to ensure people received the care they needed. For instance, staff and the management told us they felt more suitable care was needed for a person, whose needs had gradually deteriorated since moving to the service. The manager regularly informed the person's social worker regarding the deterioration and felt alternative care facilities for this person were needed. The manager told us the social worker was addressing this matter.

We received concerns about the service prior to this inspection visit. We were told that people were not given choices and the care and supported provided by staff was institutionalised. We were also told bed time routines were not flexible. People we spoke with told us they were always given choices and were able to spend their time as they preferred. For example one said, "It is up to me when I go to bed and when I wake up." Another person stated, "I am always given choices. The staff always knock on my bedroom door before entering." One person's relative told us their family member was given choices, they said, "[Name], has a lot of choices which includes choices at meal times." The relative also said the care provided was not institutionalised and they felt there was a family orientated environment at Arboretum House. People told us the staff supported them effectively. One person told us, "I am not just saying this but, I cannot fault them [staff] they are very good."

Good

Is the service well-led?

Our findings

At the last inspection visit during November 2015, the provider had not notified us of the outcome of referrals which they had made to the supervisory body for authority to deprive a person of their liberty. At the time we discussed this with the acting manager, who informed us that they were not aware of this legal requirement. This was a breach of Regulation 18(4B) of the Care Quality Commission (Registration) Regulations 2009. We did not receive an action plan from the provider to say how they planned to make the required improvements.

Since the last inspection they had reported significant information and events in accordance with the requirements of their registration. However during this inspection we saw that a person was on an authorised DoLs, we had not been notified of this outcome. We discussed this with the manager, who confirmed they had been off work for a significant period of time and were not aware this had not been submitted to us. The acting manager completed the relevant notification and submitted this.

We reviewed the statement of purpose; a statement of purpose is a document which includes a standard required set of information about a service. Since the last inspection the provider has been providing care to a younger adult. The manager told us they would be changing their registration details with us to reflect these changes and to update the statement of purpose to reflect this.

The current manager was in charge of day to day management of the service and provided support to the rest of the staff team. Following this inspection visit, the manager's application for registering as the registered manager was successfully completed on 5 September 2016. A registered manager is a person who has registered with the CQC to manage the service.

People and staff we spoke with spoke positively about the manager. One person said, "The manager is very nice, she listens." Comments from staff about management included, "The staff respect the manager, she is a very good leader" and "[Name] is a good manager, she can work with her staff and still hold authority."
Prior to the inspection we received concerns that the managers were in an office on the ground and did not see what was happening on the first floor.
We saw the management office had been relocated on the first floor so that management could be more accessible to people. 'Yellow cards' were also placed in people's bedrooms, which they could attach to their bedroom door if they wanted to speak to staff regarding any issues. People we spoke with told us they had no concerns and felt confident if they raised anything it would be addressed.

Since the manager returned to work they had put into place an action plan, to improve the quality of the service provided to people using the service. Some of the action points had been achieved such as displaying photographs of staff who worked at the service.

Prior to this inspection visit during July 2016 we received information from Derby fire and rescue service, who had issued some recommendations for the provider to follow. The manager showed us information to confirm that action had been taken to address the recommendations. For example we saw some staff had

completed fire evacuation training and others were due to attend a session during September 2016. Smoke detector devises had been ordered and staff had been remembered not to wedge open doors.

People and staff raised concerns about the uncertainty which surrounded them regarding the future of Arboretum House. Since the last inspection some care homes operated by Derby City council had undergone a period of consultation on the future running of these services, which included Arboretum House. People and staff told us they were waiting to hear about the outcome of the consultation. One person said, "I have been here for several years, I am worried about what's going to happen." A relative stated, "My only worry is the future of the home."