Coate Water Care (Arbory) Limited

Arbory Residential Home

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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Arbory Residential Home is a care home providing personal care to up to a maximum of 60 people. The home does not provide nursing care. At the time of our inspection there were 42 people using the service, some of whom were living with dementia. The accommodation at Arbory Residential Home is arranged over 2 buildings. The Lodge has accommodation over 2 floors and is an older building that has been repurposed into a care home. The Court is a newer, purpose built building where the accommodation is arranged over 3 floors. There are communal lounges and dining areas and a secure garden area.

People's experience of using this service and what we found
Staff had not always assessed, monitored and managed people's safety well and some environmental risks were not being adequately managed. There were insufficient numbers of staff deployed to meet people's needs. Medicines were administered by suitably trained staff and in a person centred manner, but some improvements were needed to ensure that people always received their medicines as prescribed. Visiting could take place flexibly and booking was no longer required. Staff understood how to protect people from avoidable harm or abuse. Staff understood their responsibility to report safety related incidents. Some reviews and investigations into incidents could have been more thorough to help ensure every opportunity for learning was taken.

Improvements were needed to ensure that the MCA was fully understood and implemented in line with legal frameworks. The provider had not ensured that the premises and equipment within it were clean, secure and properly maintained. There was evidence that the provider was investing in the service and was undertaking a refurbishment programme, staff told us this was starting to make a difference. We saw some positive interactions where care and kitchen staff were encouraging and supportive when helping people to eat and drink. However, we also saw some examples, where the lunch service was more chaotic, and less person centred. The provider had not ensured that all staff received an induction when they first starting working at the service. There was no embedded programme of supervision being used to develop and motivate staff and review practice and performance. The provider offered staff a good range of training and most staff were up to date with this. Some care plans lacked completeness or contained conflicting information whilst others were more reflective of people's needs. Staff worked with health care professionals to meet people's healthcare needs.

Governance systems had not been operated reliably or effectively the provider had not maintained adequate oversight of the quality and safety of all aspects of people's care. Statutory notifications had not been submitted appropriately to CQC. The provider has implemented a number of changes to address this. Feedback about the new manager was positive. Staff expressed a growing confidence that they were trying to make improvements. Permanent staff knew people well and promoted their independence. However, more needed to be done to ensure that a varied and meaningful programme of activities was provided.

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

Rating at last inspection
The last rating for this service was good (published 24 December 2020).

Why we inspected
We received concerns in relation to the quality of people's care, the management of falls, the cleanliness of the home, staffing levels and the quality of the food. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement with 6 breaches based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well led key question sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Arbory Residential Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, governance, staffing, the premises and the need for consent. We also identified a breach due to the lack of notifications.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Arbory Residential Home

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was undertaken by 1 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.

Service and service type
Arbory Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Arbory Residential Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post, however, they had resigned and had not been in the service since 16 October 2022. They have applied to cancel their registration to take affect from the 22 November 2022. A new manager had been appointed and had been in post since 5 October 2022. They have not, as yet submitted an application to register.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was asked to complete a Provider Information Return (PIR) prior to this inspection, but this was not due to be submitted until after we carried out the inspection and so we were not able to use this to inform our inspection planning. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We received feedback from 3 health and social care professionals.

We used all this information to plan our inspection.

During the inspection
We spoke with 8 people living in the home and 6 relatives. We also spoke with the regional manager, home manager, deputy manager, maintenance person, 3 care staff, an agency worker, the chef and 3 members of the housekeeping team. Following the inspection, we received feedback from a further 4 staff and 1 relative.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained as requires improvement. This meant that there was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
- Staff had not always assessed, monitored and managed safety well.
- Some risk assessments such as those relating to skin care, choking or seizure management lacked detail or completeness.
- One person, who received bed based care, had bed rails in place, but no bumpers fitted. Securely fitted bed bumpers are important to help mitigate risks associated with entrapment and to prevent injuries from impact against the bed rails. When pointed out, the manager took action to address this.
- A more proactive approach to anticipating and managing some falls was required. Post falls checks were not consistently taking place to ensure that people were not deteriorating. The provider plans to introduce a new form to start recording these.
- The chef was not clear about which people had modified diets; they had no information available within the kitchen to reference.
- Some environmental risks were not being adequately managed.
- Whilst action was taken to address this, we were concerned that Items had been stored in a stairwell that was a fire escape.
- We had made a recommendation at our last inspection that the provider review their legionella risk assessment as we were not assured that this was sufficiently robust, or that it had been completed in line with relevant guidance issued by the health and safety executive. This had not been addressed. The provider has now arranged for this to be completed.
- Hampshire Fire Service had visited the home on the 14 July 2021 to evaluate the fire safety. They had indicated that 3 improvements were needed. Some of this work was yet to be completed. For example, 1 of the actions was that a fire drill take place using night-time staffing levels. This had not been completed when we inspected 17 months later.
- The electrical installation within the home was assessed as unsatisfactory in November 2020. Whilst the most urgent actions had been addressed, a number of other remedial actions, assessed as 'Potentially dangerous - urgent remedial action required' were recommended in order to achieve a satisfactory status. A quote for this work to be completed was obtained in February 2022 but it remains uncompleted.

Risks to people's health and wellbeing and those arising from the environment had not always been managed safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us they felt safe at the service. One person said, "I feel safe, I just feels it". One relative said,

"They make sure they are all safe" and a visitor said, "I know [Person] is safe and gets on well here".
● Systems were in place to monitor the prevalence of infections and there was a tracker to monitor progress with the healing of pressure ulcers and wounds.

Staffing and recruitment
● Our observations and the feedback we received from staff and relatives indicated that there were not sufficient numbers of staff deployed at all times to meet people's needs.
● Over the course of the 2 days we inspected the service, we observed people did not always receive timely support and communal areas were, at times, left unsupervised. For example, we visited the communal lounge in the Lodge on day 1 of our inspection at 3pm. There were no staff at all on this floor but there were 5 people in this area. This was for a period of approximately 10 minutes. The staff member allocated to this area was supporting a colleague on the first floor.
● We observed other similar incidents where it was hard to locate staff. For example, on day 2 of our inspection, there were 8 people in lounge / dining area on the top floor of the Court unit, but no staff were supervising this area. Again, this was for a period of approximately 10 mins as the 2 staff were supporting another resident in their room. We asked the manager if they were comfortable with this arrangement, they said that they were not.
● Each of the staff we spoke with, raised some concerns about staffing. One staff member told us when asked if there were always enough staff deployed, "No definitively not… Seniors are included in the numbers on the floors which means we run short because they spend most of the day doing meds or in the office… We are constantly having fantastic staff leave, they are not replaceable, and no effort is made to keep them".
● Another staff member said, "We have been told we are over staffed… but if you are working in Court you cannot under any circumstances take residents for a bath as there are not enough staff to cover the floor".
● A third staff member said, "I think the top floor in Court is a full on floor sometimes they could do with an extra member of staff for personal care, mealtimes and putting people to bed".
● Another staff member said it was hard to relieve their colleagues for their breaks and prevent incidents from occurring between 2 particular people.
● At lunch time, we observed that 1 person who had one to one care was wanting to go outside into the garden. The only staff member in this area was not able to facilitate this as they were also overseeing the lunchtime service in the dining room.
● We heard about the impact of staffing in other areas also. One staff member raised concerns about the lack of meaningful interaction with people who were cared for in their rooms. This was also commented on by a social care professional who told us, "If a person is confined to their room by choice, or illness or frailty it seems they may be left unattended and on their own, save for a regular quick 'check' for quite long periods".
● We found evidence that people's basic needs were not always being met. For example, we observed that a number of men had not been shaved for several days. This was confirmed by daily records which showed that 1 person had only been shaved 6 times in November 2022.
● We observed 1 person walking in the corridor, they were upset and indicated that they needed help with going to the toilet. Neither we nor the manager were able to find a member of staff. This was because there was no member of staff on that floor at the time was assisting another person.
● Concerns were also expressed to us about the staffing levels at night. Night shifts started at 8pm and there were 5 staff were on duty at night, this was 2 in the Lodge building and 3 in the Court building. This was essentially one staff member per floor and one, usually the senior, floating between floors to support as necessary. However, staff cited challenges around managing people who might still be awake but in need of one to one support to help avoid incidents, whilst also attending to people who needed 2 staff to meet their needs.

● Staff also spoke of the impact of vacancies in the housekeeping team which meant that they had to take on responsibility for some wider tasks, 1 said, for example, "Staff have to keep leaving the floors to stock up on kitchen items, laundry items, looking for bin bags and paper hand towels".
● We received mixed feedback about staffing from relatives. One said there was the "Right measure and balance out on each floor. I'm here nearly every day so I see a lot" and another said, "[Family member always looks immaculate". However, others raised some concerns. One relative said, "They need more staff, on the top floor they have 2 members of staff, after lunch, if they have to change [Person] it means that there is no one around to help anyone else" and another said, "I don't think there are enough. To me it's worrying about prompting to drink…There are a few members of staff who were here and have now left, there is a high turnover of staff."
● Staffing levels were calculated using a dependency tool. This was regularly reviewed to inform the staffing levels. However, as a result of our observations we were not assured that this tool was effective.

There were not always sufficient numbers of staff deployed to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People raised no specific concerns regarding staffing levels. One person said, "There's always somebody around… I can have a bath sometimes in the mornings, sometimes in the evenings" and another said, "Plenty [Of staff], I can do anything I want, when I want. I have baths when I like."
● The home had a number of vacancies that they were trying to recruit to in the care team, for seniors, for housekeepers and for activities staff.
● Agency were being used to fill gaps in the rotas.
● The provider had obtained a license from the home office to recruit staff from overseas and had employed a number of staff successfully via this route.
● Most of the required recruitment checks had been completed. However, we found in one instance that not all recruitment processes and checks had been completed appropriately. When we discussed this with the provider they completed a risk assessment immediately.
● Some of the agency profiles did not include sufficient information. For example, whilst they provided a date that a DBS check had been completed, it did not record the outcome of this. The provider has now made amendments to the information required from the agency concerned.

Using medicines safely
● Some improvements were needed to ensure that people always received their medicines as prescribed.
● One person had been administered a pain relieving medicine that was past its expiry date. We were concerned that that this could have made the medicine less effective as it was used outside of the timeframe recommended by the manufacturer.
● Records did not provide assurances that topical creams were always being applied as directed. The provider's medicines policy did not include guidance for staff on the systems and processes for recording the administration of topical creams. The provider told us the medicines policy was going to be shortly reviewed and changes were also being introduced to the way in which their electronic recording system and electronic medicines administration records (eMARs) worked together to support the safe administration of topical creams.
● Two prescribed thickening powders were found in a kitchenette cupboard. They had not been stored securely. This was a concern as incidents have been reported where harm has been caused by accidental swallowing of thickening powders.
● Medicines records were complete and contained no gaps. The stock held matched that indicated by the medicine's records. Medicines were stored within appropriate temperature ranges.
● More detailed records were now being maintained to show why medicines, were at times, not

administered. It was evident that staff had tried again to administer medicines that people had at first refused.
● Medicines were administered by suitably trained staff and in a person centred manner.
● People were happy with the support they received with their medicines.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
We were somewhat assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● Visiting could take place flexibly and booking was no longer required.
● Feedback about the visiting arrangements was positive with all relatives saying they felt welcome at the service. One relative said, "Now I don't have to book so I can come whenever I like".

Systems and processes to safeguard people from the risk of abuse
● Staff understood how to protect people from avoidable harm or abuse.
● Safeguarding concerns had been escalated to the local authority and there was evidence that the manager was working with other agencies to ensure relevant actions had been taken to address any immediate risks and to ensure people's safety.

Learning lessons when things go wrong
● Staff understood their responsibility to report safety related incidents and there was evidence that these had mostly been reviewed by the manager.
● Incident forms provided assurances that remedial actions had been taken following falls, for example, seeking advice from relevant healthcare professionals, reviewing equipment and informing family members.

● Some reviews and investigations into incidents could have been more thorough to help ensure every opportunity for learning was taken. For example, in September 2022 1 person was admitted to hospital with high blood glucose levels and dehydration. Records did not provide assurances that a detailed review of the person's care, prior to the hospital admission, had taken place to identify learning which could have been used to improve the care provided.
● In response to a number of incidents, we found that general terms such as 'continue to monitor' were used. It was not clear to us what this meant in practice and how this would improve outcomes and safety for people.
● Whilst daily meetings were held with the heads of each department to share information about any new or emerging risks, a common theme in feedback from care staff was that information from these meetings was not always being effectively shared with them. The new manager is implementing regular staff meetings to ensure that staff were involved in developing and improving the service.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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 appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Improvements were needed to ensure that the MCA was fully understood and implemented in line with legal frameworks.
- A number of people using the service lived with advanced dementia, but there was a lack of evidence of people's capacity to consent to the care and support being provided had consistently been assessed when required.
- Those mental capacity assessments that were in place, lacked detail and evidence to support the judgements reached.

This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Improvement plans created by the home indicated that they had already identified that this was an area where improvements were needed, and plans were in place to provide the senior with training that would equip them with the skills and knowledge that they needed to complete mental capacity assessments effectively.
- The new manager demonstrated a good working knowledge of the DoLS. They had taken action to seek accurate information from the local authority regarding which people had an authorised DoL in place and, which had been applied for, but not yet authorised. They were in the process of reapplying for any that had

expired.

Adapting service, design, decoration to meet people's needs
● There were areas of the home where the fabric of the building, paintwork and some of the fixtures and equipment within it were in need of updating or repair.
● The kitchenettes needed a more thorough cleaning and, in some cases, refreshing to make these a pleasant space for people to use. There were brooms stored in the kitchenettes that were very dirty.
● The carpet on the stairs in the Lodge building was stained and there was a strong odour of urine in part of the first floor of this area. One of the toilets and bathroom in this area also had a strong smell of urine within it and was not a pleasant space for people to use.
● Records did not provide assurances that all of the monthly cleaning tasks in the kitchen were being completed. When we visited the kitchen, there were areas where it could have been cleaner. There were stains up the wall under the main kitchen hatch.
● There was an evident lack of basic crockery. We observed 1 staff member having to wash another person's dessert bowl in order to provide people on the floor above with their pudding.
● The lack of crockery was a theme in the feedback from staff, with 1 saying, "We are always running low on crockery, cups, bowls and plates, we end up giving [People] desserts in teacups".
● We also observed that some of the glasses offered to people needed to be more thoroughly cleaned and the biscuit jar that was being used was stained and dirty.
● The automatic releases for fire doors were dirty and did not look like they had been cleaned for some time and some furniture needed replacing as it was so worn that it would not have been possible to keep clean.
● Some equipment, such as hoists were observed to need cleaning.
● Staff raised a number of concerns about aspects of the environment and of the equipment within in, for example, about the reliability of the nurse call system and the lack of sufficient moving and handling equipment such as slide sheets.
● A number of the relatives and staff spoke with regret about the lack of attention being paid to the external grounds and the loss of flower beds. We found that some areas of the gardens were overgrown and the outer grounds, which were visible from the living spaces, were littered with rubbish and building materials. The provider told us they had engaged a new gardening contactor to address this.
● Staff told us that a number of people's rooms lacked personalisation. We visited 1 person who was cared for in their room and found that they had neither a television or radio to provide some stimulation or a sense of company.
● People had memory boxes outside their room to help orientate them and there was some accessible signage to support people to recognise where the toilets or communal rooms were, but in general, there was scope to further adapt the environment to meet the needs of those living with memory loss or dementia or other sensory deficits, enabling them to meaningfully interact with the environment in which they lived. There were for example, no menus displayed or activity timetables. We noted that clocks were on the wrong time. When this was pointed out, action was taken to address this.

The provider had not ensured that the premises and equipment within it were clean and properly maintained. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was evidence that the provider was investing in the service and was undertaking a refurbishment programme, staff told us this was starting to make a difference.
● Since we last inspected, a new lift, laundry, and well equipped kitchen had been installed. In the lodge building, 1 of the lounges had been completed renovated to create a modern and comfortable space. This room was shortly going to be available for people to use.

● The home were recruiting for a second maintenance person.
● The provider had identified that it needed to strengthen its housekeeping team and they were advertising for an additional, full time, housekeeper so that a cleaning service was available across all 7 days, including in the evening.

Supporting people to eat and drink enough to maintain a balanced diet
● We saw some positive interactions where care and kitchen staff were encouraging and supportive when helping people to eat and drink. In 1 example, we saw that a staff member returned several times to a person, who was refusing their meal. Each time, they tried a slightly different approach to encourage the person to accept a meal. On the fourth time, the person accepted the meal and started to eat.
● In another part of the home, we observed that the kitchen team were attentive, offering sauces and assistance to cut up food. Show plates were used to support people to express their preferences between the food options and there was evidence of people being offered a range of snacks including crisps, biscuits and cakes.
● Overall, the feedback about the food was that it was satisfactory. Comments from people included, "Food is average I suppose. Sausages is one of the better ones", and "It's good food. I think most of us usually enjoy the food. It wasn't so good today as it is usually. Maybe they didn't have enough so they filled it up with mashed potatoes. Too much vegetables and not enough meat but that's quite unusual. There is a choice. Nothing seems too commercialised."
● A relative told us, "The food is very nice and there is plenty of it, they give her fruit and treats".
● However, we also saw some examples, where the lunch service was more chaotic, and less person centred. In 1 area, people had been encouraged to come to the table early, but then kept wandering off. At one point 2 people had been encouraged to sit down, but their chair was some distance from the table. Instead of being supported to stand and move closer to the table, they were left to lean over to eat. In another area, there was no ambience, staff just stood back, observing, but not really engaging. On another floor, a daytime TV talk show was playing loudly whilst people were having their lunch.
● We observed that some people who were cared for in their rooms were left to eat with little interaction from staff who were busy completing other tasks. We observed people laid in bed asleep with their meal left on a tray next to their bed. Staff told us that mealtimes were challenging due to staffing levels and meant they were not always able to support each person in a flexible manner.
● Fluid intake was monitored and levels across the home appeared very high. The process for recording fluid intake was being reviewed to ensure that this was recorded accurately and therefore provided an effective tool at assessing and monitoring hydration when required. We did visit 1person who was cared for in their room, but they had no fluids available in the room.

Staff support: induction, training, skills and experience
● The records, for 2 of the 4 new staff, we reviewed did not include an induction. Inductions are a formal process and help to ensure that new staff receive essential information about their role and responsibilities. The manager has now taken action to ensure these inductions have been completed retrospectively.
● Whilst staff told us they felt well supported, there was no embedded programme of supervision being used to develop and motivate staff and review practice and performance. The new manager has started to address this with some supervision sessions already delivered and more planned.
● The provider offered staff a good range of training and most staff were up to date with this.
● The feedback from some staff was that they would value more face to face training.
● From 1 July 2022, all health and social care providers registered with the Care Quality Commission were required to ensure that their staff received training in how to interact appropriately with people who have a learning disability and autistic people. Staff were in the process of completing this training.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Some care plans lacked completeness or contained conflicting information whilst others were more reflective of people's needs.
● There was some evidence of care plans containing personalised information but this was not consistent, or in some cases sufficient.
● Care plan audits were being used to drive improvements in this area.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People felt that staff supported them to stay as well as possible. For example, 1 person said, "If they think you're not feeling very well, they're very good" and another said, ""If I'm not well they look after me, they're good. I'm pleased with that as they're on the case straight away".
● There was evidence that staff worked with a range of community healthcare professionals. We were able to see examples where people had been referred to external services for further assessment and treatment. One relative told us, "If she has a water infection, they let me know, they look after her well" and another said, "The staff generally recognise if my [Relative] is unwell and take appropriate and quick action to seek a medical review". A third relative said that if they had any concerns, they "Go to the one of the seniors. They're really on the ball, proactive not reactive".
● One person's family did express some concerns about the management of their relative's diabetes and felt they had not been kept in the loop regarding this. They felt this was an area where improvements could be made.
● Staff were working with the homes GP to undertake medicines reviews and reviews of people living with dementia which involved checking for new symptoms or changes in behaviour and how these might best be managed. Work was also being undertaken to assess the impact of regular pain relief in preventing falls.
● Staff were embedding the use of an escalation tool that uses physical observations to assess whether a person's health is deteriorating and in doing so supports the decision making of healthcare professionals.

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Whilst a clear governance framework was in place, we were not assured that this had been operated reliably or effectively. We were not assured that the provider had maintained adequate oversight of the quality and safety of all aspects of people's care.
- The inspection identified a number of areas where the safety and quality of the service was compromised, and fundamental standards were not being met. A recommendation made at our last inspection regarding the management of legionella within the home had not been acted on by the provider.
- This inspection also identified concerns regarding how some risks to people were mitigated, the cleanliness of the home and the numbers of staff deployed. We also found that legal frameworks regarding consent were not being effectively implemented.

The provider had not ensured that there were effective systems in place to assess, monitor and improve the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Statutory notifications had not been submitted appropriately to CQC. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them. We found that a number of historic safeguarding concerns from 2021 and earlier in 2022 had not been notified as required.

This was a breach of Regulation 18 (Notification of other Incidents) of the Care Quality Commission (Registration) Regulations 2009.

- Prior to the inspection, the provider had commissioned a full review of the governance arrangements in place both at home level and regional level. Some concerns were identified with the completeness and accuracy of some of the governance tools and the level of oversight that had been maintained.
- In response, the provider made a number of changes, which included recruiting a new regional management team to ensure adequate oversight of the quality assurance arrangements within the home.
- It was clear from the current improvement plan that many of the concerns our inspection found had already been identified by the new manager and regional team and plans were in place to address these.
- Feedback from staff about the new manager was cautiously positive. Most staff told us that their initial impressions of the new manager were positive, and they expressed a confidence that they were trying to

make improvements. Comments included, "We have a new manager just started…she seems nice and approachable", "The new manager is trying her best to sort things out" and "[Managers name] is bringing it back to how it used to be".

● Some staff commented that they would like the new manager to have a greater visibility within the home, work more directly with people and lead by example.

● A social care professional told us, "[Manager's name] the new manager has been very welcoming and appears to be proactive in doing the best for the residents".

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The manager was aware of their responsibility to act in an open and transparent way when things went wrong, and we saw examples where relatives had been notified of safety related events that had occurred.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● We saw that overall, staff knew people well, promoted their independence and as time allowed, took a genuine interest in providing support in way that would enhance the person's day. One person told us, "They're [Staff] definitely kind and good" and another said, "It's not too officious and I can recognise aspects of it that you have in your own home. You can wander around and feel quite relaxed". A third person simply referred to the staff saying, "They are friends".

● Similar feedback was received from relatives, 1 of whom said, "I don't think they could be more kind, sometimes residents have words, they step in, it's one of the best places" and another said, "Absolutely. That's the reason [family member] is so far from home. He could be nearer to home, but everyone here is so caring. I need [Person's name] to have hugs when I'm not around… There is care, companionship, empathy, kindness and they are tactile. I see them giving cuddles".

● Despite expressing some challenges, all of the staff, we spoke with, told us their colleagues were all kind and caring to people and supportive of one another.

● A social care professional praised the way in which staff respected people's choices and preferences. They said, "One of the aspects of The Arbory that I have really liked is their acceptance of the resident with all their eccentricities and foibles and their willingness to try to accommodate and support the person in being themselves". They spoke positively about how staff had in the past encouraged people to help in the garden and plant and harvest vegetables and said, "I have observed some real gentleness and kindness from a number of staff.

● Despite this positive feedback, it was evident from people's records and from our own observations that the service was not providing a varied programme of meaningful activities that met each person's social and emotional needs.

● During both days of the inspection, we did not see any organised activities taking place and we observed that people were sat for extended periods of time with limited engagement with each other or with staff. One visitor said to us, ""All [Person] has now is telly, he doesn't do anything else".

● It was the provider's view that there should be a whole team approach to providing activities, but staff told us, they did not always have time to engage with people as much as they would like alongside their care tasks.

● One of the 3 vacant posts for activities staff had recently been recruited to and recruitment of additional activities staff remained a priority for the provider.

● A number of staff and relatives also raised concerns about the lack of a visiting hairdresser. One staff member said, "We have been without a hairdresser for nearly a year, family members have been coming and cutting their family hair and also staff have been cutting residents hair". A relative said, "Hair is a major concern. I think they could make more of an effort with her hair, she's quite unkempt". We have been

informed that a hairdresser has now been retained and will be starting in the new year.

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

● The service was embedding the use of a system called 'resident of the day' which helped staff review care and risk management plans on a monthly basis. More needed to be done though to evidence that people and their family and friends were involved in this process and that it provided a genuine opportunity for them to give feedback about the care provided.

● There had not been any resident or relatives' meetings for some time and a theme in the feedback we received from relatives was that they did not always feel that information about changes within the service were shared with them in a timely manner. A number of relatives told us, for example, that they had not been informed that there had been a recent change in manager. One said, "We didn't get an email informing us. They are looking after our most treasured and it would be nice to know". The new manager was taking action to address this had made arrangements for a mince pie evening to be held with relatives on the 19 December 2022. This was used to share information about staffing changes, future plans for the home and to listen to relatives' views and feedback. Plans were put in place to ensure that these meetings would be held quarterly moving forward.

● People's protected characteristics were considered as part of the assessments of their needs and when drafting relevant care plans.

Working in partnership with others

● The leadership team and staff worked with a range of health and social care professionals to meet people's needs.

● The provider responded in an open and transparent way to requests for information to support this inspection.

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 18 Registration Regulations 2009 Notifications of other incidents Statutory notifications had not been submitted appropriately to CQC. This was a breach of Regulation 18 (Notification of other Incidents) of the Care Quality Commission (Registration) Regulations 2009.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Legal frameworks for consent were not always being followed. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was an inconsistent approach to managing risks to people's health and wellbeing and those arising from the environment. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment

The provider had not ensured that the premises and equipment within it were clean and properly maintained. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that there were effective systems in place to assess, monitor and improve the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient numbers of staff deployed to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.