ACL Homes Plus Limited

Arthur Court

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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Arthur Court is a residential care home providing personal care to up to 19 people. The service provides support to people with a variety of mental health conditions, and some people were autistic or had a learning disability. At the time of our inspection there were 16 people using the service, with 4 people being in receipt of personal care.

People's experience of using this service and what we found
People, relatives and healthcare professionals gave positive feedback about Arthur Court. However, we found that guidance was not always in place to inform staff how best to support people. When people moved into the service staff completed assessments, however the written assessments were not robust. Accident and incident oversight was not always documented and used to inform and update care plans. Checks and audits were not effective in identifying and making improvements identified during the inspection.

Medicines were managed safely. People told us they felt safe living at the service. The service was clean and well maintained.

There were sufficient staff in place, who received training and support to meet people's needs. Staff worked with healthcare professionals to provide joined up care to people. People told us the food was good at the service, and people were encouraged to maintain a healthy balanced diet. The service was homely, and people's rooms were personalised.

There was a positive culture within the service. Staff interactions with people were kind and compassionate. People told us they had positive relationships with staff. People were supported to be as independent as possible. Staff, people and their relatives felt involved in the service, and were committed to make improvements.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service however did not always this practice.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

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 outstanding (published 6 October 2016).

Why we inspected
This inspection was prompted by a review of the information we held about this service.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Arthur Court on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to risk mitigation and good governance at this inspection. 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 effective findings below.

Is the service caring?

Good

The service was caring.
Details are in our caring findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.
Details are in our well-led findings below.

Arthur Court

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 carried out by 2 inspectors.

Service and service type
Arthur Court 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. Arthur Court 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
At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave a short period notice of the inspection because we wanted to ensure the service was providing a regulated activity.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements

they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 4 people who used the service and one relative about their experience of the care and support at Arthur Court. We spoke with 7 members of staff including the registered manager, director, manager from another of the providers locations, senior carers and carers. We also spoke with 2 healthcare professionals.

We reviewed a range of records including 4 care plans and multiple medication records. We looked at 3 staff files in relation to recruitment and supervision. A variety of records relating to the management of the service, including auditing and monitoring records were reviewed.

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 Good. At this inspection the rating has changed to Requires Improvement. This meant 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.

Learning lessons when things go wrong

- The service had not managed incidents affecting people's safety well. Incidents had not been reported appropriately and managers had not investigated incidents and shared lessons learned.
- Accidents and incidents were documented, and there was a system in place to review and complete follow up actions, however, this was not always completed and effective.
- Following incidents of distress, incident reports did not always detail actions taken to learn from the incident and make improvements. The registered manager told us this was completed verbally between the management team, however there was no documented evidence of this, including updates to care plans.
- During one incident of distress, an unplanned intervention took place. There was no record of investigation into this incident, no review of care plan or risk assessment, no de-brief for the staff and no health checks completed for the person. The registered manager could not provide evidence they had notified the relevant stakeholders. Following the incident, further training was sourced for staff, however there was a lack of understanding and oversight in relation to the incident.
- There was no formal system in place to have oversight into accidents and incidents to review and identify trends. The registered manager told us this was completed verbally within the management team, however, could not demonstrate actions taken to address learning.

Assessing risk, safety monitoring and management

- People's care records did not help them get the support they needed because care records were not accurate, complete, and up-to-date.
- Although we found no evidence people had been harmed, care plans and risk assessments were not robustly detailed to inform staff how to reduce risks to people, and support and reduce any distress.
- Some people were at risk of choking; however, care plans and risk assessments were inconsistent, and not sufficiently detailed to inform staff of actions to take if someone were to choke. Staff we spoke with understood how to respond to someone choking, however the lack of guidance left people at risk if a staff member was new, or if people were supported by agency staff.
- The provider had purchased an anti-choking device to be used in the event a person choked. The provider had ensured staff had received training in how to use the device, however there was no guidance in place for staff to refer back to.
- Care plans and risk assessments did not provide staff with sufficient information about people's needs and how best to support them. For example, people living with schizophrenia did not have specific care plans detailing how this may affect the person day to day, and how best to support them to reduce the risk of a decline in their condition. People at risk of constipation did not have detailed guidance to inform staff

when to escalate concerns to the relevant healthcare professional.
● There was no documented evidence to confirm that all staff had taken part in a fire drill. There had been no fire drills completed at night, this presented a safety and fire risk.
● Some radiators, including those in some people's bedrooms, were unguarded. There were no risk assessments in place. This presented a risk of burns should a person be in contact with a hot surface for too long, for example, if they were unresponsive or lacked the mobility or cognitive capacity to move away from hot surfaces.

The registered person failed to assess and mitigate specific risks to people. This is a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
 People were kept safe from avoidable harm because staff knew them well and understood how to protect them from abuse. The service worked well with other agencies to do so.
● There were systems and processes in place to reduce the risk of abuse to people. A relative told us, "They are safe and very well taken care of."
● Staff had received training in safeguarding people, and demonstrated an understanding about risks to people, and how to escalate and report concerns. Staff told us, "I would raise concerns with the supervisor, or I could whistle blow. I'm never worried about that because the staff here are really nice." People we spoke with told us they were content living at the service. One person told us, "I have lived here for years, and I wish I could have lived here longer."
● The registered manager was aware of their responsibilities around safeguarding people and worked with the local authority to address any concerns raised.

Staffing and recruitment
● The service had enough staff to meet people's needs, including for one-to-one support for people to take part in activities and visits how and when they wanted. Staffing was reviewed and amended depending on people's activities or health appointments.
● People told us they were happy with the support they received. Staff told us there were enough staff. A staff member told us, "Very happy with the staffing at Arthur Court," and another staff member told us, "I've never worked a shift where we are short of staff. I've never had a situation where we didn't have enough staff."
 Staff recruitment and induction training processes promoted safety, including those for agency staff. Staff knew how to take into account people's individual needs, wishes and goals.
● There were effective systems in place to ensure new staff members had checks completed before to working with people. For example, all staff members had Disclosure and Barring Service checks. These provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely
● Staff reviewed each person's medicines regularly to monitor the effects on their health and wellbeing and provided advice to people and carers about their medicines.
● Medicines were stored and administered safely in line with the providers processes.
● People had been supported to have medicines reviews and, in some cases, had been supported to reduce the number of medicines. A relative told us, "Arthur Court have gone above and beyond with [my loved one]. When they first arrived, they were heavily medicated, and staff have really helped them with their medicines."
● We completed a reconciliation of medicines and found that the stock level matched the recorded levels of

medicines on the medicines administration records. Checks were completed to ensure medicines were stored in line with the manufacture's guidelines at a suitable temperature.

● All staff had received training and competency checks to ensure they were cable of administering medicines to people. A staff member told us, "They teach us about the medicines we administer and what they are for. I've never had that before. The medicines procedure is really well structured. It helps you to make sure you don't make a mistake".

● Checks were completed by staff on the stock levels of medicines. Following a medicine audit, it was identified there had been a medication error. Improvements were put in place to reduce the risk of the error reoccurring with the introduction of an electronic system which required staff to scan the medication before administering. Following this there were no further errors recorded.

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 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 promoting safety through the layout and hygiene practices of the premises.

● 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

● Visitors were welcomed at the service, and people were encouraged to spend as much time with their loved ones as they wanted.

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.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- Staff had not completed a comprehensive assessment of each person's physical and mental health either on admission or soon after.
- Prior to people moving into the service, an assessment of their needs was completed by the registered manager. Staff and the registered manager spent time with people to understand their needs and get to know the person.
- Assessment documentation was not robustly completed and detailed to help inform care plans. Some sections were not completed, and other sections lacked detailed information about the person. We discussed this with the registered manager who confirmed this would be reviewed as part of their new care planning system.
- Although staff knew people well and knew how to de-escalate and support people during times of distress, support plans did not always set out people's needs or inform promoted strategies to support people. Support plans lacked learning from incidents and had not always been updated following incidents.

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.
- Staff did not always demonstrate best practice around assessing mental capacity, supporting decision-making and best interest decision-making.
- Staff had received training and understood people's rights to make decisions about their care and support. People told us they made choices about what they wore, the things they liked to do and what food

they wanted to eat.
● Documentation to support decision making was not always robust and reflective of the support delivered. For example, supporting care plans for people who lacked capacity around decision making to go out without support were not always in place.
● One person's care plan detailed they had a DoLS in place which 'would remain'. However, there was no information to inform staff when the DoLS should be reviewed, and to prompt staff to review restrictions in place to ensure they remained the least restrictive options. We discussed this with the registered manager who confirmed they would review all care plans to ensure they were accurate.

Staff support: induction, training, skills and experience
● Staff could describe how their training and personal development related to the people they supported.
● Staff knew people well and had the skills to support people with their needs. Healthcare professionals told us, "There are very few services within the area that can meet the needs of this client group well" and, "Staff know their clients well and are very good at communicating and liaising with [healthcare professionals] in a timely way."
● New staff had an induction which included completing training and shadowing experienced staff. All staff gave us positive feedback about the support they received from their peers and managers. A relative told us the staff were, "Excellent."
● Staff had not all completed training in supporting people with a learning disability and autistic people. Following the inspection the registered manager had arranged for all staff to receive training in supporting people with a learning disability and autistic people. The registered manager had identified the need for staff to complete de-escalation training including interventions, and this had been scheduled.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink sufficient amounts to maintain a balanced diet. One person told us the food was "Delicious!"
● People came together to decide what they wanted to eat and were encouraged to gain skills in relation to cooking and meal planning.
● People were encouraged to make healthy food choices, and to have a varied diet. A relative told us that their loved one was underweight when they arrived at the service but has been supported to gain weight. The relative told us, "If they don't like something, staff will always offer alternatives until they are happy".

Adapting service, design, decoration to meet people's needs
● People's care and support was provided in a safe, clean, well equipped, well-furnished, and well-maintained environment which met people's needs. The service was homely, well decorated and designed. People had different areas within the home where they could spend time together or quiet time independently.
● People personalised their rooms and were included in decisions relating to the interior decoration and design of their home.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People received support from a range of healthcare professionals, depending on their needs. A healthcare professional told us, "There is good consistency in the service, and they are very transparent with any issues – we are with them, and they are with us."
● People were referred to health care professionals to support their wellbeing and help them to live healthy lives. One person told us, "I am not worried about anything, and if I need to go to the doctor, I go with staff."
● Staff worked well with other services and professionals to prevent readmission or admission to hospital.

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 our last inspection we rated this key question outstanding. At this inspection the rating has changed to good. This meant 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, relatives and healthcare professionals told us that people were treated with kindness and compassion. A relative told us they were most impressed by, "Staff taking the time getting to know [my loved one] and that staff have been able to support them to being a much better place physically and emotionally."
- One person old us, "I feel I can live the way I like and there is a lot of people to talk to…I would recommend this place."
- During our inspection we observed kind interactions between people and staff. Staff were clearly fond of people, and there was a shared light-hearted atmosphere.
- People's individual needs were known and met. For example, one person was supported to attend church daily.

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

- Staff supported people to express their views using their preferred method of communication. For example, supporting people with reviews and healthcare appointments to support their decision making.
- Staff took the time to understand people's individual communication styles and develop a rapport with them. Staff knew people well and had the time to spend with people to get to know them.
- Staff supported people to make decisions about the support they received. For example, one person wanted to go out more, and needed staff support to do this. Staff ensured that all processes were followed to ensure the person went out more.

Respecting and promoting people's privacy, dignity and independence

- People's dignity and privacy was respected. Staff supported and encouraged people to be as independent as possible. People were encouraged to gain new skills, for example learn to cook, or attend college.
- Staff understood people well, and knew what support people needed, and what they were able to do independently. People were encouraged to do their washing and maintain a clean environment within the home and their rooms.
- People were supported to seek paid or voluntary work, leisure activities and widening of social circles. For example, one person was supported to visit a friend they lived with previously.

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 Outstanding. 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

- Systems and process were not always in place or effective to improve the service and ensure the required documentation was in place.
- Documentation including care plans and risk assessments were not robust and provided inconsistent information. For example, one person's care plan stated they were at risk of choking, and in another part of the care plan that they were not at risk. Bowel monitoring charts were not consistently completed, and there was no information to confirm what action staff had taken when the chart was not completed.
- Some documentation contained wording which was not respectful and empowering of people. This had not been identified and acted on through checks and audits.
- Staff completed a series of checks and audits, however there was no management oversight of these checks to ensure that any areas for improvement were being identified. The registered manager told us that a new auditing system would be embedded with improved oversight of the service.
- The provider had purchased an electronic care planning system and were preparing to move documentation online. The registered manager was aware care plans needed updating and improving and had a plan in place to make the improvements with the implementation of the electronic care system.
- The registered manager was not always up to date with regulatory and legislative requirements. For example, not all staff had completed training in supporting people with a learning disability and autistic people which became a legal requirement in July 2022. The registered manager was not aware of guidance to support people with a learning disability or autistic people and were not meeting some aspects of this guidance. For example considering goals and implementing a person cantered plan outline people's goals and aspirations and how they planned to support the person to achieve them.

The registered person failed to assess, monitor and mitigate risks to the quality and safety of the service and to individual people using the service. This is a breach of Regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014

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

- People, relatives, staff and healthcare professionals told us there was a positive culture at the service which encouraged good outcomes for people.
- Management were visible in the service, approachable and took a genuine interest in what people, staff, family, advocates and other professionals had to say.

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 registered manager understood their responsibilities to be open and honest when things went wrong.

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

● People, relatives and staff felt engaged in the service, and able to make a positive impact to help improve the service. A relative told us that they had not had to raise any concerns but were confident that the management would act and make any improvements needed if they needed.

● People, and those important to them, worked with managers and staff to develop and improve the service.

● Staff told us the communication was strong with the management team. A member of staff said, "Especially the managers they make sure they communicate on a daily basis about everything. You get back and forth communication with the director – they are part of the team they know everything that is going on."

Working in partnership with others

● Staff and the management team had strong working relationships with healthcare professionals and within the local community.

● Staff supported people to be as involved as they wanted to be within the local community.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person failed to assess and mitigate specific health risks to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person failed to assess, monitor and mitigate risks to the quality and safety of the service and to individual people using the service.