# Ramos Healthcare Limited

# Arden Court

## Inspection report

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## Ratings

| Overall rating for this service | Requires Improvement |
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| Is the service safe? | **Requires Improvement** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Requires Improvement** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

Arden Court is owned by Ramos Healthcare Limited and is located on a busy main road in Eccles, Greater Manchester. The home provides care for people with nursing, residential and continuing health care needs. The home is close to local shops, bus routes and has adequate car parking facilities located at the front of the building.

At our last inspection of Arden Court in May 2016, the home was rated as 'Inadequate' overall and for the key questions 'Safe' and 'Well-led'. The key questions for 'Effective', 'Caring' and 'Responsive' were rated as 'Requires Improvement. Due to the overall rating of inadequate, the home was placed in special measures. We also issued three warning notices with regards to safe care and treatment, good governance and staffing. This inspection looked at any improvements made since then.

Although we found the provider had made improvements, we did identify continuing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to person-centred care, safe care and treatment , good governance and staffing. You can see what action we told the provider to take at the end of the full version of this report.

At the time of our inspection, there was no registered manager in post. The home had a manager that had applied to the Care Quality Commission (CQC) to register and they had their registered manager interview scheduled the following week. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People who used the service and their relatives told us they felt the service was safe. There were appropriate risk assessments in place with guidance on how to minimise risk. Staff recruitment was robust with appropriate checks undertaken before staff started working at the home.

We found the arrangements to manage people's medicines were not consistently safe. This was because PRN (when required) protocols were not always in place and prescribed creams were not stored securely. There had also been two separate instances where people had run out of their medication because appropriate ordering systems weren't in place.

We received a poor response from people living at the home, staff and visiting relatives with regards to the staffing levels at the home. Whilst a formal dependency tool was used to determine staffing numbers, the agreed numbers of staff on duty each day was not consistent. Whilst staff said they felt people's care needs were not compromised as a result, they reported feeling rushed and unable to spend time with people. This was reflected in our observations during the inspection. We have made a recommendation with regards to staffing levels in the detailed findings of this report.

We found staff received training in areas such as safeguarding, infection control, dementia and fire safety which were accurately recorded on the training matrix. There was no record however to confirm staff had undertaken recent first aid training and eight members of staff had not yet completed practical training in relation to moving and handling. Three of these members of staff worked at the home at night and were required to provide pressure care by supporting people to re-position during the night.

The expectation at the home was that staff would receive supervision six times a year and an annual appraisal. These hadn't been taking place consistently as identified in the homes policy and whilst we saw evidence of some group supervision, this meant staff weren't consistently being given the opportunity to discuss their work confidentially.

The people we spoke with said the food served at the home was of good quality and we saw people being supported to eat by staff. People were weighed on a regular basis and this increased and was more frequent when they were identified as being at risk of losing weight.

People had been given the opportunity to express the foods they liked and didn't like, however we found instances where these choices and preferences hadn't been respected by staff.

We found the home worked closely with other health professionals and made appropriate referrals when there were concerns.

We found DoLS (Deprivation of Liberty Safeguard) applications were made as necessary by the home manager, although staff were not always aware of the people subject to DoLS. The manager told us they would look at ways to disseminate this information to staff.

The people we spoke with and their relatives, said they thought staff were kind and caring but reported a lack of continuity of care due to a high turnover of staff and regular use of agency staff. We also observed interactions in communal areas to be limited as staff seemed rushed and unable to engage and stimulate people throughout the day unless the interaction was task led.

People living at the home said they felt treated with dignity and respect. Staff were also able to describe how they aimed to treat people well when delivering care.

In the care plans we looked at, there was inconsistency with regards to the recording of people's likes, dislikes and preferences. Additionally, the care plans we looked at did not demonstrate that families had been involved in the planning of people's care and whilst reviews were done, they were signed off by staff and did not involve people living at the home and their families. This meant that staff would be unable to deliver care that was personal or met people's individual needs and would hinder staff engaging with people in a meaningful way.

We found the activities coordinator demonstrated a good knowledge of people's life history and , needs but they told us this was disseminated verbally amongst the staff team and not captured on a document to plan care and treatment.

During the morning of the inspection, we saw people were sat in lounges unaccompanied by staff and observed little stimulation offered to people living at the home. In the afternoon, we observed 14 people in the dining room downstairs receiving a hand massage and people's nails being painted by the staff and care coordinator.

The home had an activities coordinator in post that scheduled and planned activities but we noted that this was not decided or planned in conjunction with people living at the home. The activities coordinator told us that there wasn't an activities timetable and activities were scheduled dependent on whether people presented as being likely to engage that day. If people were tired, the activities coordinator did not schedule an activity and took people individually in to the community or spent one to one time with people.

We looked at how the manager audited the quality and safety of the service. We found the medication audit had not been effective. We also found the audit of records just looked at whether the care intervention had been completed rather that look at the content to ascertain that care had been delivered in line with people's preferences. We found audits had not consistently been effective in identifying and rectifying some of the issues we found during this and previous inspections. For example, we saw no recent audits of care plans, staff training, supervision or medication. We had found some concerns with care plan documentation such as a lack of consistency with regards to life histories and consent forms being signed. There were also gaps in both staff training and supervision. Some of these issues also weren't rectified as a result of provider audits.

We identified several continuing breaches of the regulations in areas such as the management of medicines, quality assurance systems, staffing and storage of confidential information. A robust auditing and quality assurance system would identify these concerns and ensure people received an improved quality of service as a result.

Staff spoke positively about management at the home and said the manager was supportive and approachable. Staff said the manager had made changes for the better since starting working at the home.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

The service did not have appropriate arrangements in place to manage medicines safely.

We received poor feedback about current staffing levels and agreed staffing numbers were not always consistent when looking at the rotas. We have made a recommendation about this in the detailed findings.

People told us they felt safe and staff had a good understanding about how to report any concerns.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

There were gaps in staff supervision and appraisal. The training matrix identified staff had not received first aid training and several staff had not completed practical training in moving and handling.

We saw instances where people were given foods they had specifically stated they did not like.

Although DoLS applications were made as required, not all staff working at the home were aware of which people were subject to DoLS which could place them at risk.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

We observed little interaction between staff and people living at the home. People were sat for long periods in communal areas with no staff presence and little stimulation.

Some of the feedback received indicated there was a high turnover of staff which greatly effected the staff's ability to provide continuity of care.

The people we spoke with said they felt treated with dignity and respect by staff.

## Is the service responsive?

**Requires Improvement**

The service was not consistently responsive

Care plans were not reviewed in conjunction with people living at the home.

People were supported to engage in activities but they were not reflective of their interests to support their well-being.

People using the service and their relatives knew how to raise a concern or
make a complaint. We saw concerns had been responded to appropriately and in the required timeframe.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well-led

The management were visible to staff, relatives and people who used the service and we received positive feedback about the home's leadership from people, their relatives and staff.

Systems for audit & quality assurance required strengthening in order to identify failings found during the inspection.

We found confidential information about people's care was not kept secure.

# Arden Court

**Detailed findings**

## Background to this inspection

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

This inspection took place on Wednesday 15 February 2017 and was unannounced. The inspection team consisted of two adult social care inspectors from the Care Quality Commission (CQC).

Prior to the inspection we reviewed all of the information we held about the home in the form of notifications, previous inspection reports, enforcement notices and safeguarding incidents. We also contacted any relevant stakeholders from Salford City Council which included Safeguarding, Infection Control, Environmental Health and the CCG (Clinical Commissioning Group). We also contacted Salford Healthwatch. This was to see if they wanted to share any information in advance of the inspection.

During the inspection we spoke with people and viewed care records and documentation in order to help inform our inspection judgements. This included three people who used the service, two visiting relatives and 10 members of staff. We spoke with the manager, proprietor, two nurses, four care staff, the activities co-ordinator and a kitchen assistant. Records looked at included five care plans, five staff personnel files, eight MAR (Medication Administration Records), training records, building checks and any relevant quality assurance documentation.

Requires Improvement

# Is the service safe?

## Our findings

The people we spoke with said they felt safe living at the home. One person told us; "I'm safe. Only staff come in to my room". A second person told us; "I feel safe. I've always got my call bell". A relative told us; "No concerns, [person] is safe and receiving care that meets their basic needs".

As part of the inspection we looked at how medication was handled. We looked at eight medication administration records (MAR) and the stock of medication for these people to see if medicines were administered safely. We found improvements were required in order to protect people from the risks associated with the unsafe handling of medicines.

We found people's photographs were on the MAR which reduced the risk of people's medicines being given to the wrong person. The MAR sheets detailed times medicines were to be administered. The storage of medicines was appropriately maintained and safe, the clinic room was tidy and clean and the trolleys were well organised. Controlled drugs were also stored securely, with two signatures provided by staff when administered. However, we saw the ordering system for people's medicines needed strengthening. We found two people that had run out of prescribed medicines for a number of days which could lead to adverse effects for the person as a result of not having their medicines as prescribed.

We found MAR needed strengthening. On one MAR chart a medication that had been discontinued remained on the chart as still being required. We found information was not consistently recorded to guide nurses when administering medicines which were prescribed to be given "when required" (PRN), this included medicines prescribed for anxiety, pain and constipation. There was no information available to guide nurses when a variable dose of medicine was prescribed to support nurses to administer the most appropriate dose of medicine.

We found nurses were not documenting on the reverse of the MAR, the exact time PRN medication was given so nursing staff were not documenting the exact time PRN had been administered to demonstrate sufficient time was maintained between doses. Nursing staff were also not identifying why the PRN had been administered or the outcome of administration to ascertain a clinical picture. This exposed people to the risk of their medicine not being given consistently and people could experience unnecessary discomfort as a result.

Medicines which were stored on the medication trolley and treatment room were stored safely and at appropriate temperatures which were monitored daily. However, we saw prescribed creams were not stored safely and were visible on people's cupboards and drawers in their bedroom. A risk assessment had not been completed to determine it was safe to store creams in bedrooms. We were told of one person who lived at the home in particular, who often entered other people's bedrooms. This presented the risk of creams being ingested unsafely.

This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because current systems at the home did not ensure the proper and safe

management of medicines.

We checked to see if there were sufficient staff working at the home in order to meet people's needs. On the day of the inspection, staffing numbers consisted of eight care staff (four working upstairs and four working downstairs) and two nurses (one on each floor). At night there was a nurse and three care staff (two upstairs and one down stairs). The home used a dependency tool to calculate staffing levels and we were told that a minimum of seven care staff would always be on during the day and three at night (in addition to nurses). This was to provide care to 29 people living at the home at the time of the inspection.

At the time of the inspection the home used agency staff frequently and we were told that staff turnover at the home was high. A nurse told us there were approximately 14 people living at the home who required full assistance from two members of staff with all care needs. We were also told that only two people could mobilise independently. Whilst the majority of staff told us people's care needs were not compromised as a result of staffing levels, they told us they were busy and found it difficult to spend quality time with people. One member of staff said; "Like anywhere else you have your good and bad days. I feel we are able to meet peoples care requirements currently, but we are rushed off our feet".

We reviewed the homes staff rotas between the period of 30 January and 27 February 2017 and saw occasions were staffing numbers had fallen and there had only been five or six care staff on duty on certain days. A member of staff told us; "There are good numbers on today but at times the care staff numbers do drop down to five or six, especially if people are off sick". Another member of staff said; "A shortage of staff is a big problem here. Most days it's four staff upstairs and three downstairs. Today there are eight on but that is not always the case and we do struggle. I feel we still work well and meet people's needs but it can be a struggle". Another member of staff said; "We definitely need another member of staff at night, especially to assist with turning and re-positioning people".

We asked people living at the home and visiting relatives about current staffing levels at the home and received largely negative feedback. One person living at the home said; "I don't think there are enough staff, no". A second person said; "I think they could do with more staff. They are always very busy. I sometimes can't do what I'd like or go to bed when I want because there aren't the staff available at that time". A relative told us; "I don't think there are enough staff and there are even less at weekend. There is a quick turnover of staff which is a concern". A second relative added; "There are not enough staff. It's sad too that a lot of staff left".

We recommend that the service re-evaluates the current dependency tool, to ensure there are sufficient and consistent numbers of staff available, to safely meet the care needs of people living at the home.

As part of the inspection we looked at the systems in place to safeguard people from abuse. The manager maintained an accurate record of any safeguarding incidents which had taken place at the home which captured any investigation notes, outcomes if known and relevant strategy meeting minutes. The home manager routinely sent safeguarding notifications through to the CQC as required and prior to our inspection, informed us of some poor practice they had been informed of relating to staff at the home. This displayed an open and transparent approach towards safeguarding incidents. There was a poster displayed on the nurses station informing people of who they could contact if they had concerns about their safety. The staff training records we looked at showed all staff had received safeguarding training during 2016, which would be updated within the required timeframe.

The staff we spoke with were clear about their responsibilities with regards to safeguarding and how to report concerns. One member of staff said; "Signs of safeguarding could include bruising, cuts, people

looking dirty and even being left without their continence needs met. I would not hesitate to report concerns to my manager". Another member of staff said; "My immediate course of action would be to speak with the manager. I also have the contact details for safeguarding, CQC and the police". A third member of staff added; "If a persons personality was off or they suffered unexplained weight loss then that would give me cause for concern that something might not be right".

We looked at how the home managed risk. People had risk assessments in their care files with regards to nutrition, waterlow (for skin), mobility and moving and handling. These were reviewed monthly by staff to ensure that the information remained relevant. The home also monitored accidents and incidents, with an accurate record maintained alongside any actions taken. Any trends were also monitored by head office and shared with other homes within the organisation to promote learning and monitor any re-occurring themes.

Regular checks of the building were undertaken to ensure the premises were safe for people living at the home. We saw checks had been undertaken of electrical portable appliances, electrical installation of the building, fire alarm systems, fire extinguishers, gas safety, legionella and the lift. The manager maintained an overarching spread sheet which provided information about when checks were last completed and when they were next due. This would ensure that checks would not fall behind and could be monitored closely. We did however observe one sluice room door to be unlocked despite a key pad being in place to prevent unauthorised access. The sluice was located next to the bedroom of a person who was mobile and could place them at risk if cleaning products were not stored securely.

We looked at the systems in place with regards to cleanliness and infection control. Overall, we found the home to be clean and tidy. There were some strong smells of urine and faeces early in the day, however this did diminish throughout the inspection. A relative told us; "Cleanliness of the home is very good but the aroma can be variable and there is a strong smell of urine at times". We checked bathrooms and toilets and found they were clean and were equipped with appropriate hand hygiene guidance, paper towels, liquid soap and foot operated pedal bins. Cleaning schedules were in place and were checked at regular intervals by the manager to ensure work was being completed and we observed staff wearing PPE (Personal Protective Equipment) either when assisting people with care tasks or during meal preparation. This would help reduce the risk of the spread of infections. The home was recently inspected by the infection control team at Salford Council and scored 93%.

We checked to see that staff working at the home were recruited safely and looked at five staff personnel files and saw evidence of robust recruitment procedures. The files included written application forms, interview questions/responses, contracts of employment, proof of identity and two references. There were Disclosure and Barring Service (DBS) checks undertaken for staff in the files we looked at. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people. This showed us staff were recruited safely.

Requires Improvement

# Is the service effective?

## Our findings

We asked people living at the home and their relatives if they felt staff had good skills and knowledge in order to provide effective care. We also asked about the quality of the environment. A person told us; "99% of staff seem well trained. You always get the odd one that doesn't come up to scratch". A second person said; "The staff come and go so there is no consistency". A relative said; "The more experienced staff have left. The home needs some continuity". Another relative told us; "[Person's] bedroom isn't homely. It is a bit stark and bland. It would benefit from better lighting. The home needs upgrading".

Newly recruited staff followed a formal induction programme and were required to undertake a range of basic mandatory training and to read and sign certain policies prior to starting their employment. The induction was centred around the care certificate, with the aim of providing staff with a thorough understanding of working in a care environment. Staff also told us they were introduced to other residents and were given the opportunity to 'Shadow' existing, or more experienced members of staff. One member of staff said; "I did an induction and it covered moving and handling, fire safety, safeguarding and infection control. The induction was good because I hadn't worked in care before. I feel more than comfortable with things now". Another member of staff said; "I was shown around and introduced to everybody. I had worked in care before, but the induction gave me a good start to working at this home. It was very thorough".

We looked at the training staff were provided with to support them in their roles and reviewed the training matrix. This showed staff had received training in safeguarding, health and safety, manual handling theory, fire safety, infection control, MCA/DoLS, dementia, food hygiene and medication. The training matrix did not cover first aid training and stated eight members of staff had not yet completed moving and handling practical training. We could see from looking at staff rotas that three of these staff worked at the home at night and would be expected to undertake tasks such as the turning/re-positioning of people during the night.

We also looked at the supervision and appraisal staff received whilst working at the home. We were told that staff received supervision six times a year and an annual appraisal. However, the manager acknowledged these hadn't been taking place as frequently as indicated as other areas within the home had taken priority. We did see some evidence that group supervision had taken place, but this meant staff would be unable to speak about issues or concern in confidence. We asked staff about current supervision and appraisal arrangements. One member of staff said; "I've worked at the home for about six months but have only had one supervision so feel they could be more consistent". Another member of staff added; "I have had supervision here, but they don't take place every two months which I'm told they should".

This meant there had been a breach of regulation 18 (2), (a) with regards to Staffing. This was because staff did not always receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Overall, we found the home was working within the requirements of DoLS and MCA, with applications made to the local authority as necessary, with necessary paperwork kept in people's care plans. A record of which people were currently subject to DoLS and those awaiting assessment was located in the managers office. However, this information was not appropriately disseminated to staff. For instance, two members of staff were unable to tell us which people were subject to DoLS which could place people at risk. One member of staff said; "I know the information is in the office but I couldn't tell you which people are in it". A second member of staff said; "I'm unaware which people are currently subject to DoLS". We spoke with the manager about this concern who informed us they would look at ways to effectively communicate this information to all staff.

Staff were aware of how to seek consent from people before providing care or support. During the inspection we observed staff seeking consent from people such as if they would like to take their medication or if they would like assistance to stand from their chair. People living at the home also said staff sought their consent before delivering care. One staff member said; "I would always make sure a person was awake first before delivering care to them. I would ask first and check it was what they want". Another member of staff said; "If a person was refusing personal care I would respect that and maybe try a bit later on and see if they were more forthcoming".

We looked at five people's care files to ascertain whether people's nutritional needs were being met. We saw people had nutrition care plans in place which identified people's dietary needs. We saw one person was identified as requiring a fortified diet, milkshakes, snacks and foods in line with their preferences. We saw staff had documented the person's food in the daily records but they had not consistently documented the consistency of the food the person had received or whether it had been fortified. We noted from the food record that the person had been given foods that were identified on their food dislikes list which was not in line with their preferences. We could not ascertain from the records that snacks had consistently been given between meals. However, milkshakes had been consistently provided and this was confirmed by people living at the home as something the service did well.

Staff also recorded how much fluid a person consumed and daily recommended fluid intake was identified on the record to guide staff as to what an adequate fluid intake was for that person. We looked at samples of fluid intake sheets during the inspection and saw they were regularly completed by staff with high levels recorded. Drinks were also available in bedrooms and lounge areas. The manager had also implemented a system to check these records each day to ensure they were being completed properly by staff. People's body weights were also consistently checked and monitored by staff, with people being weighed more frequently (usually weekly) if they were identified as losing weight.

We asked people living at the home and their relatives for their opinions of the food. A person told us; "The food is good, it's a good standard. There are some bad days when I don't like anything but I'm offered other things and they are very good with providing me with milkshakes and fluids". A second person said; "The food is good and there are choices if I don't like something". A relative told us; "The food is very good. [Person] had lost weight but they've put it back on. They seem to understand what [person] would like and they get plenty snacks and drinks". A second relative told us; "What I have seen of the food, it is good. They even provided me with a meal at Christmas. The meal was very good and it was very kind of them to do

that".

There were records in peoples care plans to demonstrate they received regular input from health care professionals as required. These included doctors, dieticians, speech and language therapists (SALT), podiatrists and tissue viability nurses (TVN). A person told us; "I see a nurse or doctor quickly when unwell".

Requires Improvement

# Is the service caring?

## Our findings

We asked people living at Arden Court and their relatives for their views and experiences of Arden Court and if they felt they received a good level of care. One person told us; "I'm happy living at Arden court. It is the best place that I can be. 99% of the staff are kind, caring and fantastic people. You always get the odd one, whatever job you are in". A second person said; "I'm quite happy living here. The staff are alright. Not so bad". A third person added; "The staff are nice, kind and very helpful". A relative told us; "My overall impression is the home has a nice garden. I would like to see people using it more though. [Person] is fairly happy here". A second relative said; "Generally the staff are good. kind and caring".

We asked people living at the home if they would recommend the home to other people requiring the level of care provided. One person told us; "I would definitely recommend the home, its good". A second person said; "I don't want to go anywhere else so I'd definitely recommend this home".

We found there were shortfalls in the home which meant people's immediate and on-going needs were not consistently met to demonstrate a caring culture. Whilst we found staff had good intentions, interactions were task led and there was little stimulation or interaction observed between staff and people, particularly in communal areas. We observed there to be a lack of atmosphere and on several occasions during the day, we saw people had fallen asleep, with no staff presence in the communal room. Staff were seen to be supporting people in bedrooms or taking people downstairs to the dining room. This meant there wasn't a co-ordinated approach amongst staff to ensure people received appropriate stimulation and interaction throughout the day, with a continuous staff presence where people were seated. A relative told us; "People are just sat around. Staff don't engage with people. Staff just put food in front of people. I leave the lounge and feel quite depressed".

We were also told of a lack of continuity amongst staff, which relatives felt impacted on the care provided. A relative told us; "If I was the manager of this home, I would be very concerned about staff turnover". A second relative said; "Staff leaving is a worry. I'm not sure if it's the money or hours. Every week it's another two or three that have left".

We checked to see that people living at the home were treated with dignity and respect by staff. We observed staff knocking on bedroom doors before entering and also closing doors if they were about to deliver personal care. We saw people were wearing clean clothes and their hair was neat and tidy. The staff we spoke with demonstrated an understanding of how to treat people with dignity and respect. One member of staff said; "I always close doors and curtains during personal care and make sure there are no interruptions. I will also cover people up and make sure they know what is going on out of respect". Another member of staff said; "I aim to treat people living here as if they were my own grandparents. If I'm helping a person out of the shower then I will offer them a towel to cover themselves up".

People said they were treated with dignity, respect and were given privacy at the times they needed it. A person told us; "I'm asked if I want my door open and I prefer looking out so the staff prop it open for me". A second person said; "They respect my wishes. I don't like my door shut so they leave it open for me. They

shut it when helping me with anything personal".

We looked at how people we supported to maintain their independence. At one point during the inspection, we observed a member of staff encouraging a person to eat their food themselves but offered to help them if needed. The staff we spoke with told us about how they aimed to allow people to maintain their independence when providing care. One member of staff said; "It's very important to let people try, so I will sit with people and encourage them but be on hand if required". Another member of staff said; "Even if it means people eat their food with their fingers then I am fine with that as it means they can do it themselves. If they wanted full support though I would give it to them".

Requires Improvement

# Is the service responsive?

## Our findings

People living at the home and their relatives told us the service was not always responsive to the person's needs. One person told us; "I do sometimes have to tell the staff what to do and what I need." A relative told us; "I've never been asked about [person's] life. I do brief the staff about [person's] needs. The staff have a lot of demands and keep changing so they don't know".

In the five care files we looked at, we found inconsistencies in the documentation in people's care files regarding the capture of information pertaining to people's life histories, background information, employment history, interests, likes and dislikes. People's likes and dislikes, personal preferences and hobbies were not consistently identified by the service to plan care and treatment. It was also unclear from the care files who had capacity to agree to their support. It was evident from the relatives that we spoke with and the care files that we looked at that information had not consistently been explored or gathered from families to guide staff to support people living at the home. This meant that staff would be unable to deliver care that was personal or met people's individual needs. It would also hinder staff engaging with people in a meaningful way. Care plans and reviews were signed by staff which meant the service could not demonstrate that people and their relatives had been involved in reviews of their on-going care or support.

We found the activities coordinator demonstrated a good knowledge of people's life history and , needs but they told us this was disseminated verbally amongst the staff team and not captured on a document to plan care and treatment.

We received a mixed response from people and their relatives as to whether care and support was delivered in line with people's preferences. A person told us; "I don't get a bath or shower as often as I would like because the staff are restricted for time but I do get them". A relative told us; "[Person's] personal care is not always great. [Person] has not always been changed or had their hygiene attended too".

We also saw instances were foods had not been provided in line with people's preferences. One person had received foods that they were documented as not liking. A second person had received foods in excess of what they were able to tolerate which had resulted in them experiencing adverse effects. This had resulted in their relative having to inform staff again to prevent this from reoccurring.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Person-centred care.

We found instances where the service had been responsive to people's changing needs. The relative of one person told us; "[Person] came in with skin breakdown. Staff sorted person's skin out though". We looked at the care records for another person who had a pressure sore and saw that the pressure sore had been documented correctly and pictures taken of the wound which had visibly improved. Another person whose care records we looked at, had documented skin care needs which was body mapped and improving. This had also been photographed by staff which is deemed to be good practice to determine whether the area is healing.

We checked the provision of equipment for the people identified as being at high risk of sustaining pressure sores and found they had the correct equipment in place. For example; people were either sat on a pressure relieving cushion or in bed with an airflow mattress. Position changes had been consistently completed as directed every four hours. This showed that the service had responded appropriately to the identified risk of skin breakdown.

During the morning of the inspection, we saw people were sat in lounges unaccompanied by staff and observed little stimulation offered to people living at the home. In the afternoon, we observed 14 people in the dining room downstairs receiving a hand massage and people's nails being painted by the staff and care coordinator.

We asked people and their relatives about the activities offered. One person told us; "I see the activities coordinator a lot. They come in daily for a chat and make sure I'm being treated properly". A second person told us; "I'm not interested in activities so there is enough going on for me". We received a mixed response from people's relatives as to whether there were sufficient activities taking place. A relative said; "Residents lack stimulation. The TV is going but that's it. They do have entertainers in weekly and you see people are engaged and are tapping their feet. They don't utilise the garden enough. Even in summer". A second relative told us; "They are at least trying to do something. There are singer and groups that come in. They do try and get people to participate".

The home had an activities coordinator in post that scheduled and planned activities but we noted that this was not decided or planned in conjunction with people living at the home. The activities coordinator told us that there wasn't an activities timetable and activities were scheduled dependent on whether people presented as being likely to engage. If people were tired, the activities coordinator did not schedule an activity and took people individually in to the community or spent one to one time with people.

We saw singers were scheduled three times a week to come in to the home to entertain people. A hairdresser visited the home weekly and the activities coordinator scheduled pampering activities on the same day. We were told people enjoyed a sing song, colouring and a bit of baking depending on people's abilities. The staff dressed up on special occasions and there were boozy afternoons scheduled were people were offered shandy or snowballs. Weather permitting there were sun and sangria afternoons and a family barbecue was arranged in June or July.

We looked at the results of a recent resident survey that had been conducted. We found the survey required strengthening as it only looked at whether people were happy or sad and asked people to rate the current activities on offer. The survey did not look at other areas such as; whether people liked the food, staff, whether people felt they were treated with dignity and respect. The survey did not capture people's opinions to analyse the information to improve the quality of care received.

There was a system in place to handle and respond to complaints and we saw any complaints made had been responded to appropriately. We saw the home had an appropriate policy and procedure in place, informing people of the steps they could take if they were unhappy with the service they received. A person told us; "I tell them if I've got an issue and they sort it".

Requires Improvement

# Is the service well-led?

## Our findings

At the time of our inspection, there was no registered manager in post. The home had a manager that had applied to the Care Quality Commission (CQC) to register and they had their registered manager interview scheduled the following week. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We asked staff what it was like to work at Arden Court and if there was a good culture. One member of staff said; "It's alright but there is a divide between night and day staff. We are always coming into something different each day which isn't done right". Another member of staff said; "I'd say it's not a bad place to work and is a good little home really". Another member of staff added; "It's going really well and I'm enjoying it. I feel happy and relaxed. All around I'm loving it and the day staff work really well together".

Staff also told us leadership and management at the home was strong and that the new home manager had made a difference to how the home was run. One member of staff said; "There have been a lot of improvements and lots of systems put in place by the new manager. I feel I can go to the manager with anything. Since I have been here there has been changes for the better". Another member of staff told us; "I love the manager. The manager is always available if I need them and I can talk to them about things and they are always very understanding".

We found there was a clear management presence at the home. The home manager was visible throughout the inspection. We asked for a variety of documents to be made accessible to us during our inspection and these were provided promptly. We saw the home manager completed walk rounds during the inspection which involved the manager checking people's care records to ensure care had been delivered in line with people's needs. The manager signed the documentation at the time it was checked and we observed them identify a discrepancy with staff as to why a delay had occurred in the time a person had received their pressure care. This enabled the manager to have an overview of the home and proactively address areas identified.

We found some improvements had been made since our previous inspection. This included, regular checks being undertaken to ensure pressure relieving mattresses and bed rails were safe and in good working order. We found daily records had been strengthened in regards to; pressure care and daily food and fluid intake records were we found no omission in the completion of these records during the inspection.

The home manager also completed night and weekend spot checks which involved the manager coming in to the home unannounced at different times of the night and weekend to ensure staff were meeting people's needs at these times. This meant the manager ensured standards were maintained at these times when there was not a management presence within the home.

We also found accidents; incidents and safeguarding had been appropriately reported as required. We saw

that the manager had ensured statutory notifications had been completed and sent to CQC in accordance with legal requirements.

People living at the home and their relatives said they knew the manager and told us they felt improvements had been made since they had started working at the home. One person said; "I've spoken to the manager a few times now. They listen very carefully and are getting things done". A second person said; "I know the manager. They are very good". A relative told us; "The manager is very nice and very competent. I was very disappointed when I saw the rating the home had. The manger wants to get things done and lift the home". A second relative said; "The previous leadership was laxidazical. I've confidence in the current manager. The last few months have been better".

At our previous inspection we raised concerns about the storage of records within the home. We still found this to be an issue during this inspection. This was because we found the storage of confidential information was poor as care files containing confidential information was left unattended frequently throughout the inspection at an unstaffed nurse station which was located on the corridor. Care plans were also stored in a metal filing cabinet, but this was unlocked and meant unauthorised persons could access the files.

We looked at how the manager audited the quality and safety of the service. We found the medication audit had not been effective. We also found the audit of records just looked at whether the care intervention had been completed rather that look at the content to ascertain that care had been delivered in line with people's prefernce. We found audits had not consistently been effective in identifying and rectifying some of the issues we found during this and previous inspections. For example, we saw no recent audits of care plans, staff training, supervision or medication. We had found some concerns with care plan documentation such as a lack of consistency with regards to life histories and consent forms being signed. There were also some gaps in both staff training and supervision.

We looked at the most recent provider audit which was done in January 2017. This provided a focus on care plans, medication, staff files, staffing levels/rotas, management of finances, storage of confidential information, the environment, service/maintenance records and leadership/management. This audit had also not been entirely effective. For instance, the audit had picked up that care plans should be stored away when not in use on the nurses station, however we observed they had been left out during the inspection and not stored securely. The audit also identified a missing PRN protocol one MAR looked at, however we found inconsistencies with PRN protocols being in place in other MAR we looked at which meant this action had not been followed through appropriately. The audit also said all mandatory training had been completed, however we found there to be gaps in moving and handling practical training and no evidence of recent first aid training.

We also identified several continuing breaches of the regulations in areas such as the management of medicines, staffing, quality assurance systems and storage of confidential information. A robust auditing and quality assurance system would identify these concerns and ensure people received an improved quality of service as a result.

This meant there had been a breach of Regulation 17 (2) (a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not effectively assessed, monitored and improved the quality and safety of the services provided in the carrying on of the regulated activity and records were not kept securely.

We looked at the minutes from the most recent staff meeting which had taken place 20 December 2016. We noted a set agenda had been devised following input from CQC. The staff meeting covered; confidentiality,

feedback from professional visits, staffing, the environment, training, results of surveys and audit. However, there was still no record of actions from previous meetings that had been undertaken or any record of how things raised had been responded to as identified at our previous inspection.

We recommend the home introduces a means to demonstrate this. For example, 'You said, we did' to ensure that staff issues are being responded to appropriately.

We also looked at the most recent residents and relatives meeting which had taken place in May 2016. Topics of discussion during this meeting included staffing, complaints, mobile phones, improvements, residents rooms, menu's, fluids, personal care and activities.
A relative told us; "I'm invited to relative meetings but I haven't attended".

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<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br>The provider did not have systems in place to ensure care was designed with a view to achieving service users preferences and ensuring their needs were met. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br>The provider did not have systems in place to ensure medicines were managed safely. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br>The provider had not effectively assessed, monitored and improved the quality and safety of the services provided in the carrying on of the regulated activity and records were not kept securely. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br>The provider had not ensured staff always received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. |