Bupa Care Homes (BNH) Limited

The Arkley Care 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 caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place over two days on 10 January and 18 January 2017 and was unannounced. We last inspected this service on 17 February 2016 and it received an overall rating of Good.

The Arkley Care Home is a nursing home registered to provide accommodation, nursing and personal care and treatment of disease, disorder or injury for up to sixty people.

There was a registered manager in post on the day of the inspection. 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 and staff told us they thought there were too many agency staff. The home was trying to recruit new nurses. We saw on the day of inspection people were having their basic needs met but the care was affected by the level of agency staff being used.

Effective support in the form of supervisions and appraisals for staff were not always taking place which meant staff were not getting the full support they needed to effectively carry out their role.

The Arkley Care Home was not complying with the Mental Capacity Act 2005. Applications for DoLS were not made in a timely manner and documentation around mental capacity were not accurately completed.

Complaints were not recorded effectively or people making complaints supported through the process.

The provider had sent in extra managers to help make improvements in the home and regular audits were taking place that picked up some issues. We saw that further improvements were required.
Medicines were being stored, administered and disposed of safely by staff who had been trained and had their competency in administering medicines tested.

People and their relatives enjoyed the food and found there was a range of food on offer and it was tasty. We saw that some people could not always reach their drinks and fluid intake for those people at risk of dehydration was not consistent.

We saw kind and caring interactions between staff and people and relatives and people said the staff were friendly and helped them.

People fed back to us they enjoyed the activities on offer and when suggestions were made they were listened to at meetings held for feeding back opinions.

We found breaches of six of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We

are taking enforcement action against the registered provider and will report further on this when it is completed.

You can see what action we told the provider to take at the back of the full version of the report.

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. People and staff told us that there were often different agency staff in the home. There was not always continuity of care.

Medicines were managed, stored and administered safely.

The home was clean and tidy.

Is the service effective?

Requires Improvement

The service was not always effective. The Arkley Care Home was not acting in accordance with the Mental Capacity Act 2005.

Staff were not receiving regular supervision.

People were offered a range of foods. Fluid intake was not always recorded.

People had access to a health care professional when needed.

Is the service caring?

Good

The service was caring. People and their relatives told us the permanent staff were kind.

Relatives were kept informed of changes in their relative's needs.

People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive. Complaints were not always recorded and the complaints procedure was not always followed.

The care records were not person centred. Forms used to assess needs were comprehensive in structure but often not filled out in detail with people's preferences and histories.

People told us they enjoyed the activities on offer and trips out were organised.

Is the service well-led?

Requires Improvement

The service was not always well-led. There were gaps in recording daily care provided and audits did not always pick this up or act on their findings.

Staff felt supported but said concerns were not always followed up by the management team.

We saw evidence of partnership working and support was provided from outside of the organisation.

The Arkley Care Home

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. This service was last inspected on 17 February 2016 and was awarded a rating of Good. The inspection took place over two days on 10 January and 18 January 2017 and was unannounced.

The inspection team was made up of three adult social care inspectors, one pharmacist inspector and two experts 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.

Before the inspection we reviewed previous inspection reports and notifications we had received from the service. During the inspection we spoke with ten people using the service, and eight relatives. We interviewed 15 staff and looked at five staff personnel files. We tracked the care of seven people and looked at their care files. We reviewed policies and procedures, training records, incidents and accidents and quality control documents. We contacted social workers and health care professionals and had feedback from local authorities.

Requires Improvement

Is the service safe?

Our findings

People said "I am safe yes. No I do not worry", "yes I am safe and I like it here" and "oh yes I do feel very safe". Relatives that we spoke with were confident that their family members were safe, receiving appropriate care and were adequately protected. One relative said "Yes she is safe but sometimes they are short staffed here. More so at weekends. She's safe in her room and the security is good." Another relative said "it is now. We had an incident… but it seems better now."

We asked people if there were enough staff to meet their needs. People told us "there are different girls. I don't really know their names" and "no, definitely not enough staff." One person said "No there are not enough staff. We have just lost five nurses" and another person said "they are always busy." One relative we spoke with said "I try and come at different times during the day and they are often short staffed." However, other relatives were happy and felt there were enough staff to meet the needs of their family member.

Care workers and nursing staff felt there was not always enough staff to meet the needs of people. Staff said they felt management in the home were under pressure from the provider to take all people referred so beds were filled. They said managers tried to find staff cover when care staff went off sick but this was not always possible at the last minute. Six staff we spoke with had concerns about the high needs of people living in the home. Staff described some people as having acute or psychiatric needs, regularly calling out and needing assistance, including regular urgent medical treatment. Two staff told us they felt some people might be inappropriately placed at the home and needed to move to higher dependency or psychiatric units with specialist support and this contributed to the feeling there were not enough staff.

The deputy manager told us they were struggling to recruit and retain nurses and were relying on agency nurses. They said, "it is important for us to ensure people receive safe services and hence, we have many agency nurses, as we lost five nurses in the last three months." We asked the registered manager why there was a high turnover of nursing staff and they said nurses had been offered better pay elsewhere. We looked at the rota and saw that staff ratios during the day time on the ground floor were one nurse, and three care staff for 15 people. We saw two people had one to one care staff and these staff were in place throughout the day. On the first floor there were two nurses and five or six care staff to care for 27 people. At night there was one nurse and two care staff on each floor. On the day of inspection we saw that people were having their immediate needs met but that care staff and nurses felt there could be more staff to ease the workload during busy periods.

People also told us there were lots of agency staff working, particularly at night. One person said "they use a lot of agency staff. They have had a lot of problems keeping staff." Another person told us "And the ones who are nasty are the agency ones. You have to wait up to half an hour for them to come, mainly at night". People we spoke with said sometimes they did not recognise the agency staff and they were not as comfortable receiving personal care from care staff they did not know.

Staff were able to discuss risks that people faced and what steps they could take to help people to reduce these risks. We saw risk assessments for specific areas such as pressure sores, falls, diabetes and bed rails.

These were reviewed monthly and checked by the deputy manager. While individual risk assessments were available, they lacked evidence of positive risk-taking to encourage people to develop their skills to remain or become more independent. For example, for one person who had suffered a fall out of their chair the management plan was to tell them not to lean forward to pick things up. There was no further comment as to whether this was an interim measure and the person would be supported to lean forward but in a safer way. This meant they were being told to sit back all the time when they wanted to reach for something which was not promoting their independence. Overall, staff felt risks to people's care and welfare needs increased when there were reduced staffing levels but risks were currently just being managed to avoid incidents and accidents.

Where risks had been identified for people we saw from looking at care records there was not always clear evidence appropriate care had taken place. For example, for one person at risk of pressure sores, the recommendation from a health professional was for them to be turned every two hours. The daily care record did not record how often they had been supported to reposition themselves and did not mention being turned for the duration of the day. For another person, a recommendation from a health professional was to apply a cream to help prevent a sore developing twice a day. Out of 25 days, it had been applied twice on two days, once on seven days and not recorded as being applied at all on 16 days. This person was being put at risk of a pressure sore developing as recommendations were not being followed. We fed this back to the home on the day of inspection and have received feedback from the home that the risk has now been minimised.

For people at risk of dehydration and pressure sores the recording of how much fluid they had taken was inconsistent, with some daily records stating "adequate fluid taken" rather than how much in quantity. This may have put them at further risk of dehydration as it was not clear how much fluid they had taken in a 24-hour period. We fed this concern back to the regional and registered managers on the day of inspection and we have received feedback from the home since the inspection to say they have improved the way they record fluid intake.

People in the home and who were at risk of pressure sores had a specialist airflow mattress to help reduce the risk of sores developing. There was no record of what setting these mattresses needed to be for each person to minimise the risk of sores developing. If the mattress was on an incorrect setting, it might not reduce the risk of a sore developing. This was noted by the provider in an audit they completed four days prior to the inspection but settings were not added in to care files by the time we inspected. We have identified these issues as a significant concern under well-led.

We looked at five staff files and saw they each had records of interviews, references and criminal records checks which showed that internal recruitment procedures were being followed. We asked the manager about a disciplinary issue for a staff member noted in their file and they had no knowledge of it and it had not been assessed as a risk.

We checked if the home administered medicines safely. We looked at medicines storage, medicines administration record (MAR) charts, and medicines supplies. All prescribed medicines were available and stored securely in locked medicines cupboards. This assured us that medicines were available at the point of need and the provider had made suitable arrangements about the provision of medicines for people.

Overall, people received their medicines as prescribed, including controlled drugs. We looked at nine MAR charts and found no gaps in the recording of medicines administered. There were separate MAR charts for people who had topical medicines prescribed to them (such as creams). These were filled out on a daily basis by carers. However, we found that staff did not sign to indicate they had transcribed the instructions

from the prescription and there were no countersignatures. Also, we found that there were five instances where care staff had not signed to say they had applied the cream. This meant we could not be sure that creams had been applied to people as prescribed.

Medicines to be disposed of were placed in pharmaceutical waste bins and there were arrangements in place for their collection by a contractor. Controlled drugs were stored in accordance with legal requirements, with weekly audits of quantities done by two members of staff. We observed people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. People's behaviour were not controlled by excessive or inappropriate use of medicines. For example, we saw 10 PRN forms for pain-relief/laxative medicines. There were protocols in place which covered reasons for giving the medicine, what to expect and what to do if the medicine did not have its intended benefit.

Medicines were administered by nurses that had been trained in medicines administration (including a probationary induction period). We observed a member of staff giving medicines to a person and found staff had a caring attitude towards the administration of medicines for people. A recent improvement made by the provider included consolidating monthly supplies from the pharmacy supplier into one day, to avoid any delays or errors from occurring. This had been highlighted previously from the provider's audits and showed they had improved in this area.

Staff that we spoke with, including the deputy manager and registered manager had an understanding of the different kinds of abuse, how to spot the signs of abuse and how to report it and follow it up to ensure that people were safe. Staff had completed training in how to safeguard people.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. We checked whether the service was working within the principles of the MCA.

The home did not always follow good practice or compliance with the MCA and we identified several examples where legal requirements had been breached. We saw two 'do not attempt cardio pulmonary resuscitation' (DNACPR) forms where there were gaps that asked if the person had capacity to make decisions and whether the patient had been communicated with about this decision. We saw a mental capacity assessment with gaps where tick boxes had not been completed. For example, a section asking if there was a Legal Power of Attorney for financial/ health and welfare was not ticked whether yes or no and stated 'next of kin'. This was not fully completed and so it was unclear whether the person had a legal representative or not. We saw a best interest decision form made in relation to checking stock levels of medicines. This was incorrectly filled out as the person had full capacity. This showed a lack of understanding by the home of when the form needed to be used.

The DoLS tracker used to record the status of DoLS applications showed that nine people had applications that had not been responded to, with the earliest application being made in May 2016. For each of these applications the tracker showed that there had been no follow up to find out the status of the application, despite there being a column on the form for monthly follow ups. We asked the deputy manager if the tracker was up to date and were told it was. We asked the deputy manager to confirm which people the home thought had capacity and who did not. We compared this with the DoLS tracker and saw there were four people for whom a DoLS application had not been made who lacked capacity, and nine people that the home said had variable capacity that had no application made.

On the day of inspection we asked the deputy manager why one person who moved in five months prior to our visit did not have a DoLS in place. They had been assessed as not having capacity and there was a restriction on their liberty. The deputy manager said they had "been busy with nurses." Some of the forms to capture best interest decisions were comprehensive in their structure but, in places, the records were filled out incorrectly showing a lack of understanding of the principles of the MCA and the responsibility of the home to ensure it was in keeping with these. Staff we spoke with were able to describe the MCA and had been on training. This knowledge was not translated into correctly filling out documents about consent. We asked the registered manager to ensure the home was upholding the principles of the MCA during the inspection.

The above evidence demonstrates a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people if they thought staff had the relevant skills and experience to care for them. One person

said "yes they do. I think they look after me well. I feel well", another said "some do. There are lots of new ones and they try", and one person told us "mostly yes. They could do with more senior staff to train them."

One staff member said, "I have had enough training and receive regular refresher training, too."
Several staff told us they received sufficient training to do their jobs effectively but that as the staff team had mixed skills and experience, those with limited experience could benefit from more shadowing and more support than they were currently receiving. The majority of staff said training needed to improve in checking the training was implemented in day-to-day care. For example, one staff member said staff were given workbooks in most areas and told to read them. Other staff said they had worked at the home for a while and did not feel they had many training needs due to their experience. We looked at training records and saw that training was up to date for care staff and nurses and in keeping with the home's policy. Training was offered externally and internally with both online learning and face-to-face options used. Staff were offered additional training in order to meet people's specific needs such as pressure sore management. Feedback from staff suggested that more in depth training could be provided with a follow up to check understanding.

We looked at staff supervision and appraisal records and saw some gaps, Supervision records showed not all staff received regular one-to-one supervisions. For example, we reviewed the staff supervision matrix and noted there were no supervision dates recorded against 15 staff members. Other staff members who had received supervision had not received them every two months as described by the registered manager. For example, some staff had only received end of year reviews or appraisals and not supervision sessions. We saw that at least 20 staff had not had an appraisal by the end of 2016. Staff that we spoke with felt the management team were friendly and approachable but that there could be more support, particularly when staff went off sick. We told the registered manager and deputy manager about a PIN number that had expired for a nurse who worked in the home that showed they were fit to practise as a nurse, they assured us this would be followed up immediately.

The above evidence demonstrates a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw records of induction for new staff and spoke to the area trainer who said new staff have a five-day induction including being enrolled on to the care certificate. The care certificate is a set of standards that should be covered as part of induction training for new care workers. After classroom induction sessions, new staff shadowed more experienced staff. We spoke to one newly recruited staff member who told us they attended the induction training and found it "useful" and were shadowing experienced staff members which they found "very helpful". They further said, "I feel welcomed, staff and management are supportive."

We saw from care files and talking to people and relatives that people's dietary needs and preferences were identified and being met. People told us they liked the food and there was a range on offer. One person said "the food is very good. I have it pureed but it is still very tasty. I like the dinners especially and I get to choose from the menus. I forget sometimes what I am having so I check the menu at the table." A relative said "the food is good and there is a lot of choice. My [relative] refuses food sometimes and they offer alternatives that are not on the menu. The chef is brilliant."

We looked to see that people had drinks available and in reach throughout the day. One person said "they bring you drinks to your room and leave it on the table for you. I can reach it but sometimes at night I can't reach it" and another said "no I can't lift the jug so they put it on my table. I can't reach it sometimes so I wait." We saw that in communal areas people had drinks available and when care staff entered rooms they offered drinks but these were not always left within reach.

We saw from care files that people were supported to access healthcare services when they needed to for appointments or if they became unwell. People we spoke with told us they were seen by a doctor if they asked. One person said "They ask me why and look at me. They write it down and they tell the doctor." Another person said "I tell them [staff] and if they think I need one [GP] they call them and they visit." Relatives we spoke with said they were happy with access to see doctors and other health professionals and felt that changes in health for their family member were communicated to them.

Good

Is the service caring?

Our findings

People that we spoke with said the permanent staff were caring and kind. One person said, "They are very nice and they help me a lot." Another said, "They help me a lot and make sure I am looked after." Relatives that we spoke with described some settling in issues that were resolved quickly but were happy with the care their relatives were being provided with and said staff were kind, courteous and respectful. One relative told us this had been the best out of other homes their relative had tried previously. Another said, "They [staff] seem to like [my relative]. [My relative] is always chatting with them and they sit with us and have a chat about how [my relative] feels and family."

We saw people responded positively to permanent staff and looked happy to see them. One person told us "they know what I like and what I need very well. The staff look in my book and ask me what I need if they don't know me but I tell them. I think they know me and what I like doing." Another person said, "yes they do know me well. They know what I can do and they help me do it if I cannot do it myself." Nurses, care staff and the registered manager were able to tell us about the needs of people and their personalities and what they liked and did not like. One relative told us of one staff member whose visits brightened their family member's day and they spent time with them doing an activity they enjoyed, for example rubbing aromatherapy oils into their hands and arms.

We saw caring interactions between staff and people throughout the day that we visited. Staff spoke to people as they were supporting them and we heard laughing and saw people smiling throughout the home. Where one person was persistently calling out staff went and sat with them after a few minutes and talked with them about their day and their life and they responded by smiling and making jokes and was comfortable with the staff who sat next to them.

When we asked people if staff talk to them while delivering care and respect their dignity and privacy, they said for the most part staff do. "Lots say hello before they come in. Sometimes they knock and ask if I'm decent" and "Some breeze in and out and come sit and chat and tell you why they are coming in." One person said, "Some do. They turn up next to me and I don't hear them come in. They just do what they come to do and leave sometimes. The night people are quiet so they don't wake anyone up." Staff spoke of people in a respectful manner and people and relatives told us that the majority of staff knocked on doors and respected their privacy.

We spoke with the registered manager who talked about helping people to do more for themselves and felt it was important to "explore any residual dependence". The registered manager gave the example of one person who was bed bound and after much encouragement and support they were now much more mobile and happier. We saw at mealtimes people being encouraged to eat without staff support but staff were available if people did require assistance.

For one person where English was not their first language there was not a staff member who spoke that language or any interpreters or other tools used to foster two-way communication. The manager told us about a person who had food cooked especially for them because they liked it and it was part of their

cultural heritage. Some people had in care files details of their spiritual or religious needs but these were not detailed and did not capture how they would like to practise their religion.

Relatives we spoke with said that they were happy their relative was being cared for and most of the time were kept up to date with any changes in their family members health or well-being. We saw that for people whose family lived far away staff supported them to stay in contact via email.

Several people, whose abilities to make choices were mentioned throughout their files, did not have their significant choices further explored in their files. For example, for one person whose intention it was to return to their home, their file did not capture how this was going to be achieved or what steps were put in place to support them to improve their independence. We saw that people had choices over what they ate and what activities they participated in and for most people, whether they spent their day in their room or in communal areas with other people.

Requires Improvement

Is the service responsive?

Our findings

We found there was a risk that staff would not have up to date and appropriate information available to them to deliver responsive care due to gaps in care plans. Where a need had been identified there was not always guidance or a detailed care plan for staff to follow. Staff told us that one person had a history of behaviour that challenged the service. There was no care plan about the behaviour or any mention of challenging behaviour in their care notes. For another person one part of their care plan said they do not get confused and in another stated they do become confused. The structure and layout of care documents were comprehensive but they often contained gaps or were inconsistent. These gaps and inconsistencies put people at risk of receiving care that was not tailored to their needs.

Care plans did not always contain information around people's preferences. People's social and personal backgrounds were missing in some places. For one person, it was not clear if they had contributed to the "my day, my life document" as the section to record if they had contributed was left blank. For another person there was conflicting information on the preferences of staff gender when assisting them with personal care. Specific details were missing in some documentation about what plans there were to achieve people's goals and to review progress towards achieving their goals. For one person who had a goal to move back to the family home, there was no plan around how this was going to be achieved.

Files did not always show there was meaningful consultation with people in some aspects of their care. For example, records in files stated people could make and express choices over decisions about their care but did not always specify what their preferences might be. There was not, for example, evidence of a person-centred approach to how people spent their day or an account of life history to inform care planning. For example, one person's hobbies and interests were listed as "likes chatting" with no detail as to what they like talking about or any other interests. People also did not have an influence on decisions made about their living environment. The deputy manager told us on the day of inspection the Edwardian suite that had been recently redecorated in the home had not consulted people about their ideas or preferences on the re-decoration.

On the day of inspection we saw one person whose first language was not English had not had their communication needs fully assessed and this was affecting how they were cared for. For example, the care plan said they make a noise or facial expression to get attention. When we asked care staff about this person they said the person does not speak any English. We saw when care staff entered the room they did not talk to this person. However, when we met the person we were able to hold a brief conversation in English with them and they were able to express their views verbally. We saw no evidence of staff proactively finding ways to maximise communication with this person. We fed back this concern on the day of inspection.

The deputy manager told us on the day of inspection one person remained in bed because "we don't have a suitable chair…they might be transferring to another home" and another person who stays in bed there is "some talk about an assessment" for a chair. When we spoke with one of these people about getting out of bed they said sometimes they stay in bed when poorly but when they do want to get out they are regularly told "no you stay in bed". Some people remained in bed even if they preferred to get out because they had

not yet been assessed for equipment that they needed and their individual needs were not being met. We fed this back to the registered manager on the day of inspection.

The above evidence demonstrates a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We asked people and their relatives whether complaints were responded to and we had a mixed response. Relatives told us they would go to the registered manager if they needed to complain and felt comfortable doing this. One person said, "If you ask them for something they will always do it and they listen to what you say". However, we saw for another person their complaints had not been recorded or responded to within the provider's timeframe. The provider was not following their policy on complaints and people were not treated equally when they made complaints. We saw that actions taken to resolve complaints were not always recorded and it was not clear from the records if they had all been resolved. We spoke to the provider on the day of the inspection about treating each person who complains fairly and making sure that all complaints were recorded and taken seriously.

The above evidence demonstrates a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people and their relatives how quickly staff responded when they called for help using the call bell. A relative said "my [relative] says you wait for quite a while at night when you ring and you hear bells going all the time in the morning." One person said, "I can't reach the bell, I wait and they come." On the day of inspection, we saw one bell ringing for several minutes and asked why it had kept on ringing and if it had been answered. The manager and regional manager told us the call bell system had been upgraded recently and it was a fault that it kept ringing and that the call had been answered.

People told us they liked the activities on offer and the staff who supported with the activities were fun and encouraged them to join in. One person said "I do singing and bingo and I am doing flower arranging later. I am getting my hair done soon. I like a chat with the girl who does it. I have been on walks outside in a chair." Another person said "the activities are good. You get to see people and have a chat." We saw from records and talking with people that some people joined in activities daily while others preferred to spend time in their rooms or the garden.

We saw evidence of people attending a meeting to feed back about the service and contribute to ideas for activities. The records of these meetings showed people had asked to visit the seaside and eat fish chips so a day trip was organised to Southend. Another person had said who their favourite author was and the home bought in some books by that author. Meetings for people who live in the home were taking place three times a year and notes reflected that people were generally happy with the care and had a few suggestions that were considered. For example people said they did not enjoy visiting entertainers coming too frequently so the home agreed to reduce the frequency.

Requires Improvement

Is the service well-led?

Our findings

There was a system of surveys and audits in place for the service, to ensure that areas for improvement were identified and addressed. Audits were completed on medicines, care records, risk assessments, the safety of the environment and the overall quality of care in the home. The deputy manager also conducted a weekly clinical walk around and held weekly clinical meeting with nursing staff. In this meeting they discussed the changing needs of people and associated risk. Any pre-admission information for new people and best nursing practise in areas such as tissue viability, pressure sores, medicines and behaviour that challenged the service. The provider used quality metrics to monitor on-going performance, with areas monitored monthly including pressure ulcers, weight, mortality, medicines errors, and hospital admissions.

The provider had sent extra resources in to the home to help with areas it recognised needed improving, including actions noted on the home improvement plan. The regional manager had an open attitude to making improvements and had completed a quality audit of the home three days before the inspection which highlighted many of the same issues noted on the day of our visit. We saw the provider was aware of some of the areas for improvement we raised but not all had been identified and addressed.

During the inspection we identified a number of issues with record keeping and found the provider was not ensuring documents were up to date, accurate and complete. We saw that supervision records were not in place for all care staff and some staff had not had appraisals in 2016. Consent documents were not all in place and documentation around the MCA was incomplete. Care records had gaps and inconsistencies for some people and we found gaps in recording of fluid intake and repositioning charts that were not picked up on in clinical audits or raised in clinical meetings. We found the governance systems and processes to assess and monitor the quality and safety of the service and ensure all relevant information was kept on file for people receiving care was not always effective. The audit system was robust in design but it was not ensuring that action was taken after an issue had been recognised or that risks were mitigated.

The above evidence demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us the registered manager was friendly and approachable, they felt supported but felt more could be done to relieve the pressure in terms of staffing levels and busy points in the day. Feedback from the staff team was that teamwork had improved recently. However, they felt that issues with staff who were struggling with the work, were persistently unwell or not contributing to the running of the shift as they should have been, were not addressed by the management team. Staff felt that these issues were left unresolved.

People knew who the registered manager, deputy manager and regional manager were and said the registered manager was visible and often said hello. During the inspection we found staff were working hard to cope with the day to day work. We saw care staff and the registered manager wanted to do a good job but were focussed on the tasks of care rather than the people that were being cared for.

We saw evidence of partnership working and that the home had input from health professionals such as dieticians, and occupational therapists. We saw that the local authority quality in care team had been working with the home and providing support to improve the standard of care. We saw that managers from other homes visited The Arkley Care home to support the management team with completion of audits and feeding back on improvements.

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 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure that persons employed by the service provider in in a regulated activity received such support, training, professional development, supervision and appraisal as is necessary to enable them to carry out te duties they are employed to perform.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to provide care and treatment that met peoples needs, did not carry out collaboratively with the relevant person an assessment of the needs and preferences of the service user. The provider failed to design care or treatment with a view to achieving service users' preferences and ensuring their needs are met.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to gain consent of the relevant person in regard to care and treatment, and for people unable to give consent because they lack capacity to do so, the registered person did not act in accordance with the Mental Capacity Act 2005.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effectively systems and processes to maintain securely an accurate, complete and contemporaneous record in respect of each service user, included a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment.

The enforcement action we took:

Warning notice