Arborough House Ltd

# Arborough House Limited

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Requires Improvement** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

This unannounced inspection took place on 2 August 2017. The inspection was bought forward due to information of concern we had received about staffing levels, the management of the home and the care provided to people.

Arborough House is a care home that does not provide nursing care. It provides support for up to 14 older people, some of whom live with dementia. At the time of our inspection there were 12 people living at the home. Accommodation is over three floors and stair lifts were available for all except one, the lower floor.

At the time of our inspection visit there was a registered manager. 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.

At the last inspection in July 2016 the service was rated Requires Improvement. We found a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 because the management of medicines was not safe. At this inspection we found the management of medicines remained unsafe. Storage of medicines was not secure because medicines were not always locked away and the keys were left on top of the trolley. Temperatures of medicines storage were not checked. Creams were unlabelled, undated and the wrong creams were left in people's rooms. There were unexplained gaps in the recording of medicines and the stock and recording of antibiotic medicines did not tally. Where medicines were administrated covertly there were not clear support plans in place.

Risks associated with people's needs and support were not always understood or assessed and plans were not developed to guide staff to reduce risks. Up to date fire safety information was not available. Staff were unable to find Personal Emergency Evacuation plans for everyone living at the home. No health and safety checks were carried out and some window restrictors were broken.

The recruitment of staff did not always ensure the appropriateness of potential applicants to work with vulnerable people because checks which would help the provider assess their character did not always take place effectively. Most staff had been trained to understand their roles and responsibilities in safeguarding, although their knowledge varied. Whilst care plans had been developed to guide staff about how to respond to the management of allegations made by on person, this was not followed. Allegations made were not investigated and were not reported to the local authority safeguarding team or to the Commission.

Staff did not receive regular supervisions or appraisals and training received was not effective. Some training that would support staff to work effectively with people had not been provided and staff lacked an understanding of these needs.

Staff sought permission before providing personal care however where this was required for the use of

equipment it had not been sought. Staff lacked an understanding of the Mental Capacity Act 2005 and where this needed to be applied in full, it had not. Staff did not have knowledge of those people subject to DoLS or understood what this was for.

Staff were not consistently kind or caring in their interactions with people. At times their communication was abrupt or dismissive. They did not always demonstrate they respected people's dignity and privacy.

Audits to assess the quality of service provision were not completed regularly and were ineffective in identifying improvements needed. Action plans were not developed to ensure improvements were made. The registered manager did not understand their responsibilities in line with duty of candour. The provider had not ensured a policy was in place. Notifications required by CQC were not submitted.

During our visit staffing levels met the needs of people, however we were not confident this was always the case and have made a recommendation. The recruitment of staff was safe but records held in relation to this required improvement.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Following the inspection we requested the provider send an action plan telling us how they would take action to address our immediate concerns. In addition we referred our concerns to the Local authority. We are now considering our regulatory response.

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

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not always safe

The management of medicines remained unsafe.

Risk associated with people's needs were not always understood by staff and approaches had not been developed to reduce these.

Where allegations were made we were not confident these had been investigated and reported appropriately.

The recruitment of staff was not always safe as appropriate checks did not take place before staff commenced work. Although during our visit staffing levels met the needs of people we were not confident this was always the case and have made a recommendation.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff did not receive regular supervision or appraisal. Training provided was not always effective to ensure staff could support people effectively.

Staff lacked an understanding of the Mental Capacity Act 2005 and where this needed to be applied in full, it had not. Staff did not have knowledge of those people subject to DoLS or understood what this was for.

People were satisfied with the food they received and were supported to maintain a balanced diet. However, improvements required from the last inspection in relation to the choice of food and the use of monitoring charts had not been made.

Staff accessed other professionals to ensure support provided was appropriate for people's needs.

People were satisfied with the food they received and were supported to maintain a balanced diet. However, improvements we found were needed at the last inspection in relation to the

choice of food.

Staff accessed other professionals to ensure support provided was appropriate for people's needs.

## Is the service caring?

**Requires Improvement**

The service was not always caring.

Staff were not always kind or caring in their interaction with people and did not always demonstrate they respected people's dignity and privacy.

People were supported to maintain their independence and were involved in making decisions about their support and the home.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Staff knew people's preferences but people were not consistently supported to receive personalised care.

The service had a complaints procedure and people felt at ease to raise concerns.

## Is the service well-led?

**Inadequate**

The service was not well led.

Audits to assess the quality of service provision were not completed regularly and were ineffective in identifying improvements needed. Action plans were not developed to ensure improvements were made.

The registered manager did not understand their responsibilities in line with duty of candour. The provider had not ensured a duty of candour policy was in place.

Notifications required by CQC were not submitted.

The provider had displayed their rating from the previous inspection.

# Arborough House Limited

**Detailed findings**

## Background to this inspection

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

This inspection took place on 2 August 2017 and was unannounced.

Two inspectors carried out the inspection with the support of an expert by experience. The expert by experience had personal experience of caring for a person with dementia. 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 information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. This information helped us to identify and address potential areas of concern. We also attempted to gain feedback from social care professionals involved in the service.

During the inspection we spoke with five people and two relatives. We also spoke with eight staff, including the acting manager. We also spoke with both directors of the provider company. We sought feedback from two visiting professionals; however neither said they knew the home well, having not visited for some months, so were unable to make any comment.

We looked at care records for five people and the medicines records for all 12 people living in the home. We looked at recruitment records for three staff, supervision and appraisal records for 13 staff and all staff training records. We also looked at a range of records relating to the management of the service such as activities, accidents and complaints, as well as quality audits.

It was not always possible to establish people's views due to the nature of their communication needs. To help us understand the experience of people who could not talk with us, we spent time observing interactions between staff and people who lived in the home.

Following the inspection visit we spoke with the registered manager and also requested they send us information related to health and safety, fire safety and governance systems. At the time of this report we had not received all the information we had requested as the registered manager was not able to locate it all.

Inadequate

# Is the service safe?

## Our findings

People told us they felt safe living at Arborough House. One person, told us, "I've no worries and no one troubles me here." Another person told us, "we are very safe here, no complaints". People told us staff gave them their medication but could not always recall what this was for.

At our last inspection in July 2016 we found the management of medicines was not safe. There was lack of proper recording of medicine administration and important information relating to some medicines was not complete. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We required the provider to take action to address this and they sent us an action plan in September 2016 which said they had taken action and were compliant with the legal requirements.

At this inspection we found the management of medicines remained unsafe. Medicines storage was unsafe. Some medicines were stored in a locked trolley in the lounge; however the keys were often stored on top of this trolley or on top of a cupboard in the lounge. In the conservatory were four boxes of medicines that were not locked. People, relatives and visitors accessed this room throughout the day. A fridge in the conservatory containing medicines was not locked. The temperature of storage was not checked.

We found prescribed creams in people's bedrooms that did not belong to them. For example, for one person we found a tub of cream, two tubes and a spray that belonged to two people who had passed away. We found some creams were not labelled with the appropriate prescription label which meant we could not be sure who the creams had been prescribed for. These creams had not been labelled to indicate when they had been opened.  For example in the communal bathroom we found a tube of undated soft paraffin, which had also expired. A member of staff could not tell us what this was for and placed it back in the cupboard.

There were unexplained gaps in the recording of medicines and the stock and recording of antibiotic medicines did not tally for three people. Where medicines were administrated covertly clear support plans were not in place and there was no evidence of pharmacy involvement.

Medicines were administered on an individual basis, in line with best practice guidance. The member of staff waited and checked people had swallowed their medicine and signed the Medicines Administration Record after each administration. One person told us "I get my medicines, even [in the evening] and I can get Paracetamol if I need it." However, this member of staff was frequently disturbed during the medicines round. This meant the member of staff would become distracted and this could result in potential medicine errors.

The failure to ensure the management of medicines was safe was an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People may not have always been protected from the risk of potential abuse or harm. One person's daily records reflected incidents that could constitute abuse towards others. For example, records stated they had been both verbally and physically aggressive towards other people living at the home, including

throwing furniture at one person and "making the ladies scared". These incidents had not been reported to the safeguarding team as potential incidents of abuse and no investigation had been carried out.

A care plan had been developed to provide guidance to staff on how to respond to the management of allegations of abuse and neglect made by a second person. This stated, "Ensure all reports are dealt with immediately and investigated thoroughly. Report to senior. Involve key professionals." However, records demonstrated that this guidance was not always followed. We found records whereby the person had made allegations about staff on four occasions in July 2017 but there were not records to demonstrate these concerns had been investigated and reported to the local authority safeguarding team or to the Commission. We discussed this with the acting manager as the registered manager was on annual leave. The acting manager was unable to tell us if these allegations had been investigated and reported. We reported these to the local authority responsible for safeguarding. We spoke to the registered manager about these following the inspection. They confirmed they had spoken to the person and family member following the allegations but had not recorded this or reported the allegations.

The failure to ensure allegations of abuse were appropriately investigated and reported was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

Risks associated with people's needs and support were not always understood or assessed and plans were not developed to guide staff on how to reduce the identified risks to people. For example, one person had a diagnosis of dementia which caused them to display behaviour which posed a risk to them and to others. Staff told us how they felt this person's behaviour impacted on other people and on the person. Staff told us how this person could lie on the floor, in doorways and on the stairs for hours at a time and staff were not able to manage this. No assessment of how this person's diagnosis impacted on them had been completed. No assessment of the risks these behaviours posed to the person and others had been completed and no plan was in place to guide staff on how to manage these behaviours and risks. Staff had not received training to help them understand and manage the person's condition. We also found a letter from a health and social care professional on file for this person. This identified a known risk that had resulted in damage to doors and windows. No assessments of this had been undertaken and no plan developed to reduce this risk. One member of staff told us on one occasion they had rolled this person out of the door way so that other people could be supported to bed. They also said that a commode was placed in the conservatory so that people could use the toilet due to this person blocking the door way. These matters had not been reported to the local authority by the registered manager. The registered manager told us this only happened once. We reported these concerns following our inspection.

This person was also living with diabetes, however the risks associated with this condition had not been assessed and no plan was in place to guide staff on how to manage this person's health condition. There was no information about the things they should look for which may indicate complications had arisen and what action staff should take. Two staff told us they had not received any training to help them understand diabetes and were unable to tell us what they would monitor for or the action they would take should risks to this person arise.

A second person had recently moved into the home for a period of respite care (short term care). Staff told us this person had only moved in 2 days prior. A scrap piece of paper in this person's folder identified they were at risk of falls and suffered a 'skin complaint'. Whilst a folder was in place for this person, no risk assessments had been undertaken and no care plans developed to guide staff.

Up to date fire safety information was not available. The acting manager showed us a fire risk assessment which was dated 2009. They were unable to provide us with any evidence of recent fire checks. We were

unable to see that every person had a Personal Emergency Evacuation Plan (PEEP). A PEEP is a bespoke 'escape plan' for individuals who may not be able to reach an ultimate place of safety unaided or within a satisfactory period of time in the event of any emergency. One member of staff told us there was an evacuation folder but was not able to find this. We referred our concerns to the fire and rescue team. We also discussed these concerns with the registered manager following the inspection. They provided us with copies of the PEEPs that staff were unable to find. They told us everyone living at the home did have a PEEP and was unable to explain why staff were unable to locate them. The registered manager said they would implement a whole home grab pack by the fire exit which would contain all relevant information. Failure to ensure staff knew where this information was could place people at risk in the event of an emergency. They also told us and shared evidence that a fire risk assessment was in place dated 2015 and weekly fire system checks were undertaken. However, feedback from the fire and rescue service was that the laundry room door lacked a self-closer [a typical high risk room], regular training and drills were not in place and they had concerns about the standard of the two of the doors by the front entrance which should be fire doors.

Not all staff were able to demonstrate a clear understanding of fire procedures. One member of staff said at night they would only call 999 if a fire was confirmed, whereas we saw the directions were for staff to call 999 and then go and check the relevant zone. This staff member said they had been trained to use the evacuation mat, but it could only be used for a small person and they were unable to find it. We later found it in the entrance hall.

Window restrictors were in place in the form of chains. However two of these had snapped and one had become loose on the window. We spoke to one of the directors who told us they undertook a "handyman role" in the home on a weekly basis. They told us there were no records of health and safety checks. They were not aware the window restrictors were broken and said these had been checked "about 3 months ago". They were not aware if a risk assessment or records of these being checked were in place. We discussed this with the registered manager following the inspection who confirmed there was no risk assessment of health and safety checks carried out. They told us new window restrictor had been ordered.

The failure to ensure risks were assessed and plans developed to mitigate these was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could be not always be confident they were supported by staff who were appropriate to work in care because recruitment practices did not always ensure staff character was assessed. Whilst the manager had sourced two references for one member of staff, these were not from their most recent employer. The acting manager said the registered manager had followed this up with a telephone call but had not recorded it. For a second member of staff their reference and DBS check were dated almost a year after they commenced their role. The registered manager said they did not do a risk assessment but said this member of staff did not work unsupervised during this time. In addition where checks with professional bodies would support the provider to assess a staff members character this had not been done. For a third member of staff there was no identification held on file.

A failure to ensure all records required under schedule three and a failure to undertake sufficient checks assess a potential applicants character before they commenced work was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Potential new staff completed an application form and were subject to an interview. Following a successful interview, Disclosure and Barring Service (DBS) checks were carried out to ascertain if the staff were suitable to work with people at risk.

There were sufficient staff to meet people's needs throughout the day and when all shifts were covered. One person told us, "Yes, there's enough staff about." Observations during our visit showed that staff responded to people's needs promptly and they did not wait for extended periods of time. The registered manager confirmed that they did not have a system in place to assess the number of staff that may be needed. The service operated with two care staff between 8am and 9am, three between 9am and 1pm, two from 2pm to 5 pm and three from 5pm to 8pm. Overnight there were two waking night staff. However staff told us there were times when all shifts were not covered. Rotas viewed showed six occasions from 20 June 2017 when the 5-8pm shift was not covered leaving two care staff. One member of staff and the acting manager told us that only having two staff at this time made it difficult because the evening meal needed to be prepared for people and one person needed almost one to one support. At night, staff were not trained to administer medicines, so people had to rely on staff contacting the on call manager if they required medicines at night. In addition, there were two staff on duty overnight and staff told us almost everyone living in the home would need two staff to evacuate them in the event of a fire. There was no record available to show this had been assessed.

We recommend the provider seek advice and guidance from a reputable source on the latest best practice in respect of developing a systematic approach to determining the number of staff and skills required to meet the needs of people using the service and keep them safe.

Requires Improvement

# Is the service effective?

## Our findings

People told us that staff asked for their permission before providing any personal care. One person said, "Yes, they do." People said staff offered them choice around the clothes they wear. One person told us "They show it to you, asking whether you would like this". They provided positive comments about the food they received and they felt well supported.

Most staff told us they felt supported by the registered manager. They said they were able to talk to them about any concerns they had. One member of staff told us, "I get supervisions quite regularly, but I will come in on my day off and talk with my manager. [They're] brilliant; I can come in here anytime and talk to her."

Staff said they received supervisions but we found these did not take place regularly for all staff. One member of staff said, "[The registered manager] comes in early to see the night shift. [They] ask if there are any problems." They said they had supervisions every six months and had an appraisal last year. A second staff member told us they received supervision or an appraisal every three months, although the last recorded supervision for this person was October 2016.

We reviewed the supervisions and appraisal records for 13 staff members. Supervisions appeared to be held when concerns were identified, for example medicine errors. However, we found that most staff had not had a routine supervision for 12-18 months. There were no records of any appraisals.

Staff told us they received a lot of training. One said, "It's always helpful." Another staff member told us all training was face to face and they were up to date with all mandatory training, including safeguarding, MCA, dementia, moving & handling. A third said, "I could do more training if I wanted, I'd just ask [the registered manager]."

Staff who administered medicines had received training in the form of a face-to-face trainer followed by the completion of a workbook. Staff were then observed administering medicines by the registered manager to make sure they were competent to administer people's medicines. This competency process was repeated yearly. One member of staff told us, "[The registered manager] is hot on medicines. [They] observed me recently due to a couple of mistakes I'd made. Due to the number of errors we were all making, [they] got a trainer to come in and do some extra training with us." However, we found multiple concerns with the management of medicines which have been reported on under the safe question. The number of medicines concerns found demonstrated the medicines training and competency process was not effective.

Most staff had been trained to understand their roles and responsibilities in safeguarding, although their knowledge varied. For example, one member of staff was clear about how to identify, prevent and report incidents of abuse. They told us, "I've got no concerns with any of the staff here, it's a fantastic team; but if I did have concerns, I'd go to my manager or the area manager, or safeguarding direct. I've got a contact name and number if I need it." However, one member of staff told us safeguarding was about keeping people safe and described using a hoist and checking the environment. Safeguarding specifically relates to protecting vulnerable adults or children from abuse or neglect and is a term that has been used for a

number of years. This member of staff had recently completed safeguarding training which demonstrated the training had not been effective.

The acting manager lacked an understanding of the Mental Capacity Act 2005 despite having completed training. They said they thought capacity assessments and best interest decisions were done by social services or mental health professionals. They said, "I've been out of care, so I'm not up to date. I just come into do a couple of shifts and go."

Training that would support staff to understand people's needs was not always available. Staff were supporting people living with a specific type of dementia and diabetes. They lacked knowledge of these conditions and an understanding of the support they should provide. Staff and the registered manager told us training had not been provided in this subject area. The registered manager said they planned to ensure these were delivered but had not yet booked these.

A failure to ensure staff received regular supervisions and appraisals to support them in their role and ensure they received training that would enable them to be competent and skilled to meet the needs of people living in the home was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

A training record was in place that the registered manager told us they used to keep staff up to date. This reflected that most staff had completed training in safeguarding, moving and handling, first aid awareness and health and safety. In addition some staff had completed training about dementia and those that had not completed this training had been issued with competency workbooks to complete. One member of staff demonstrated a good understanding of supporting people living with dementia, explaining the need to allow them to "voice their opinion", to give "person-centred care as they are all individuals" and to "divert and distract to defuse difficult situations before they develop."

The acting manager described the arrangements in place for staff to complete the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.  No one had needed to do this as all recently recruited staff had worked in care before.

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).

Staff, including the acting manager's, understanding of the Mental Capacity Act 2005 and DoLS was poor. For example, when asked about the Mental Capacity Act 2005, one member of staff told us, "Everyone is different and they all need something different. Some can be dangerous, they might hit you."

We observed throughout our visit that staff sought consent from people before providing care or support with personal care and meals. However, equipment was in use that had the potential to restrict a person

such as sensor mats (these alert staff to a person's movements) and bed rails, consent had not been sought and the principles of the MCA had not been applied. The registered manager told us bed rails should not be used as they were not needed. One person had their medicines administrated covertly. A member of staff told us they usually put the medicines in the persons in the morning as they had "never not eaten all of [their] porridge." They said the person normally took their medicines at lunchtime and in the evening, so these were given overtly. However no mental capacity assessment had been undertaken and there were no best interests decision in place relating to supporting this person with their medicines covertly. There was no support plan developed or review dates planned and there was no evidence that staff offered this person their medicines first before giving it to them covertly.

The failure to ensure consent was consistently sought and the mental capacity act was applied where needed was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that seven people had an approved DoLS in place and in date. One person DoLS had expired and the registered manager told us they had submitted another application to the authorising body. Another person's DoLS was due to expire the day after our visit but no further application had been made. The registered manager confirmed that no mental capacity assessments had been completed by staff at the home to determine that these people lacked capacity to make these decisions before submitting a DoLS. Staff were unaware of who was subject to a DoLS authorisation. When asked if anyone living at the home was subject to a DoLS one person said, "Not really." Another was not aware of anyone subject to DoLS. The acting manager told us they thought 11 people were subject to a DoLS. However, only eight people were subject to approved DoLS and two applications had been made. When we asked the acting manager if anyone had conditions attached with their DoLS, they told us one person had Korsakoff's. This is a type of dementia and not a condition of DoLS. Two people did have conditions attached to their DoLS, however these had not been included in any care plans and the acting manager was not aware of them. We discussed this with the registered manager following the inspection who was able to tell us who was subject to DoLS, who had conditions associated with their DoLS and how these were met. Whilst the registered manager was able to demonstrate an understanding, a failure to ensure a system was in place which provided staff with knowledge of authorised and expired DoLS, and attached conditions placed people at risk of having their liberty deprived unlawfully.

We recommend the provider seek advice and guidance from a reputable source on developing a systematic approach to monitoring DoLS and ensuring staff understanding.

People had a choice of meals at breakfast and dinner time, however there was no choice provided at lunchtime. This had not changed since our last inspection, however the chef told us if someone didn't want it, they could ask for something else and he could do an omelette or a salad. There was a board in the kitchen detailing people's likes & dislikes on the wall, which the chef was fully aware of. However, the option of proactively asking for a different meal depended on people's ability to do this. The lunchtime menu changed on a two week rolling basis and was also changed seasonally. No one needed supplements or fortified meals, although the chef was able to explain how they would provide these if needed.

People told us they enjoyed the food that was available to them. One said "Oh yeah, nothing wrong with it, the cook is very nice." Another told us, "The food is fine, fantastic, I have been here only two days."

People could access the kitchen to request drinks and snacks and we observed this happening. There were jugs of water and various fruit squashes available in the lounge throughout the day. People had their own mugs, together with other drinking vessels including spouted beakers.

Observations reflected people were given support and encouragement to eat their meals. People's weight was monitored regularly to ensure they were receiving an adequate nutritional intake. The registered manager told us how health professionals would be contacted if a person's weight was a concern.

People's health needs were met. Staff and people confirmed regular access to healthcare services including GP's, dentist and specialist support team was available.

Requires Improvement

# Is the service caring?

## Our findings

People told us the staff were kind and caring. One person told us, "Yeah, they are sympathetic." and another said, "Yes they are very helpful." Relatives told us, "Staff are very welcoming and very friendly." Feedback indicated that staff did not always respect people's privacy. One person told us staff did not always knock on people's door and wait before they entered. One person told us, "Doesn't seem to apply." while other people and their relatives told us staff did do this.

Staff did not consistently demonstrate respect for people's dignity and privacy. Confidentiality was not always maintained. Handovers took place in the main communal area and we observed information being shared between staff about people while they were in this room. Whilst the staff member apologised to the person and explained what they were doing, this handover should have taken place more discreetly. On another occasion the acting manager bought a visiting health professional into the main lounge to provide a handover of their visit to a member of staff. This was done in front of other service users and the inspection team.

Staff interactions were mostly kind and caring. For example, when supporting people with their medicines the member of staff explained what the medicines were for and encouraged them to take "a big drink of water." However, another member of staff was abrupt when communicating with people at times. For example, when one person started coughing on their drink, the staff member said, "You should sit up when you're drinking and when you're eating; and you should sit up when you're on the loo." It was said in an abrupt manner and was not very discreet as other people were present.

When people became distressed staff mostly showed compassion and provided reassurance. For example, one person became distressed by a TV programme. The member of staff comforted and reassured them. They knelt to the person's level, rubbed their arm and offered to change the channel. However, on another occasion a person approached a staff member. This person demonstrated signs of confusion. They said they needed to talk to someone about a matter that was bothering them and the staff member laughed. Immediately following this the staff member sat with this person for quite a period of time, discussing their concerns and providing reassurance in a kind way. However the initial response was inappropriate and could have increased this person's distress. The staff member agreed with us that this was inappropriate.

On one occasion we heard a staff member call across to another staff member, asking if people had had their breakfasts and if so, what they had. The people referred to were sat in the lounge, but were not involved in this conversation which showed a lack of respect. On another occasion a staff member informed a person that another person living in the home needed to use the toilet.

A failure to ensure people were treated with dignity and respect at all times was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by a consistent team of staff which ensured continuity and enabled people to get to know the staff. Observations reflected people were comfortable and relaxed in staff's company. Each person

was addressed using their preferred name. Care plans encouraged staff to promote independence; for example, for one person their care plans stated, "[The person] is able to wash and shave with minimum supervision. Carer only needed to wash back and feet." and "Give toothpaste and brush and explain the task. [They] can then manage on [their] own." and "Is able to choose own clothes. May refuse to dress or undress and choose to sleep in [their] clothes."

People were supported to remain as independent as possible. We observed one member of staff supporting a person to transfer to a recliner chair using their walking frame. The staff member patiently walked alongside the person provided reassurance and gave clear instructions to help them seat themselves safely and comfortably. They were then encouraged to stretch their legs and do some simple exercises to aid their mobility.

People had access to advocates when this was needed and people were supported to maintain relationships with family members.

Requires Improvement

# Is the service responsive?

## Our findings

People told us they were happy living in the home. One person said, "Yeah, I am quite happy." Another person told us, "I can please myself as to when I get up and go to bed and can have showers whenever I want. I've just had one now." No one said they had any complaints but would talk to the registered manager if they did.

Mostly people received personalised care but this was an area that could improve. The registered manager told us pre admission assessments were carried out with people before they moved into the home. Following this, care plans were developed which would guide staff about the person's needs and the way in which they should be supported. However, for one person who had very recently moved into the home, no care plans were in place. The registered manager told us they had handed this over to a member of staff to do before they went on leave. However, it had not been done and the person had moved in. The registered manager told us they would address this with the staff member.

Most staff had worked with people for a significant period of time and had built relationships with them and developed an understanding of their preferences and dislikes. A staff member described how they took a person-centred approach to some aspects of one person's care. For example, the frequency they chose to have a shower and the verbal support and prompts they provided. However, they were unable to explain why this person needed a sensor mat and told us it was policy for everyone to have a sensor mat, (a mat which alarms when stood on to alert staff to a person's movement). In an action plan sent to us by the registered manager they stated that alarm mats were in place to alert staff that a person who was at risk of falls was moving. Staff said this person had not experienced any falls; their care plan did not include a falls risk assessment; and their mobility risk assessment did not mention the need for an alarm mat. This was not a person centred approach to the care for this person. In addition, we found two people were using pressure relieving mattresses that they said they did not like. They were not aware of why they were using these and a staff member told us it was because these mattresses were on the beds in these rooms when these people moved in. Both of these people were very mobile which would help to reduce any risk of pressure sores developing. Using these mattresses just because they were there was not personalised care.

The lack of care delivery based on individual needs was not person centred and was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff and the registered manager told us they often undertook activities with people including bingo, cards, arts and crafts as well as listening to music and dancing. Previously made cards and decorations were hung on the walls of the lounge. External activities were provided. A member of staff told us, "On Thursday morning there is artwork, making cards, drawings. On Wednesday there is bingo, jewellery making and poetry. Saturday and Sundays are mainly for exercise sessions (mobility activities)." During the afternoon of our inspection visit we saw people actively participating in a music therapy session. However, this was the only activity we observed taking place throughout the day and people were left seated in the lounge with the TV on silent and music playing in the background for extended periods of time with little or no engagement from staff.

Care plans that were in place for people provided guidance to staff about how to meet some of their needs and their preferences. For example, one person's mobility care plan described how the person was able to walk independently but required staff to supervise them as they could be at risk of falling. Staff were aware of this and we saw that each time this person mobilised staff were present to observe them.

Another person's care plan for anxiety/depression identified they could become anxious "if asked to perform tasks [they] [don't] like and when the environment is noisy." It advised staff to talk in a calm way, remove them from the noisy environment and take them to a calm place, allow them to make their own choices and to stimulate with activities they enjoyed.

One staff member was able to clearly describe the causes of this person's anxiety and how they used the tactics detailed in their care plan. For example, they said, "If [Person] becomes agitated I speak softly and try to distract. [Person] gets agitated after [visits by a relative] and if there's too much noise. I bring [them] to a quiet area and put a DVD on for [them]."

Staff told us care plans were useful, although we found some of these lacked guidance about people's needs and were not always accurate. For example, one person's eating and drinking care plan stated that their food and fluid intake was to be monitored and their weight was to be checked weekly. A staff member told us this did not happen as it was not needed. They did monitor this person's weight monthly and it was stable.

The complaints procedure was displayed in the entrance hall, but this was out of date. It said that if complaints are not resolved, the complainant should contact the Commission for Social Care Inspection at Maidstone. An updated complaints procedure was found in the complaints file, dated November 2015. No complaints had been received since 2012. One person told us, "If I needed to complain, I'd go to the lady in charge [the registered manager]."

Inadequate

# Is the service well-led?

## Our findings

One person told us the service was, "As good as it could be." People knew who the registered manager was and said they would recommend the home to a friend.

At the time of our inspection there was a registered manager in place. Some staff told us how they felt the home was run well and they were supported. One said, "Staff are happy. Everything is organised. I always know my duties and who I'm working with. We work well as a team." A second staff member said, "It's a nice home. [The registered manager] is really supportive." A third member of staff told us the registered manager worked alongside them, was easy to talk to and was confident they would act on concerns. Whereas a fourth told us they felt the registered manager was supportive in personal situations but did not always listen when it related to work concerns. A fifth staff member told us of concerns they had raised which they felt had not been addressed quickly enough. They said, "Nothing happened when [x] abused us, but when [x] did it to the manager and owner they did something about it. I felt let down. All I wanted was an apology. Two months and nothing was done until they wanted to corroborate their grievance with [them]."

The registered manager told us they were supported by a regional manager who visited the home twice a week. They said this was a very recent change. In addition, there were two directors for the company. One of the directors visited the service weekly and told us they did not undertake any audits of the service as they were responsible for handyman tasks. They said they did not know if the other director conducted audits. Staff and the registered manager said the other director did not visit the service regularly and did not carry out any audits. The registered manager told us how the regional manager had organised a meeting with the directors to ensure they were clear about the support they needed to provide to the regional and registered manager.

Whilst a management structure was in place, there was limited management support available to staff in the absence of the registered manager. The registered manager was on holiday at the time of our visit. An acting manager was in place who told us they were a bank worker and worked approximately 12 hours a week in the home. The regional manager who supported the registered manager was also on holiday at the time of our inspection and the acting manager said they could get support from the registered manager of another service owned by the directors. They later told us this person was not registered. One member of staff told us they were unaware this person was acting as manager while the registered manager was away.

Since the introduction of the changes to the way in which CQC inspect locations, Arborough House has not achieved an overall rating of good or a rating of good in the well led question. At both January 2015 and July 2016 inspections; the well led domain was rated as overall requires improvement. During inspections in 2013, 2014 and 2015 we found the provider was in breach of the regulation that related to monitoring and assessing the quality of the service. This had improved at the last inspection and was no longer a breach but we identified that further improvements were needed.

At this inspection systems used to monitor and assess the quality of the service were in place but not effective in proactively identifying areas that required improvement and driving these improvements

forward.

At the last inspection In July 2016 we found a breach of Regulation 12 in relation to the management of medicines and whilst the registered manager sent us an action plan in September 2016 which said they had completed all their actions, we continued to find concerns about this and it remained a breach. This reflected that the systems implemented to make and sustain improvements to the management of medicines had not been effective. Whilst medicines audits were in place and did identify some concerns, for example gaps in recording, they were not fully effective as they had not identified the concerns we had. At the last inspection in July 2016 we found staff lacked understanding regarding MCA/DOLS. There was limited choice of food and food & fluid charts were not sufficiently completed. At this inspection this had not changed.

At our last inspection we made a recommendation that the service seek and implement guidance from a reputable source on food and fluid charts to ensure they were using the most effective methods to meet people's needs. We were unable to see what action had been taken to address this. At this inspection one member of staff told us staff did not monitor the fluid input or output for anyone, whereas the registered manager told us they did this for people who were considered at risk of not eating or drinking enough. The completion of flood and fluid charts had not improved since our last inspection. They were inconsistently completed and for one person they had only been used for 11 days in July 2017. The registered manager was not aware of this until we told them. They contained no information about the amount of fluids a person should be drinking and had not been totalled or evaluated. Following the inspection the registered manager told us they or the senior carer would monitor the completion of these.

Systems used to assess the quality of the service included a monthly care plan audit and a monthly quality audit. The registered manager was unable to find audits completed after March 2017. There were no action plans developed as a result of these, which the registered manager confirmed, although they said if there were any individual actions these would be added to a care plan amendment sheet at the front of a person's care plans folder. This system was not effective for ensuring improvements to prevent the same issues arising. For example, the audits completed for January, February and March 2017 all recorded that pre admissions assessments and initial 24 hour care plans needed additional work. During the inspection we found one person had moved in without a full documented pre admission assessment and no care plan had been developed.

A quarterly home audit was in place and had last been completed in May 2017. We were not confident of the accuracy of this audit. For example, this said that menus were displayed but we found they were not. The audit also stated the home was partially meeting the standard of checking fridge and room temperatures of medicines storage daily but we found no record of these and the registered manager confirmed this did not happen. It said that all necessary documents were on file before staff started work, however we found no identification and for a second person while they had two references these were not from their most recent employer. In addition, we were not confident this system was effective in driving improvement. The registered manager confirmed there was no action plan following this and we found that where the audit had scored as, "Standard Not Met" we also found these concerns during our visit. For example, the audit dated November 2016 and May 2017 stated that the standard had not been met in relation to MCA and DoLS, no reasons were recorded and no action plan developed. We found concerns in relation to both the understanding and application of MCA and DoLS. This meant the system of quality audits was not effective in identifying concerns and driving improvements.

The last record of an infection control audit that the acting manager found was dated April 2015 and no current audit could be found. The registered manager confirmed no audit had been done since. We found

three bedrooms where the carpets required replacing due to strong smells of urine and a large faeces stain. The director told us how they had planned to replace one of these but as this room was occupied they had been unable to do this. We observed that this person spent the day in the lounge; therefore this action could have been implemented. No maintenance plan was in place and we were not assured that the replacement of the carpets had been considered until we pointed out the need for this.

Weekly reports were held in a central file and signed off by one of the directors. These were not effective in driving action. For example, we saw that these reports consistently identified the need for new baths. Staff and the acting manager told us these baths were not suitable for people as the step to get into these was too large for some people to get into. The seats were small for some people and the doors opened inwards, meaning that people who may be larger could knock the frame legs and injure themselves. No plan was in place which told us when the replacement of the baths and seats would take place. We spoke to one of the directors who told us there were no immediate plans in place to replace these because they felt staff could, "not make up their mind about what they wanted." They also said new baths could be, "quite expensive." They told us they would talk to the registered manager about these on their return. Following our inspection one of the directors told us quotes to replace these baths were being sought. However, we were concerned that the system for reporting these showed that this request had been made since December 2016 and no action had been taken until we had discussed this with the director.

There was no system in place to ensure that incidents which posed risks to people were appropriately recorded, analysed and acted upon. Staff told us of one person's behaviours and the impact these had on the person and others. No incident recording system was in place but staff noted these in daily records. Records reflected several incidents had occurred which placed this person and others at risk. The registered manager was not aware of these and told us unless they were told about these incidents they were not aware of them. They said they did not always check daily records. When another person made allegations these were recorded in daily records and there was no clear reporting process to the registered manager. No analysis of these incidents had taken place which would help to identify any patterns or trends and take action to prevent or reduce risks.

Confidential information was not kept securely. Completed Medication Administration Record charts were kept on top of the medicines trolley in the lounge. In the conservatory, people's completed daily records were kept in an unlocked drawer and people's completed care plans in an unlocked cabinet. The conservatory was used as a smoking room and a quiet room by people and visitors.

The failure to ensure systems in place to assess the quality and safety of the service, were effective in identifying concerns and driving improvement and failing to keep confidential records secure was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

People were asked for their feedback about the service on a regular basis. Staff meetings took place and staff told us this was their opportunity to raise any concerns and make any suggestions. One staff member told the registered manager "tells us to be honest and always asks if there is anything to change for the better." A quality assurance questionnaire was distributed in January 2016 which requested feedback from people. The registered manager said they had not yet sent a new questionnaire to people but planned to do this soon. The results of the last feedback were generally positive, however we found it did not ask questions about staffing or management of the service. Feedback from a visitor questionnaire was available and more up to date. This asked about the friendliness of the staff and general feedback about the environment. However this recorded that visitors would like to see the environment improve and it was recorded that management would invest in this. However, there was no maintenance plan in place to detail what would be completed and when. One of the directors confirmed this.

No duty of candour policy was in place and the acting manager and registered manager were unaware of the meaning of this. Registered persons are required to notify CQC of significant events that occur in the service. This includes any allegations of abuse and any authorised DoLS. We had not received any notifications of the current authorised DoLS for people who lived in the home. In addition, we had not received any notifications of the allegations of abuse made by one person in July 2017.

The failure to notify CQC of these significant events was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Registered persons are required to display the rating given to them by CQC following an inspection. The rating given following our inspection in July 2016 had been displayed on the provider's website and was on display in the entrance hall.

Three weeks after the inspection visit the registered manager sent us an action plan on how they would be addressing the provisional feedback they were provided from the inspection visit. Whilst this covered some of the areas of concern we had found it lacked detail about timescales and who would be responsible.