Barchester Healthcare Homes Limited

Arbour Court

Inspection report

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Ratings

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

Overall summary

This was an unannounced inspection.

The service does not have a registered manager. However, a new manager was in place and an application to become registered had been submitted to CQC in December 2014. 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.

The home provides nursing care for up to 60 people. Accommodation is on two floors and comprises of two communal lounge rooms and two separate dining areas. There are enclosed garden areas. All bedrooms are single and have en-suite facilities available. Car parking is

Summary of findings

available at the front of the building. There were 57 people living at the home at the time of our visit. The home is owned and managed by Barchester Healthcare Homes Limited.

Staff working in the home understood the care needs of the people who lived there and we saw that care was provided with kindness and dignity. The provider had skilled staff employed at the service to make sure the care provided was in line with best practice. A person using the service and a relative told us they were happy with the care being provided and the staff working at the home. Staff were appropriately trained and skilled and provided care in a safe environment.

Training was available to help make sure that the care provided to people was safe and effective to meet their needs. They had all received a thorough induction when they started work at the service and understood their roles and responsibilities, as well as the values and philosophy of the home. Throughout our inspection we saw examples of people and their families being included and consulted in the planning of their care and were treated with dignity, privacy and respect.

The provider consistently assessed and monitored the quality of care using an in house auditing system that was being completed regularly. The regional director told us that the organisation was introducing a dependency indicator care equation (DICE) tool to monitor the workforce numbers. The provider encouraged feedback from people using the service and their families.

Feedback was given in the form of complaints, comments, compliments and an annual service user satisfaction survey. Copies of the complaints procedure were displayed on notice boards around the home and were available for people to read. Feedback received was used to make improvements to the service.

We found a breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. The staff we spoke with knew how to keep people using the service safe. They could identify signs of abuse and knew the correct procedures to follow if they thought someone was being abused.

The provider had effective systems in place to manage risks to people's care without restricting their activities. The environment had been maintained to make sure that appropriate facilities were safe for people to use and meet their individual needs.

People's medicines were managed safely by trained staff. The provider had employed staff with the right qualifications and skills to work at the home.

Is the service effective?

Requires Improvement

The service was not effective.

Whilst the care plans we looked at were person centred and reflected people's needs, preferences and diversity, none of them contained the person's personal history. Improvements were needed to make sure that people's preferred activities and lifestyle were fully integrated into their care plan.

People received care from staff who were trained to meet their individual needs. Staff spoken with understood their responsibilities to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). These safeguards protect the interests of vulnerable people and help to make sure people are given the care they need in the least restrictive way.

Staff had good systems in place to help them identify any changes in people's condition. We saw that people using the service and their families were involved in their care and were consulted about their preferences and choices.

Is the service caring?

Good

The service was caring. People's care needs were recorded and staff followed the agreed care plan to deliver people's care.

During our visit we saw staff showing kindness and compassion to people using the service and their relatives. We saw that care being delivered was focused on meeting people's needs, making sure they were comfortable and treating them with dignity and respect at all times.

People being cared for in bed were routinely checked on and spoken with by staff as part of the person's daily care monitoring.

Summary of findings

Is the service responsive?

Good

The service was responsive. Care plans showed that written information about people's needs, preferences and risks to their care were up to date and had been reviewed regularly. The home worked with professionals from outside the home to make sure they responded appropriately to people's changing needs.

Records showed that people had consented to their care or where this was not possible a relative was involved in the decision making process. For those who could not, the provider made sure that proper steps were taken so that decisions were made in their best interest.

Staff communicated effectively with people to enable them to express their views about their care; future arrangements were included in their care records, such as end of life care.

Is the service well-led?

Requires Improvement

The service was not sufficiently well led because there was no registered manager in place. A new manager had been appointed in October 2014 and an application to become registered was submitted to the Care Quality Commission in December 2014.

In the absence of a registered manager, the regional director used an in house auditing tool to support the temporary manager to monitor incidents and risks. This tool identified areas for improvement and the findings were placed on a central action plan then followed up by the manager within achievable timescales. The audit tool was used on a monthly basis. This helped to make sure the care being provided was safe. Risk to people was minimised because the system in place for monitoring risk was effective.

Staff said they felt supported and were aware of their responsibility to share any concerns about the care provided at the home. They understood and worked within local and national best practice standards.

Arbour Court

Detailed findings

Background to this inspection

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

This inspection took place on 5 January 2015 and was unannounced. We made additional announced visits to the home on 6 and 7 January to continue the inspection because there was no registered manager and the regional director held relevant knowledge about the quality management systems in place at the home.

The inspection was carried out by one inspector and one specialist advisor (SPA). A SPA provides specialist advice and input into the CQCs regulatory inspection and investigation activity in order to ensure that CQC's judgements are informed by up to date and credible clinical and professional knowledge and experience.

Before we visited the home we checked information that we held about the service and the service provider. The provider completed a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR which included incident notifications they had sent us. Following the inspection we contacted relevant professionals and clinicians to obtain their views and the care provided at the home. No concerns from the local authority or the Clinical Commissioning Group (CCG) were raised.

We spoke with 10 people living at the home, three relatives, one visitor, three registered nurses (RN), one kitchen assistant, one gardener, the divisional director, four health care assistants (HCA), the home manager, the deputy manager, one activity coordinator, one administrator, the staff trainer and the regional director.

Most of the people living at the home were unable to give their verbal opinion about the care and support they received therefore we used a short observational framework for inspection (SOFI). This is a tool used by CQC inspectors to capture the experiences of people who use services who may not be able to express this for themselves. During the inspection we saw how the staff interacted with people using the service. We also observed care and support in communal areas. We looked at the kitchen and all of the bedrooms.

We reviewed a range of records about people's care and how the home was managed. These included the care plans for five people, the training and supervision records for six staff employed at the home, 25 people's medication records and records relating to how the home was managed.

Good

Is the service safe?

Our findings

Most of the people we spoke with were unable to reliably give their verbal opinion about the service provided. However it was apparent from people's laughter and smiles that they were happy and familiar with the care and support being provided. Staff told us they contacted appropriate professionals, such as the general practitioner (GP) and district nurse to share information about people's risks when they were admitted to the home.

All of the staff spoken with confirmed their understanding about their right to share any concerns about the care provided to people who use the service. They told us they were aware of the provider's whistleblowing policy and they would confidently use it to report any concerns about the home and if they witnessed poor practice. Staff told us, and training records confirmed that staff received regular training to make sure they stayed up to date with the process for reporting safety concerns. We looked at records which demonstrated staff had followed the correct procedure and reported concerns to the manager who then reported these concerns to the appropriate authorities. Risks to people's safety were appropriately assessed, managed and reviewed.

We looked at the care records for five people who were using the service. Each of these had an up-to-date risk assessment which reflected how their specific risks were identified and managed. Staff spoken with demonstrated their knowledge about the details in people's care plans and how to keep people safe. From our observations it was apparent that people using the service had complex needs. For example, during the inspection we saw that the staff were hurried whilst carrying out their duties. However we looked at the staffing rota which showed there were enough staff on duty to meet people's needs. Some of the people living at the home were being cared for in bed or preferred to stay in their room and this was recorded in their individual plan of care. During our visit, we saw that these people were being supported to eat and drink to maintain good health.

There was an effective recruitment and selection procedure in place. We looked at 6 staff recruitment files and found 5 people had been recruited in line with the Regulations including pre-employment checks and making sure RN's personal identification number (PIN) was authentic and up to date. Staff training records confirmed that staff had the right experience and training to meet people's needs. However staff spoken with told us they would like extra time to spend with people especially during end of life care. When we asked the manager how staffing arrangements were managed at the home, they told us they were in the process of introducing a workforce management tool. A workforce management system to assess staffing levels would help to staff the home to meet people's needs accordingly.

Following the inspection we contacted relevant professionals and clinicians to obtain their views about the staffing levels and care provided at the home. No concerns from the local authority, GP's or Clinical Commissioning Group (CCG) were raised.

Medicines were stored safely and records were kept for medicines received and disposed of this included controlled drugs (CD's). We looked at the medicine records for 25 people and found records completed were up to date. We observed a medicines round and saw that people received the correct prescribed medication on time. We saw that specific pharmacist and general practitioner (GP) instructions had been followed during the administration process. We saw that other special medicine instructions for people were being followed and administered in a timely manner. For example we observed a discussion between a RN and a person whose husband had indicated to her that he was in pain. The RN addressed this situation sympathetically and with empathy. We looked at the person's care plan which clearly confirmed the person's medication regime and when specific medicines should be administered. The person received the pain relief in line with the prescription.

During a tour of the home we looked at people's mobility aids and other equipment, such as bedside protectors and pressure relieving equipment and saw that these were clean. We found that all communal bathrooms were clean. We noted that the general décor of the home was in need of refurbishment and some communal soft furnishings were tired and dirty and required replacing. We looked at a comprehensive refurbishment plan in place to address the replacement issues. We saw that maintenance work was on going to help make sure areas of the home were safe for people to use. The home accommodated specialist equipment to keep people safe. Staff kept entrances and exits to the home secure to so that they could monitor who came in and left the building. This process did not restrict

Good

Is the service safe?

people's movements and they could leave the home with appropriate supervision and safeguards in place if they were able to. There was a visitor signing in and out book for people entering and leaving the building.

We saw records that showed the provider had effective procedures that helped to ensure any concerns about a person's safety were appropriately reported such as whistleblowing. Whistleblowing is when a worker reports suspected wrongdoing at work. Officially this is called 'making a disclosure in the public interest'. A worker can report things that aren't right, are illegal or if anyone at work is neglecting their duties, including when someone's health and safety is in danger.

Requires Improvement

Is the service effective?

Our findings

People's care plans included risk assessments for pressure care, falls, personal safety, mobility and nutrition. Records showed that people had regular access to healthcare professionals, such as GPs, dieticians, district nurses, dentists and opticians. Care plans and risk assessments had been reviewed monthly or more frequently when people's needs changed and were up to date. Staff had made the appropriate referrals and developed individual care plans, which were being followed to support people's needs.

From the five care plans we looked at we found staff were effectively meeting people's healthcare needs. For example, we saw records that confirmed nutritional risk assessments and speech and language therapy (SALT) assessments had been completed by an appropriate professional. The speech and language therapy service provides assessment and treatment for people who have swallowing or eating and/or communication difficulties. Records showed that people were supported by staff to maintain good dental and oral hygiene on a daily basis. We looked at one person's oral hygiene plan which included daily brushing of the person's teeth, gums and tongue and the use of a prescribed mouthwash where necessary. For urgent dental treatment people used the local NHS out of hour's dental service. From our observations and the records we looked at we noted that people were being provided with fluids at hourly intervals during the day to keep them hydrated.

We saw that where people needed to have their fluid intake and output monitored, this was being recorded by staff. Where a dietician had made recommendations for staff to follow we saw records to monitor and maintain people's weight had been completed. Staff told us they knew to contact the GP and/or dietetic service if there were further issues or concerns.

Whilst the care plans we looked at reflected people's needs, preferences and diversity, none of them contained the person's personal history. An individual personal history would help staff relate conversations to the person's life, their family and hobbies and make the person feel valued. When staff have knowledge about the past lives of the people they support they are more likely to understand their behaviours and can alter the care plan to take account of their behaviour. Additionally, a personal history helps staff to encourage people to do as much for themselves as possible. This will help the person to maintain a level of independence which might improve their self-esteem and display less challenging behaviour.

We spoke with the regional director about the lack of personal histories in people's care plans. They advised us that the organisation had begun implementing a, 'Memory Lane' dementia tool throughout the Barchester dementia homes. This dementia reminiscence tool was developed to provide activities within an environment that enables people with dementia to recall memories and events from the past. Reminiscence activities can be part of a person-centred approach to caring that improves the wellbeing of people with dementia. At the time of our inspection this dementia tool was not in place at Arbour Court. This meant that although some of the care provided was person centred, the home did not ensure that people's preferred activities and lifestyle were fully integrated into the care plan. Adequate information about an individual with dementia is considered a fundamental requirement to developing and delivering person-centred care. Understanding the person within the context of their personal history would help care staff develop appropriate care strategies and delivery methods. There is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We checked staff training records and noted staff received additional refresher training in areas such as adult safeguarding, health and safety, fire safety, dementia awareness and pressure area care training. There was an on going training plan in place which included a comprehensive staff induction. Staff spoken with told us that training was always available for them to develop their skills and knowledge in specialist areas. There was a structured supervision plan for staff and one to one supervision sessions and annual appraisals were taking place. Records showed these were planned in advance.

The new manager was making sure that the content in some of the staff supervision records were improved and written details more specific. This structure will promote staff's professional development and assist staff to talk through any issues about their role, or about the people they provide care, treatment and support to with their line manager or supervisor. Staff said they found these meetings beneficial and helped with their development to fulfil their roles effectively. A registered nurse, two HCAs and

Requires Improvement

Is the service effective?

an activity coordinator confirmed they had received a good induction when they started work at the home. They also told us that they had support when they needed it, and relevant training such as Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was ongoing.

The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) apply in England and Wales only. The Mental Capacity Act allows restraint and restrictions to be used only if they are in a person's best interests. These safeguards protect the interests of vulnerable people and help to make sure people are given the care they need in the least restrictive way. Before a person receives any type of examination, treatment or therapy they must give their permission (consent). The manager demonstrated they had a clear understanding about this legislation. At the time of our visit 10 people were subject to DoLS which were each being managed by the local authority adult social care team.

Good

Is the service caring?

Our findings

We were unable to gain people's reliable verbal opinions on the service they received at Arbour Court because of their conditions. However, we considered people's overall experience of the service by using a short observational framework for inspection (SOFI). SOFI is a tool used by CQC inspectors to capture the experiences of people who use services who may not be able to express this for themselves. Through the use of SOFI we perceived people were mostly satisfied with the care and support provided. We saw staff and people who lived in the home interacting well with each other and people staying in their bedroom were given regular attention and support from staff. We saw staff respecting and promoting people's privacy and dignity, delivering care in a person centred way according to the instructions in people's care plans. Staff had been trained in how to respect people's privacy and dignity, and understood how to put this into practice.

The provider used the Six Steps to Success North West end of life care programme. The programme was developed in the North West of England by a multidisciplinary team of end of life care professionals. The programme aims to enhance end of life care through facilitating organisational change and supporting staff to develop their roles around end of life care. The aim is to ensure people receive high quality end of life care provided by the care home and encompasses the philosophy of palliative care. The care plans we looked at set out people's preferences so that staff could support them to remain in the home and be comfortable at the end of their life. The Six Steps model was being used in the care of 31 people, whose needs were being regularly assessed and reviewed by nursing and medical staff, including a GP. This was done to help make sure people could live and die in the place and the manner of their choosing.

We saw staff asking people where they preferred to sit in the shared lounge and assisting them to their chosen seat. We also saw staff speaking to people in a kind, comforting and sensitive manner throughout the inspection. Staff were polite and respectful when they talked to people. Staff knocked on bedroom doors before entering people's individual bedroom. There was a relaxed atmosphere in the home and staff spoken with told us they enjoyed caring for the people using the service. People had free movement around the home and could choose where to sit and spend their recreational time.

Good

Is the service responsive?

Our findings

Care plans included up to date information about what name people preferred to be known by, and we saw that staff used these names when addressing people who used the service. Information on the care plans we looked at included details about the person's health, risk assessments and personal preferences. From the five care plans we looked at, each referred to the person as an individual and planned care was person centred. The plans addressed areas such as communication, tissue viability, maintaining a safe environment, personal hygiene, sleep, elimination, and mobility. We saw that people had received visits from or had visited healthcare professionals such as the GP's, chiropodists, opticians, district nurses and dentists. Records showed that people had attended hospital appointments and received coordinated care and support. Daily records made by the staff caring for people were comprehensive, dated and signed at various stages of the day as care had been delivered. Staff spoken with told us they tried their best to meet people's needs and provide a high standard of care at the home.

During the inspection we saw people moving freely around the home using handrails and aids and adaptations provided to them by specialist workers such as an occupational therapist. We saw that people who were unable to mobilise independently received care and support which was delivered discreetly and sensitively by staff. We saw staff asking people their preferences when meals, snacks and drinks were being served throughout the day. Staff were seen checking on particular people who could not verbally communicate. In these cases other communication methods were used such as holding the person's hand, using hand gestures and direct eye contact to help to improve communication. In each situation staff were responsive to people's individual characteristics so that their needs would be met based on best practice, professional guidance and in the person's best interest. Staff knew how to respond to complaints and understood the complaints procedure. We saw information about how to complain or comment was displayed on the home notice board to guide people about how they should make a complaint. There was an appropriate system to monitor and investigate complaints. Complaints raised had been addressed and resolved following organisational procedure.

We saw evidence that the provider regularly sought feedback from people and their families about the care provided. We looked at meeting notes which showed the provider was responsive to the feedback from people using the service and their families through planned resident's and relative's meetings. Feedback from the external 'Your Care Rating' 2013 resident's satisfaction survey showed that overall 89% per cent of respondents were happy living at the home. 100% felt the home was a safe and secure place to live and they were treated with dignity and respect. Over 91% of people felt the staff were capable of providing the care they needed. People were also confident their complaints would be taken seriously because they were able to express their choices and felt staff took these into consideration. Your Care Rating is conducted on behalf of care home providers by leading market research organisation Market & Opinion Research International (Ipsos MORI). It covers care homes that primarily serve older people aged 65 and over. During the inspection the regional director spoke with a person from the organisation's quality team. They advised that the results of the 2014 resident's satisfaction survey showed improvements particularly around quality of life and staff.

Requires Improvement

Is the service well-led?

Our findings

The service does not have a registered manager. However, a new manager was in place and an application to become registered had been submitted to CQC in December 2014.

It is a condition of the providers registration that a registered manager is in place. We are following this up outside of the inspection process.

The manager and regional director sought feedback from the staff through staff meetings and staff handovers and used this feedback to make changes to the service. We observed a morning staff handover and noted there was a clear management structure at the home. During the handover meeting staff shared information about any changes that had been implemented in response to people's changing needs.

All of the staff spoken with were aware of the role of the management team. They told us that the manager was approachable and was always present in the home. The values and philosophy of the home were clearly explained to staff through their induction programme and training and there was a positive culture at the home where staff felt 'generally happy' in their work. It was apparent that the manager and regional director had regular contact with the people using the service, their families, professionals and staff. Through discussion they demonstrated their knowledge about the details of the care provided to the people using the service.

The manager and regional director monitored the quality of the care provided by completing regular audits including medicines management, care records, admissions, and discharges and deaths. The audits were regularly evaluated using to continually improve how care was delivered and to achieve transparency and overall improvement in people's healthcare and wellbeing. Action plans for improvement were completed when improvements were needed. Records showed that the manager recorded incidents that happened at the home including accidents, safeguarding incidents and incidents that prevent the service from running normally. The provider notified us of any events as required. Risk to people was minimised because the systems in place for monitoring risk were effective.

There was no system in place to monitor the workforce numbers to ensure there were appropriate staff numbers on duty to meet people's individual needs. The regional director told us that the organisation was introducing a dependency indicator care equation (DICE) tool before the end of the month. This tool would help the manager to staff the home appropriately according to people's needs. A workforce management system encompasses all the activities needed to maintain a productive workforce and monitors staff training and development, time-keeping and attendance and recruitment. We saw records that showed the home held separate meetings for people using the service and relatives. The relative meeting notes we looked at discussed how people's needs could be met to protect them from the risk of unequal treatment. Private and confidential information relating to the care and treatment of people was kept secure.

Staff also told us that the providers were lovely people and said, "It's a good home to work in". They told us that the new manager always acted immediately on any concerns they reported. All of the staff spoken with told us they had a lot of confidence in the new manager's ability to make improvements to the service. They said, "She's really good and knows what needs to be done", "She's already made massive changes for the better", "She's got us some new equipment which we needed to help us in our job".

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: People who were using the service were not protected against the potential risks associated with ineffective care records because their personal histories were not included in their care plan.