Coate Water Care (Arbory) Limited

Arbory Residential Home

Inspection report

London Road
Andover Down
Andover
Hampshire
SP11 6LR

Tel: 01264363363
Website: www.coatewatercare.co.uk

Date of inspection visit:
14 August 2023
15 August 2023
23 August 2023

Date of publication:
16 October 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Arbory Residential Home is a care home providing accommodation and personal care to up to a maximum of 60 people. The home does not provide nursing care. At the time of our inspection there were 39 people using the service, most of whom were living with dementia.

The accommodation at Arbory Residential Home is arranged over 2 buildings. The Lodge has accommodation over 2 floors and is an older building that has been repurposed into a care home. The Court is a newer, purpose built building where the accommodation is arranged over 3 floors. There are communal lounges, dining areas and a garden area.

People's experience of using this service and what we found
We continued to find concerns about how some risks were assessed, monitored, and mitigated. There were still insufficient numbers of staff deployed to meet people's needs at all times. Staff understood how to protect people from avoidable harm or abuse. Some reviews and investigations into incidents could have been more thorough to help ensure every opportunity for learning was taken.

Legal frameworks regarding consent, were still not being implemented fully. The premises and equipment within it were still not well maintained. Staff did not consistently receive an induction or probationary reviews. Work was underway to embed a more comprehensive programme of supervision. Whilst the provider offered staff a range of training which most staff were up to date with, a number of staff told us they would value more face to face training. Some care plans lacked completeness or contained conflicting information whilst others were more reflective of people's needs. Improvements were needed to develop better partnership working with healthcare professionals to meet people's healthcare needs.

We have made a recommendation that staff inductions, and the supervision program are developed in line with best practice guidance.

People were not consistently receiving person centred support and did not have access to meaningful activities on a regular basis. Governance systems were in place, and there was evidence local leaders were working hard to deliver improvements, however, many of the required improvements had been hindered by continued shortfalls in staff across all departments. Improvements to the environment were underway, but more needed to be done to deliver these within a suitable time scale to ensure people's care and support was provided in a safe, clean, and well maintained environment.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 8 February 2023). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At

this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about the quality and safety of people's care, the cleanliness of the home and staffing levels. A decision was made for us to inspect and examine those risks. As a result, we undertook this focused inspection to review the key questions of safe, effective, and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service remains requires improvement.

We have found evidence the provider needs to make improvements. Please see the safe, effective, and well led key question sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Arbory Residential Home on our website at www.cqc.org.uk.

Enforcement and recommendations
We have identified continuing breaches in relation to the suitability of the premises, consent, safe care, and treatment, staffing and governance. We identified 1 new breach in relation to person centred care.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Arbory Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was undertaken by an operations manager, 2 inspectors, a medicines inspector, and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Arbory Residential Home is a 'care home.' People in care homes receive accommodation and nursing and/or personal care as a single package under 1 contractual agreement dependent on their registration with us. Arbory Residential Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. The provider has recruited a new manager, but their start date is yet to be determined.

Notice of inspection
This inspection was unannounced.

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

We used all this information to plan our inspection.

During the inspection
We spoke with 4 people living in the home and 5 relatives. We also spoke with the regional manager, home manager, regional support manager, maintenance person, administrator, 4 care staff, an agency worker, the chef and 2 members of the housekeeping team. We reviewed 11 people's medicines records and the recruitment records for 4 staff members. We also looked at records relating to the safety and management of the service.

Following the inspection, we reviewed 10 peoples care plans using the provider's digital platform and continued to seek clarification from the provider to validate evidence found. We received feedback from a further 9 staff and 10 relatives.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection, the rating has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely

At our last inspection, the provider did not have effective systems and processes in place to assess, monitor and manage safety. This was a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated activities) Regulations 2014.

Insufficient improvement had been made at this inspection and the provider remained in breach of Regulation 12.

● People were at increased risk of skin deterioration. For example, some people used air flow mattresses to reduce the risk of developing skin damage. One of these had not been set correctly according to the person's weight. This increased the risk of skin damage occurring as the equipment was not being used correctly. The processes in place to check mattresses did not include a requirement to check these were set correctly. One person's care plan stated they should not be repositioned on their back as they had a pressure ulcer. We found 6 occasions between 1 to 18 August 2023 where this guidance had not been followed.
● People were at increased risk of medicine errors occurring. One person lived with epilepsy. They had been prescribed a medicine which was to be administered in the event they had a seizure. Whilst this medicine was available within the service, no staff had been trained to administer this and there was no protocol in place to guide staff on how or when to use it. The decision to remove this medicine from the eMAR was not made in conjunction with the prescribing clinician and had not been fully assessed and associated risks mitigated.
● The systems in place had not ensured that medicines were always available for administration. For example, 10 service users had missed a total of 24 doses in July 2023 due to medicines not being available. The provider's medicines policy lacked information around actions to take where medicines were not available.
● Two people regularly refused their medicines. Whilst staff told us what action they would take when this happened, there was no information documented in their care plan about how this need should be met, or when concerns should be escalated to a health care professional.
● Medicine care plans did not provide staff with sufficient guidance about approaches and techniques that should be used to deescalate people's distressed behaviours before considering the administration of the medicine.
● One person was living with Parkinson's disease, however there was no guidance in place that described the importance of maintaining time specific medicine administration to maintain symptom control.

● In 10 of the 11 medicines records we viewed, allergies were not recorded in line with best practice guidance. This increased the risk of service users receiving medicines to which they were allergic.
● Electrical appliances and equipment had not been tested to ensure they remained safe to use.

The provider failed to do all that was reasonably practicable to assess and mitigate risks to people. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our last inspection the provider had reviewed their legionella risk assessment and were completing the required actions.
● Action had been taken to address enforcement notices issued by Hampshire Fire and Rescue Service. Remedial actions had been taken and the electrical installation within the home was now assessed as satisfactory.

Staffing and recruitment

At our last inspection, the provider had not ensured that there were sufficient numbers of staff deployed to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008(Regulated activities) Regulations 2014.

Insufficient improvement had been made at this inspection and the provider remained in breach of Regulation 18.

● The provider had failed to deploy sufficient numbers of suitably qualified staff to meet people's needs, to ensure the cleanliness of the home was maintained and to ensure the provision of activities.
● Whilst some relatives felt staffing levels had improved recently and praised the attentiveness of staff, the majority raised concerns with comments including, "They are very short staffed", "They are lovely staff but there is not enough of them… they are honestly overworked" and, "The shortage of staff is a problem, when visiting [Family member] and I want to leave, you cannot find a member of staff, I have to walk the corridors shouting hello, hello."
● The majority of staff also raised concerns about the staff levels. Comments included, "I am doing what I love most but you can only be in one place at a time, we need more staff", "If we had more staff, we could take care of the residents more" and "We are rushing around, can't give the full care you would like to give, constantly. It's not fair on the residents."
● Our review of records supported this feedback from staff as people's records and daily notes still did not consistently provide assurances that elements of personal care were being regularly completed.
● On 3 occasions, we identified people needed continence care and had to bring this to the attention of staff.
● Staff told us, and we observed, that people did not consistently receive the support they needed at mealtimes to eat and drink.
● There were insufficient staff to ensure a suitable programme of activities. There had only been an activities coordinator in post for 3 weeks over the last 8 months. We were advised overtime was being offered to care staff to support with the provision of activities, but there was limited evidence this had in practice had any impact on the delivery of activities.
● Domestic staffing levels were not adequate and had resulted in a lack of cleanliness throughout the home. Domestic staff worked hard but there was currently 60 hours vacant in the housekeeping team and on some days rotas showed there was only 1 housekeeper on duty to clean the areas where people were living.

There were not always sufficient numbers of staff deployed to meet people's needs. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staffing levels were calculated using a dependency tool. Whilst there were a small number of occasions where staffing levels have fallen below planned levels, overall, records indicated the provider was staffing above levels recommended by the tool.
● Records did not always support the provider's recruitment decisions. One of the staff recruited from overseas, did not have a police check from their country of origin. Two staff only had 1 reference which was not in line with the provider's policy.
● As at our last inspection, we found 2 agency profiles did not include sufficient information. For example, whilst they provided a date that a DBS check had been completed, it did not record the outcome of this. We were advised at our last inspection that the provider had implemented new systems to address this.
● The provider was unable to demonstrate that a profile was available for an agency worker, confirming training and DBS status, had been obtained prior to the agency worker working within the home during the inspection.

Records relating to people employed did not always include all information relevant to their employment in the role. This was a breach of regulation 17 (Good Governance)) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were appropriately stored and secure.
● People and their relatives felt staff managed medicines well. One relative said, "They usually inform me of any changes to medicines, even when they wanted to crush them…. He has come off quite a lot of medicines since he has been here as he was heavily sedated."

Preventing and controlling infection
● The provider failed to ensure the premises and equipment was thoroughly cleaned and maintained to prevent the spread of infection.
● Areas of the home were not clean and sufficiently maintained to support effective cleaning this included communal kitchenettes and some ensuite bathrooms.
● Feedback about the cleanliness of the home was mixed, however the majority of relatives said this was an area which needed to improve. Comments included, "No it is not clean enough for me", "I think this area [communal lounge] could do with a refresh… after lunch they could wipe down the tables" and, "No [Its not clean]it might be getting there but it is not there yet. It's all nice and spick and span over the other side, then you come in here and go, oh!"
● One person's bed rail bumpers were soiled, and we found 4 people's mattresses were heavily soiled increasing people's exposure to infection. The management team took action to replace these immediately.
● There was a strong smell of urine prevalent throughout the home, including in the dining areas where people took their meals. We observed 1 person enter the dining area and say, "It stinks in here."

The provider had failed to do all that was reasonably practicable to ensure the premises were clean and hygienic to prevent the spread of infection. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The new manager had sought approval from the provider for a 3 day deep clean to take place and this was due to start the week after our inspection.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● Visiting could take place flexibly and booking was no longer required.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe living at the Arbory. One person said, "Yes I like it, there is nothing wrong here" and another said, "Yes [I feel safe] no worries or concerns here."
● Overall relatives felt their family member was safe. One relative said, "Oh yes, they take good care of them…The place is safe" and another said, "Yes, he seems to be well looked after."
● Staff understood how to protect people from abuse.
● Safeguarding concerns had mostly been escalated to the local authority and notified to the Care Quality Commission, although not always in a timely way. The local leadership team were working with other agencies to address any immediate risks and to ensure people's safety.

Learning lessons when things go wrong
● The provider was planning further incident reporting training to upskill staff, but overall, we found that incident and accidents were reported appropriately, escalated internally, and reviewed or investigated by a manager.
● Learning from some safety related events had been shared with staff, for example, the learning from a recent falls and weight loss analysis. However, there was scope to further develop this approach to ensure there were no missed opportunities to identify learning from all types of incidents.
● Whilst relatives had been informed about safety related incidents, they had not always been advised of the learning from any investigations that followed. Staff raised similar concerns, for example, 1 staff member said, "You don't tend to hear what we could have done to prevent that. It doesn't go full circle."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment, and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection, the rating has changed to requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At our last inspection, the provider had not ensured that legal frameworks regarding consent were being followed. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Insufficient improvement had been made at this inspection and the provider remained in breach of Regulation 11.

- Whilst more detailed mental capacity assessments were, in some cases, in place, relevant staff still did not demonstrate best practice around the completion and recording of best interests' consultations.
- One person was subject to 1:1 monitoring but did not have a mental capacity assessment in place to determine whether they could consent to this or to ensure the approach was in their best interests.
- We observed that 1 person constantly wanted to leave the table, instead of being gently encouraging and attentive to the person, an agency worker just kept saying 'sit down' 'sit down.' On 1 occasion, they placed their arm in a way that prevented the person from rising, restricting their movements. We brought this to the attention of the manager who took appropriate action to address this.
- In relation to the 10 people we reviewed, we found in all but 3 cases, consent forms had been signed by third parties who did not have a legal right to provide consent.

This was a continued breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where people had a legally appointed representative to manage their financial affairs or to make decisions about their health and welfare, copies of the relevant documents had not been obtained. Action is being taken to address this.
● Applications for DoLS had been made appropriately.

Adapting service, design, decoration to meet people's needs

At our last inspection, the provider had not ensured that the premises and equipment within it were clean and properly maintained. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Insufficient improvement had been made at this inspection and the provider remained in breach of Regulation 15.

● People's care was not consistently being provided in a clean, well-furnished, and well maintained environment.
● Whilst some improvements had been made, there continued to be areas of the home where the fabric of the building, paintwork and some of the fixtures and equipment within it needed replacement and / or repair.
● Relatives gave mixed feedback about the environment, but most felt this was an area where improvements were needed. For example, 1 relative said, "In my family members room, there is a cracked light, a switch hanging off the wall and the water temperature is irregular."
● The corridors did not have handrails. Handrails promote safety and independent mobility. This was of concern as we observed a number of people mobilising independently in these area who were assessed as being at risk of falls.
● Records continued to raise concerns about the reliability of the nurse call system which we were told failed on at least a monthly basis due to continuing dropouts of the internet. This had been a concern at our last inspection too. The provider is seeking quotes for a new call bell system.
● Areas of the gardens were overgrown and did not provide a safe space for people due to overgrown brambles, fallen fences and uneven pathways which were a trip hazard. This was commented on by a relative who told us, "The outside space needs improving, I feel it's a little unsafe underfoot. I can't let go of [Family member's] hand when outside as its uneven. We used to do a little loop around the grounds but can't now as its too overgrown."
● The outer grounds, which were visible from the living spaces, were still littered with rubbish and building materials. At our last inspection, the provider told us they had engaged a new gardening contactor to address this, however, there had been little progress with this.

The provider had not ensured that the premises and equipment within it were clean, secure, and properly maintained. This was a continued breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was evidence the provider was investing in the service and was undertaking a refurbishment programme and a second maintenance person had been recruited to support this.
● However, the refurbishment was slow and there was a significant amount of work that is still needed to bring the home up to the required standards.

Supporting people to eat and drink enough to maintain a balanced diet

● Mealtimes were not always a positive experience for everyone. Our observations showed staff did not always have the time to provide practical support, emotional reassurance, and encouragement to all of those needing help to eat and drink. Meals were left uneaten in front of some people and alternatives were not being consistently offered.

● Overall, the feedback about the food was good. Comments from people included, "Yes I like the food, he does a great meal the chef, you can have a second helping if you want, we can have a drink wherever we want it" and, "There is plenty of it, you can't fault the food, it is first class."

● A relative told us, "I taste it and I have probably tried everything. There is a 2 week rolling menu, I know they have got their fluid charts and if I have been in, they ask me how much they have drunk" and another said, "Drinks are frequent, she had a cup of tea and apple juice when we arrived and now, they have put a jug of orange juice on her table."

● Nutritional risk assessments were in place and care plans reflected people's current needs with regards to diet and hydration, we were however concerned that these were not always followed in practice, and we have spoken about this further in the safe key question of this report.

● Records we reviewed showed people received fluid in line with their assessed needs.

● Whilst a record was maintained of the food people without specific dietary needs had eaten, for those that required a modified diet, the records simply stated the person had had a 'pureed meal'. This meant the provider could not judge from the record whether people had eaten a nutritious and balanced diet.

● We saw some positive interactions where care and kitchen staff were encouraging and supportive when helping people to make their food choices and to eat and drink. However, we also saw some examples, where the lunch service was more chaotic, and less individualised. We have reported about this further in the well led key question of this report.

Staff support: induction, training, skills, and experience

● The systems in place to ensure staff had an induction and timely probation reviews needed to be more robust. The records, for 2 of the 4 new staff, we reviewed did not include an induction record and the provider's records showed the probation reviews for a number of staff were overdue. Inductions are a formal process and help to ensure new staff receive essential information about their role and responsibilities. Our last inspection had identified similar concerns.

● The Care Certificate framework was not being used within the service. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

● Work was underway to embed a programme of supervision. 'Ad hoc' supervisions took place to review staff's performance against expected standards. These supervisions were not sufficiently comprehensive to provide staff with an opportunity to discuss skills gaps, development needs and to ensure staff were feeling well supported in their role.

We recommend the provider consider current guidance on induction and supervision programs and take action to update their practice accordingly.

● Overall people and their relatives' felt staff were well trained. One person told us, "They get on and do the job right, there's nothing to fault them for" and a relative said, "They do seem well trained… If I want to talk to someone, I talk to [team leader] she is very good."

● The provider offered staff a range of training and most staff were up to date with this.

● Feedback from staff about the quality of the training was mixed. A number of staff felt more face to face training was needed. One staff member said, "Online training is not great, I prefer face to face, a couple of

times someone has come in to do mental capacity training which was really helpful."
● Following a recent choking incident, the service undertook a range of practical workshops and used videos and demonstrations to upskill the staff team. Staff had subsequently been able to respond confidently when another choking incident occurred.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Most relatives did feel that overall, their family members received effective care, particularly when this was delivered by the permanent staff who they felt knew their family members well.
● Whilst some care plans did reflect people's needs, we continued to find others lacked completeness or were in part inaccurate.
● There was some evidence of care plans containing personalised information, but this was not consistent, or in most cases sufficient.
● Records did not always show how people had been involved in drafting and reviewing their care plans. None of the people we spoke with had seen their care plan or knew what it contained. Comments included, "I've not seen it [care plan] since being here" and, "No I don't [feel was I was involved in draft my care plan]."

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were referred to a range of healthcare professionals to support their health and wellbeing such as falls clinics, the community mental health team and speech and language therapists.
● However, a health care professional raised a concern that information sharing and communication with their service was inconsistent and this, along with gaps in the skills and knowledge of some staff, had at times impacted on the effectiveness and timeliness with which people's healthcare needs were met.
● Three people's relatives raised concerns about the lack of prompt action to address healthcare needs. For example, 1 relative said, "I have visited and found [Family members] legs quite large with liquid coming out them and staff have not been aware when I have pointed this out." This has been shared with the provider so that they can review and take appropriate remedial action.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection, the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks, and regulatory requirements; Continuous learning and improving care

At our last inspection, the provider had failed to ensure that there were effective systems in place to assess, monitor and improve the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Insufficient improvement had been made at this inspection and the provider remained in breach of Regulation 17.

● Despite a range of governance systems being in place, these had not brought about the changes necessary to ensure people received a service which was safe, effective, or well led.
● Insufficient action had been taken to rectify issues identified at our previous inspection including how some risks to people were not being mitigated, the suitability and cleanliness of the premises, the numbers of staff deployed and the implementation of legal frameworks regarding consent and assessment of capacity.
● Records relating to people's care and treatment, medicines management, recruitment, and the induction and supervision of new staff were not always complete.
● A number of the provider's policies needed to be reviewed and updated to ensure they were fit for purpose.
● A new breach was found as the systems in place did not consistently support the delivery of person centred care.
● We were not assured that feedback was always listened to, recorded, and responded to as appropriate.
● These new and continuing regulatory breaches indicated a provider failure to identify and address concerns and deliver an improvement culture through their own internal monitoring systems.

The provider had not ensured that there were effective systems in place to assess, monitor and improve the service. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had strengthened its senior leadership team to include a quality assurance manager. They were starting to take action to make improvements and strengthen the organisation's quality assurance systems.

● A detailed audit had been undertaken on 20 June 2023. This audit had identified a number of the issues we identified, and the local leadership team had begun to create an improvement plan to address these.
● The provider has shared with us a detailed action plan in response to our feedback.

Promoting a positive culture that is person-centred, open, inclusive, and empowering, which achieves good outcomes for people
● People did not always receive the support they needed to meet their continence and hygiene needs. This was evident from our observations, people's records and was also a theme in the feedback we received from relatives.
● Relative's comments included, "I went to see [Family member] last week, they were desperate for a shower, they smelled of wee" and, "[Person] is not as clean as they used to be, at home, they had a shower and a change of clothes every day, here they are not having their hair washed and they tell me it makes them not feel right".
● On 3 occasions, we had to bring to the attention of staff that people needed continence care. One relative told us they frequently had to start their visit by supporting their family member with continence care as they would be wet through with urine.
● As identified at our last inspection, more still needed to be done to ensure the environment was adapted to meet the needs of those living with memory loss or dementia or other sensory deficits, enabling them to meaningfully interact with the environment in which they lived. There was a lack of objects for people living with dementia to interact with or to orientate them to time, or to what was likely to be happening that day, or who might be supporting them.
● The redecoration undertaken, had not been completed with evidenced based research in mind to help ensure the creation of inclusive and safe environments for people with dementia.
● Some people's rooms continued to lack personalisation and whilst people had memory boxes outside their room to help orientate them, a number of these were empty.
● Care plans did not support personalised care. consistently include information about people's preferences, the things or people that were important to them, or their beliefs. Even where this information was available, there was limited evidence of these being followed in practice. For example, the use of photos or favoured books to support interactions.
● It remained evident from people's records, feedback from staff and relatives and from our own observations that the service was not providing a suitable programme of meaningful activities that met each person's social and emotional needs.
● During both days of the inspection, we did not see any organised activities taking place, but rather observed people were sat for extended periods of time with limited engagement with each other or with staff. One person told us, "It would be very, very nice sometimes to have a bit more to do."
● Comments from staff included, "[People] could do with stimulation and activities could improve" and "Many residents say they have nothing to do, and we are too busy to do it ourselves."
● The lack of activities was commented on by most of the relatives we spoke with. Comments included, "There are no activities, you just seem them wondering like zombies, there is nothing around for people to enjoy", "She either sits in her room, or wanders the floor she is on" and "They do the basics – I feel that the residents are not stimulated enough by way of activities and are pretty much left to just roam around aimlessly."
● Concerns were also expressed that only those on the ground floor, or those able to independently manage, could access the garden, meaning that access to outdoor spaces was not readily available. For example, 1 relative said, "The biggest thing is the garden, it's been lovely and warm the last few weeks and they haven't been out in the garden."
● Visiting professionals also raised concerns about the lack of activities with a healthcare professional telling us, "Staff seem to be kind and caring. It is difficult to say how much they nurture the residents as we have

seldom seen any dementia specific activities designed for the residents."
● A social care professional told us, "The activities are hit and miss, it's just watching tv or walks in the garden."

The systems in place did not ensure that people consistently received care that met their individual needs and promoted positive outcomes. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider has responded to our feedback and has purchased some additional resources to support the delivery of activities. An activities coordinator has been appointed and is going through recruitment checks.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● It was clear staff wanted to deliver good quality care and support, but the majority spoke of there being obstacles which prevented them from consistently achieving this. This included suitable staffing levels across all departments, resources, and stable leadership.
● Staff told us they tried to remain positive, valued their colleagues and worked well together as a care team, but that the above challenges did at times impact on morale. For example, 1 staff member said, "Morale is quite bad, so many managers come and go, everyone is quite worried".
● During the inspection, staff had spoken positively about the newly appointed manager and the regional management team. They told us they were already seeing improvements and obtaining greater clarity about their role, accountabilities, and responsibilities and were hopeful improvements would continue. At this point staff did not know this new manager had already resigned.
● A continued theme in the feedback we received from relatives was that communication needed to improve and they did not always feel information about changes within the service were shared with them in a timely manner. For example, very few of the relatives we spoke with knew a new manager had been appointed a month before our inspection. Comments included, "I've no idea who the manager is" and "They've got a new manager, but I don't know her name."
● We were not assured the provider had developed a culture where the views of people, their relatives and staff were listened to and used to develop the service.
● Resident meetings did not take place and there had not been a resident, or relative, survey for some time.
● Staff surveys had been undertaken in April 2023. Whilst there had been some positive feedback from staff, there had also been a number of concerns raised about culture, morale, staffing and the environment. There had been some temporary adjustments to staffing, but overall, there was a lack of evidence to demonstrate how the provider had used this feedback to improve the service.
● There was also a lack of evidence staff knew and understood the provider's vision for the service, or the values, behaviours, or attitude the provider wished staff to demonstrate.
● Relatives meetings had taken place, but a review of the minutes of these showed relatives had been raising similar concerns for some time, for example, the state of the gardens and the lack of a hairdresser. The relatives we spoke with felt that some of the things they had brought up had been addressed, but that others had not and so we were not assured therefore that feedback was being taken seriously and acted upon by the provider. For example, 1 relative said, "I did not feel listened to at the meeting or that any of the other relatives were listened to either" and another said, "We used to go to them [Meetings] but we've since discovered that everything that was said was a lie."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had a duty of candour policy and was aware of their legal responsibility to be open and

transparent when investigating incidents where something had gone wrong.

Working in partnership with others

● We received mixed evidence about how well the service collaborated and cooperated with external stakeholders.

● A health care professional raised concerns that partnership working could be challenging at times, with for example, staff not always being able to prioritise ward rounds or engaging with multi-disciplinary meetings which were opportunities to liaise with district nurses, the mental health team and consultant geriatricians.

● The local leadership team had been working with the local authority commissioning and safeguarding team and with the Care home Team from the local Integrated Care Board (ICB) to understand best practice and to improve the service, however, despite accepting the invite, no staff from the Arbory attended a recent training session laid on by the ICB

● The Local leadership team responded in an open and transparent way to requests for information to support this inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The systems in place did not ensure that people consistently received care that met their individual needs and promoted positive outcomes. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that legal frameworks regarding consent were being followed. This was a continuing breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to do all that was reasonably practicable to assess and mitigate risks to people and to do all that was reasonably practicable to ensure the premises were clean and hygienic. This was a continuing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured that the premises and equipment within it were clean, secure, and properly maintained. This was a continuing breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient numbers of staff deployed to meet people's needs. This was a continuing breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that there were effective systems in place to assess, monitor and improve the service. Records relating to people employed did not always include all information relevant to their employment in the role. This was a continuing breach of regulation 17 (Good Governance)) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

We issued a warning notice telling the provider they were required to become compliant with Regulation 17 (1) (2) (a) (b) (c) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 above by 13 November 2023.