Arrowsmith Rest Homes Limited

Arrowsmith Lodge Rest Home

Inspection report

Bournes Row
Hoghton
Lancashire
PR5 0DR

Date of inspection visit:
05 September 2018
06 September 2018

Date of publication:
04 October 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We carried out an inspection at Arrowsmith Lodge Rest Home on 5 and 6 September 2018. The first day was unannounced.

Arrowsmith Lodge Rest Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Arrowsmith Lodge Rest Home provides accommodation and care and support for up to 35 people, including people living with dementia. The service does not provide nursing care. There were 24 people accommodated in the home at the time of the inspection.

Arrowsmith Lodge Rest Home is an extended detached property which is situated in a residential area of Houghton on the outskirts of Bamber Bridge, Preston. There are a range of amenities close by including a bus link to Preston and Bamber Bridge village centre. Accommodation is provided on two floors with a passenger lift and chair lift access. Car parking is available for visitors and staff.

The service was managed by a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 carried out on 19 and 20 July 2017, the service was rated as 'Requires Improvement'. We found four breaches of the regulations in respect of risk management, safe recruitment and a lack of effective monitoring systems and a continued breach in relation to people's needs not being recorded clearly. This was the second occasion the provider had failed to meet the regulations as they were also rated as requires improvement in July 2016.

At this inspection, we found the rating had improved to 'Good'.

Monitoring of the service had improved. Effective quality assurance and auditing processes helped the provider and the registered manager to identify and respond to matters needing attention. The management team were aware further improvements were needed and there was a plan in place to support this. There were systems to obtain the views of people, their visitors and staff. People felt their views and choices were listened to.

Recruitment procedures had improved. A safe and robust recruitment procedure was followed to ensure new staff were suitable to care for vulnerable people. Arrangements were in place to make sure staff were trained and competent. We observed people's calls for assistance were promptly responded to but we received mixed views in relation to the availability of staff. Following the inspection, we were told action had

been taken to improve the staffing numbers.

Records relating to people's care and support had improved. The information in people's care plans was sufficiently detailed to ensure they were at the centre of their care. People's care and support was kept under review and, where possible, people were involved in decisions about their care. Risks to people's health and safety had been identified, assessed and managed safely. Relevant health and social care professionals provided advice and support when people's needs changed.

People's medicines were managed in a safe manner. People had their medicines when they needed them. Staff administering medicines had received training and supervision to do this safely.

The home was clean, safe and comfortable although further improvements were needed to provide a pleasant environment that was suitable for people living with dementia. There was a plan in place to ensure improvements were ongoing. Appropriate aids and adaptations had been provided to help maintain people's safety, independence and comfort.

People were happy with the personal care and support they received. They told us they felt safe in the home and that staff were caring. Staff understood how to protect people from abuse. People told us they did not have any complaints and knew how to raise their concerns.

Where possible, people were supported to have choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff respected people's diversity and promoted people's right to be free from discrimination.

People had access to a range of activities both inside the house and in the local community. People living in the home, their visitors and staff told us this felt this could be improved. People were given a choice of meals and staff knew their likes and dislikes. We discussed how the dining experience could be improved for people. People's nutritional needs were monitored and reviewed and appropriate professional advice was sought when needed.

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.

People felt safe and protected against the risk of abuse. Staff understood how to protect people and were clear about the action to take if they witnessed or suspected abusive practice.

The management of risks to people's health and wellbeing had improved.

Recruitment practices had been improved. People had mixed views about the availability of staff. We noted staff were attentive to people's needs.

People's medicines were managed safely and administered by trained and competent staff.

Is the service effective?

Good

The service was effective.

Improvements to the environment had been made and the management team were aware of where further improvements were needed. A development plan was available and was kept under review. A system of reporting required repairs and maintenance was in place.

People enjoyed their meals and their dietary needs and preferences were met. We discussed how improvements could be made to people's dining experience. People were supported appropriately with their healthcare.

Staff were provided with a range of training and development which enabled them to meet people's individual needs.

Staff had received training to improve their understanding of the MCA 2005 legislation. People's capacity to make safe decisions and to consent to care had been assessed.

Is the service caring?

Good

The service was caring.

People said they were treated with care and kindness. We observed good relationships between staff and people living in the home.

People could maintain relationships with family and friends. There were no restrictions placed on visiting.

Staff respected people's rights to privacy, dignity and independence. The lack of bedroom door locks could impact on people's rights to privacy; the provider was taking action to address this.

Where possible, people could make their own choices and were involved in decisions about their day.

Is the service responsive?

Good

The service was responsive.

People were supported to take part in suitable activities inside and outside the home. However, people told us they would like more activities.

Each person had a care plan that was detailed and reflected the care they needed. People's needs and risks were kept under review.

People told us they knew who to speak to if they had any concerns or complaints and were confident they would be listened to. The complaints information was being reviewed to ensure people knew who to direct their complaints to.

Is the service well-led?

Good

The service was well led.

The service had a registered manager in post who was responsible for the day to day running of the home. People who lived at the home and staff felt the home was managed well.

There were effective systems to assess, monitor and improve the quality and safety of the service. Shortfalls had been recognised and had been followed up; the registered manager was aware of where improvements were needed.

There were systems in place to seek feedback from people living in the home, visitors and staff.

Arrowsmith Lodge Rest Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

An unannounced comprehensive inspection took place at Arrowsmith Lodge Rest Home on 5 and 6 September 2018. The inspection was carried out by an adult social care inspector and an expert by experience on the first day, and by one adult social care inspector on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

In preparation for our visit we checked the information we held about the service and the provider and included this in our inspection plan. We considered the previous inspection report and obtained the views of the local authority safeguarding team. We looked at the report (April 2018) following a visit undertaken by the local authority contract monitoring team. We analysed information from previous complaints and safeguarding alerts and incorporated the themes into the planning of this inspection. We reviewed information from statutory notifications sent to us by the service about incidents and events that had occurred at the home. A notification is information about important events, which the service is required to send us by law.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give us some key information about the service, such as what the service does well and improvements they plan to make.

During our inspection visit, we spent time observing how staff provided support for people to help us better understand their experiences of the care they received. We spoke with six people living in the home, five

visitors, five care staff, the registered manager and the provider. We also spoke with a healthcare professional.

We had a tour of the premises and looked at a range of documents and written records including four people's care plans and other associated documentation, three staff recruitment and induction records, staff rotas, training and supervision records, minutes from meetings, customer survey outcomes, complaints and compliments records, medication records, maintenance certificates and development plans, policies and procedures and records relating to the auditing and monitoring of service.

Following the inspection, we asked the registered manager for additional information. This was provided as requested.

Good

Is the service safe?

Our findings

During the last inspection, we found the provider had failed to ensure people were protected against the risks to their health, safety and wellbeing. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time, we found staff did not have clear and accurate guidance on how to manage risks in a consistent manner. Following the inspection, the provider sent us a monthly action plan which set out the action they had taken and intended to take to improve the service.

During this inspection, we found improvements in the way the risks to people's health, safety and wellbeing were managed. Risk assessments were in place including those relating to falls, moving and handling, skin integrity and nutrition and hydration. Assessments included information for staff about the nature of the risks and how staff should support people to manage them. They were updated regularly and information about any changes in people's risks or needs was communicated between staff during shift changes. However, we noted there was no clear information to guide staff with the action to take in response to skin integrity risk scores. Following the inspection, the registered manager told us she had addressed this with the district nursing team.

Records were kept in relation to accidents and incidents that had occurred at the service, including falls. Referrals were made, as appropriate, to the GP, the falls team and the district nursing team; we also observed alarm mats and sensors in use for people who had been identified at risk of falls. We were told the registered manager was made aware of any incidents and accidents at handover sessions although the records were not signed to support this; the registered manager assured us she would address this. The registered manager carried out a monthly analysis of the information to identify any patterns or trends.

We found individual risk assessments and strategies were in place to help identify any triggers and guide staff how to safely respond when people behaved in a way that challenged the service. We discussed with the registered manager how the records relating to distraction techniques used by staff to distract people, could be improved to reflect the good practice undertaken by staff. Appropriate action had been taken in response to incidents of this type such as the referral to the mental health team. A relative said, "Some residents are very difficult but the girls manage very well." Records confirmed staff had received training in this area which helped to keep them and others safe from harm.

People's money was managed safely. Financial protection measures were in place to protect people. Staff were not allowed to accept gifts or assist in the making of, or benefiting from people's wills. We noted there were systems in place to respond to concerns about staff's ability or conduct; there was good evidence the registered manager had acted appropriately to keep people safe.

During the last inspection, we found the provider had failed to follow safe recruitment processes. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time, we found that not all the checks had been completed before staff began working for the service. Following the inspection, the provider sent us a monthly action plan which set out the action they had taken and intended to take to improve the service.

During this inspection we found improvements to the recruitment process. We looked at three staff recruitment records and found the necessary checks had been completed before they began working at the service. This included an enhanced Disclosure and Barring Service (DBS) check, which is a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. Proof of identification and suitable references had been obtained. However, a full employment history had not been obtained and it was not clear who had provided the references and in what capacity; the registered manager showed us a revised application form and reference request form to be introduced for any new applicants. These checks helped ensure that staff employed were suitable to provide care and support to people living at the home.

We received mixed views about the availability and numbers of staff. Comments included, "I have to wait sometimes for help. They are very busy", "Generally I get what I need, although sometimes I have to wait. The staff here are constantly busy" and, "I don't have to wait too long if I need help. There is someone around."

Relatives said, "The staff turnover has been a problem. I think things are starting to settle down", "The staff has changed a lot but it appears to be getting better", "The staff don't always have quality time with the residents" and, "They always appear to have so much to do."

Staff said, "We now have some good staff", "We need more staff for the type of resident we care for" and, "I go home some evenings and have not had any quality time with the residents. All I have time for is personal care."

During our visit, we observed people's calls for assistance were promptly responded to and staff were attentive to people's requests and available in the main lounge. We noted staff were only able to take time with people when they were supporting them with a personal care task such as assisting them to move or with their meals. We discussed our observations and people's comments with the registered manager. Following the inspection, we were told the staffing numbers had been increased and recruitment of new staff was underway. A dependency tool was used to provide guidance about the recommended numbers of staff.

We looked at the staffing rotas and found a designated senior carer was in charge with three care staff throughout the day and a senior carer and two care staff at night. There were sufficient ancillary staff such as cooks and cleaners. Following the inspection, the staffing had increased to one senior carer and four care staff throughout the day. The registered manager worked in the home five days each week and provided out of hours support as needed; she also provided assistance at mealtimes. We were told any staff shortfalls due to leave or sickness were covered by existing staff, the registered manager or by agency staff who were known to the home.

During the inspection, we observed people were comfortable in the company of staff. We observed staff interaction with people was kind, friendly and patient. People told us they felt safe. They said, "I like the staff. I feel safe although some residents fight", "I feel safe", and "The staff are very kind." A relative said, "I have no problems with the home. [Family member] is kept safe and is well cared for."

Staff had safeguarding vulnerable adult's procedures and whistle blowing (reporting poor practice) procedures to refer to. Safeguarding procedures are designed to provide staff with guidance to help them protect people from abuse and the risk of abuse. Staff had received safeguarding training and there were designated safeguarding champions in the home that provided advice and guidance to other staff in this area. Staff understood how to protect people from abuse and were clear about the action to take if they

witnessed or suspected abusive practice. They told us they would have no hesitation in reporting any concerns either to the management team or to other agencies and were confident the registered manager would listen and respond appropriately to their concerns.

The registered manager was clear about their responsibilities for reporting incidents and safeguarding concerns. Action to be taken and lessons learned from incidents had been discussed with staff during meetings and with the provider at management meetings. Arrangements were in place to respond to external safety alerts to ensure people's safety.

We looked at how the service managed people's medicines. Staff had access to a full set of medicines policies and procedures. We found there were safe processes in place for the receipt, ordering, administration and disposal of medicines. Care staff who were responsible for the safe management of people's medicines had received training and checks on their practice had been undertaken. We observed staff provided patience and consideration when administering people's medicines.

We sampled four people's medication administration records (MARs) and found they were accurately completed. A photograph identified people on their MAR and any allergies were recorded to inform staff and health care professionals of any potential hazards of prescribing certain medicines to the person. People had consented to their medication being managed by the service; we were told no-one was managing their own medicines. There was a system to ensure people's medicines were reviewed by a GP that would help ensure people were receiving the appropriate medicines. The temperatures of medicine storage areas were recorded.

We looked at the arrangements for keeping the service clean and hygienic. We found all areas to be clean although we found extractor fans were dusty. One person told us, "My room is usually clean." There were infection control policies and procedures for staff to refer to and staff received trained in this area. Staff were provided with protective wear such as disposable gloves and aprons; suitable hand washing facilities were available to help prevent the spread of infection. The service had a designated cleaner each day and basic cleaning schedules were in place. An additional cleaner had been employed recently.

An infection prevention and control champion had been appointed and was responsible for conducting checks on staff practice in this area, attending local forums and for keeping staff up to date. The laundry had sufficient equipment to maintain people's clothes. We noted some people needed to be moved using a hoist and sling. However, they did not have individual slings which was not in line with current good practice guidance to reduce the risk of cross contamination. Following the inspection, the registered manager told us additional slings had been ordered.

Equipment was stored safely and we saw records to indicate regular safety checks were carried out on all systems and equipment. People had access to a range of appropriate equipment to safely meet their needs and to promote their independence and comfort. There were arrangements in place for ongoing maintenance and repairs to the building. Records showed repairs were undertaken promptly.

Training had been provided to support staff with the safe movement of people. We observed staff using safe practices and offering re-assurance when supporting people to move around the home. Records showed staff were trained to deal with healthcare emergencies.

Records showed staff had received fire safety training. Regular fire alarm checks had been recorded to ensure staff knew what action to take in the event of a fire. Each person had a personal evacuation plan in place in the event of a fire, that assisted staff to plan the actions to be taken in an emergency.

The environmental health officer had awarded the service a five-star rating for food safety and hygiene. There was key pad entry to the home and visitors were asked to sign in and out which would help keep people secure and safe. People were advised that CCTV was used to monitor people's safety in the communal areas.

We found that records were managed appropriately at the home. People's care records and staff members' personal information were stored securely and were only accessible to authorised staff.

Good

Is the service effective?

Our findings

People told us they were happy with the service they received and felt staff were knowledgeable and competent in their work. Comments included, "I feel at home here." A relative said, "I am happy with [family member's] care." Another said, "[Family member's] appointments are made by the home. It's a big help."

Before a person moved into the home, a thorough assessment of their physical, mental health and social needs was undertaken to ensure their needs could be met. Most people, or their relatives, were enabled to visit the home and meet with staff and other people who used the service before making any decision to move in. This allowed them to experience the service and make a choice about whether they wished to live in the home and staff could determine whether the home was able to meet their needs.

We looked at how people were protected from poor nutrition and supported with eating and drinking. People told us they enjoyed the meals and that they had a choice. People said, "I get regular food", "The food is okay but I would like more choice", "The food is nice and they feed me regularly" and, "Yes, I do like the meals. They are always cooked to my liking." Relatives said, "[Family member] seems to enjoy what he is given" and, "The food is of a reasonable standard and [family member] eats what she can."

We observed lunch being served on both days and found some improvements could be made to enhance people's dining experience. People were asked for their choices earlier in the day although their choices were not confirmed again whilst at the dining table. The cook said, "I ask the residents in the morning what they want for lunch. Most can't make a decision so I have to know their likes and dislikes." The menus were not displayed and were not available in a suitable format for people living in the home. Following the inspection, the registered manager told us picture menus were being developed. Some people sat at the dining tables whilst others remained in their armchairs and were provided with a small table. We noted people's choices with respect to this were recorded in their care plan. However, we did not observe people being offered a choice of whether they would like to sit at the table or not. The dining tables were not attractively set, cutlery was made available and although napkins were not provided on the first day of our inspection they were made available on the second day; hand wipes were not offered following the meal. Condiments were not available on the tables but were offered during the meal. Protective clothing was provided to maintain people's dignity and independence.

The meals served were nicely presented and served on coloured plates which provided a contrast for people with sensory disabilities. We noted a vegetarian option was available; people were offered extra portions and offered bread and butter. We overheard friendly conversations and banter during the lunchtime period and we observed staff patiently supporting and encouraging people with their meals. However, we also observed staff standing over people rather than sitting with them. A cold drink was provided during the meal but people were not offered any alternatives such as a warm drink. We observed drinks being offered throughout the day. Following the inspection, we discussed with the registered manager, how people's mealtime experience could be improved.

Information about people's dietary preferences and any risks associated with their nutritional needs was

shared with kitchen staff and maintained on people's care plans. Staff provided people with appropriate food and drink in line with their care plan. Food and fluid intake charts had been implemented for those people deemed at risk; records were monitored to identify any deficits in people's dietary intake. People's weight was checked at regular intervals and appropriate professional advice and support had been sought when needed.

We looked at how the service trained and supported their staff. The training plan showed that staff received a range of training that enabled them to support people in a safe and effective way. All staff had achieved or were working towards a recognised care qualification. The service participated in training provided by the local commissioners, which had helped the staff to provide people with safe, effective and consistent care.

Staff were provided with regular one to one supervision and told us they were supported by the registered manager. Supervision provided staff with the opportunity to discuss their responsibilities and to develop their role. Staff were also invited to attend regular meetings and received an annual appraisal of their work performance.

New members of staff participated in a structured induction programme, which included an initial orientation to the service, working with an experienced member of staff, training in the provider's policies and procedures, completion of the provider's mandatory training and, if new to care, undertaking the Care Certificate. The Care Certificate aims to equip health and social care workers with the skills and knowledge which they need to provide safe, compassionate care. Agency staff also received an induction when they started to work in the home; this helped keep themselves and others safe.

Staff told us communication about people's changing needs and the support they needed was good. Records showed key information was shared between staff and staff spoken with had a very good understanding of people's needs and the management of the home.

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 make 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).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. There were policies and procedures to support staff with the MCA and DoLS and records showed staff had received training in this subject to help improve their understanding of the processes. We were told appropriate applications had been submitted to the local authority for consideration and three people had authorisations in place.

People's overall capacity had been assessed and their capacity and consent to make specific decisions about care and support was referred to in the care plans. This ensured staff acted in people's best interests and considered their choices. We observed staff asking people for their consent before they provided care and treatment such as with administering medicines or with moving from one part of the home to another. Staff understood the importance of gaining consent from people. One person told us, "They ask me what I want to do and where I want to go." Where people had some difficulty expressing their wishes they were supported by their relatives or an authorised person.

We noted people had 'do not attempt cardiopulmonary resuscitation' (DNACPR) decisions in place. Each person's doctor had signed the record and decisions had been taken in consultation with relatives and relevant health care professionals. A DNACPR decision form in itself is not legally binding. The final decision regarding whether or not attempting CPR is clinically appropriate and lawful rests with the healthcare professionals responsible for the patient's immediate care at that time. Where possible, we found people's care plans reflected their decisions and preferences in relation to this.

We looked at how people were supported with their healthcare needs. People's care records included information about their medical history and any needs related to their health. Records showed that the advanced nurse practitioner and district nursing team regularly visited the service and monitored the care and treatment of people in their care; appropriate referrals were made to a variety of healthcare agencies. People considered they received medical attention when they needed.

Information was shared when people moved between services such as transfer to other service, admission to hospital or attendance at health appointments. People were accompanied by a record containing a summary of their essential details and information about their medicines; where possible, a member of staff or a family member would accompany the person. In this way, people's needs were known and considered and care was provided consistently when moving between services.

We looked at how people's individual needs were being met by the adaptation, design and decoration of premises. We looked around the home. We found the home was comfortable and warm and aids and adaptations had been provided to help maintain people's safety, independence and comfort. Communal areas were comfortable and spacious.

We found the home to be spacious and bright but found some areas in need of redecoration and refurbishment. However, most of the issues had been identified on a recent audit and there was a development plan for the home which was updated each month by the registered manager. Following the inspection, we were told the lounge carpet had been replaced and both lounges had been decorated. We noted some bedroom doors and corridor lighting had been replaced and a ground floor bathroom had been refurbished. There were plans to refurbish the shower room, to provide new blinds for the main lounge and to replace any stained or old furnishings. A system of reporting any needed repairs and maintenance was in place.

At our last inspection of July 2017, we found a number of the bedroom doors were fitted with unsuitable locks and we advised the registered manager to consult with the fire safety officer about this. The registered manager and the provider assured us they would ensure appropriate locking devices were provided and would notify us on completion of the work. During this inspection, we found most of the door locks had been removed and not replaced; this meant people's privacy had not been considered. We discussed this further with the registered manager and the provider who assured us suitable locking devices would be discussed with people and their relatives, and provided initially on a request basis.

The ground floor corridors provided plenty of safe walking space for people and old photographs and various displays were positioned along the corridor walls. On the ground floor, people's bedroom doors were painted in a range of bright colours; we were told this was to help people recognise their bedrooms. The first-floor bedroom doors were plain although the registered manager told us work was ongoing to ensure all bedroom doors were brightly coloured. There were no personal items displayed outside people's bedrooms, such as photographs or names which would help people with a sensory disability to recognise their individual bedrooms. We were told further work was underway to make the home more suitable for people living with dementia.

People told us they were happy with their bedrooms and some had arranged their rooms with personal possessions that they had brought with them; this promoted a sense of comfort and familiarity. Some bedrooms had en-suite facilities and bathrooms and toilets were located within easy access of bedrooms; commodes had been provided where necessary.

The gardens and decking areas were safe and secure, and people had enjoyed sitting out in the warmer weather. However, these areas needed attention to make them more interesting for people living with dementia. We discussed areas for improvement with the registered manager and provider.

Good

Is the service caring?

Our findings

People spoken with were happy with the care and support they received. They told us they were treated with care and kindness and were treated equally and fairly. They said, "The staff care for me", "The staff are very kind and care for me" and, "I think the staff care about me." Relatives said, "I think the care here is good", "The staff always provide good care and it's not always easy", "The staff are a very caring group" and, "The staff at the home are lovely."

People made positive comments about the staff at Arrowsmith Lodge Rest Home. They said staff were kind, professional, pleasant, friendly and caring. We saw a number of compliment cards that highlighted the caring approach by staff. People had commented, "Many thanks for welcoming us each visit", "Thank you so much for wonderful care and kindness" and, "Thank you so much, you have all worked exceptionally hard to ensure [family member] was well cared for, happy and as near to home life as possible."

People were encouraged to maintain relationships with family and friends. Friends and relatives confirmed there were no restrictions placed on visiting and we saw they were made welcome.

During our visit, we observed staff interacting with people in a caring, affectionate and respectful manner; we observed lots of smiles, hugs and laughter. We observed good relationships between staff and people living in the home and staff were knowledgeable about people's individual needs and personalities. There was a key worker system in place which provided people with a familiar point of contact in the home to support good communication. Where possible, people could make their own choices and were involved in decisions about their day.

We observed people were treated with dignity and respect and without discrimination. There were policies and procedures for staff about caring for people in a dignified way. This helped to make sure staff understood how they should respect people's privacy, dignity and confidentiality in a care setting. People were dressed comfortably and appropriately in clothing of their choice. We observed staff supporting people in a manner that encouraged them to maintain and build their independence skills.

People told us the staff respected their privacy. We observed staff ensured personal care interventions were carried out behind closed doors in the person's bedroom or bathroom. All staff were bound by contractual arrangements to respect people's confidentiality. However, we noted the locks had been removed from most people's bedroom doors. We discussed, in detail, how this compromised people's rights to privacy. The registered manager and provider assured us this would be addressed following discussion with people and their relatives. We will review this at the next inspection.

People's wishes and choices with regards to spiritual or religious needs was recorded; we observed people receiving religious services in the home. People's wishes and choices with regards to their ethnicity and receiving personal care from female or male carers was recorded however, their sexual orientation was not considered; this information would help staff to be aware of people's diversity. The registered manager assured us this information would be included in people's care records.

People were encouraged to express their views by means of daily conversations and during residents' and relatives' meetings. The meetings helped keep people informed of proposed events and gave them the opportunity to be consulted and make shared decisions. We found people's views had been listened to and acted on in areas such as the provision of activities and meal choices.

People were supported to be comfortable in their surroundings. People told us they were happy with their bedrooms and they could spend time alone if they wished. All staff were aware of how to respect people's confidentiality. People's records were kept safe and secure and there was information available to inform them on how their rights to confidentiality would be respected.

Useful information was displayed on the notice boards and informed people about how to raise their concerns; also included were detail about safeguarding, planned activities and events in the local community. Information about advocacy services was displayed. The advocacy service could be used when people wanted support and advice from someone other than staff, friends or family members.

People were provided with a brochure on admission to the home, which provided an overview of the services and facilities available in the home. The registered manager told us the information could be made available in other formats to ensure it was accessible to everyone. The provider told us the information was due to be reviewed and would include information regarding the use of CCTV, updated information relating to making a complaint and the lack of bedroom door locks.

Good

Is the service responsive?

Our findings

During the last inspection, we found the provider had failed to have suitable arrangements in place for planning people's care and support, in a way that met their individual needs and preferences. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time, we found information in the care plans was not always reflective of the care being given and people's preferences and routines were not consistently recorded. Following the inspection, the provider sent us a monthly action plan which set out the action they had taken and intended to take to improve the service.

During this inspection, we found improvements in the way people's care was planned and managed. We found each person had an individual care plan, which was underpinned by a series of risk assessments. The care plans were organised and included valuable information about people's likes, dislikes, preferences and routines which helped ensure they received personalised care and support in a way they both wanted and needed. Information about people's changing health needs and specialised care needs were recorded and the advice given by health care professionals was documented and followed.

People's care and support had been kept under review and records updated on a regular basis or in line with any changes. However, we noted there were gaps in some of the review dates. We were told this was due to absence of key staff; we discussed, with the registered manager, how this could be prevented in the future. By the second day of inspection, all care plan reviews were up to date. People spoken with said they were kept up to date and involved in decisions about care and support. Records of any communication with relatives were maintained and we noted they had been involved in providing useful information about preferences, interests and routines for the 'This is Me' documentation. Some people, or their relatives, had been invited to and involved in a regular review of the care plan.

Daily records were maintained of how each person had spent their day and of any care and support given; these were written in a respectful way although the quality of the information recorded, was varied. We noted personal care records were not always reflective of the support people had received in relation to personal care and bathing; the registered manager assured us these would be updated. There were systems in place to ensure staff could respond to people's changing needs. This included a handover meeting at the start and end of each shift and the use of handover sheets.

People were happy with the personal care and support they received and made positive comments about the staff and about their willingness to help them. People said, "If I need help I ask for the boss" and, "The residents can be very challenging at times but the staff cope very well." A relative said, "I have no complaints about this home. The staff care for [family member] because I can't. She is safe and happy."

We looked at how the service managed complaints. People stated that they would not hesitate to speak with a member of staff or to the registered manager if they had a complaint. The service had a policy and procedure for dealing with any complaints or concerns, which was displayed in the entrance and in the brochure. However, the information incorrectly advised people to contact CQC in the first instance rather

than the local authority or the local government ombudsman. We discussed this with the registered manager and the provider who assured us the complaints information in the procedure and the brochure would be corrected.

We looked at the records of complaints. We found three recorded complaints had been responded to regarding care and support and staff conduct. We discussed the importance of recording people's minor concerns; this would help to determine any themes and would demonstrate that people's minor concerns were taken seriously and acted on.

We looked at how people could access meaningful and interesting activities. People had mixed views about the provision of activities, "I can sit out when I like; it is pleasant in the garden", "I get fed up sometimes. I need to go out more", "I get lonely sometimes because the other ladies can't talk to me", "There are things that we can do but I would like more things to do" and, "I would like more activities." A visitor said, "There is not always enough going on. The residents need more activities."

The service employed an activities coordinator. However, at the time of our inspection the activity coordinator was on leave; this meant care staff were responsible for the provision of activities when they had time. Staff told us they did not have time to spend with people other than when completing care tasks. They said, "I would like to spend more one to one time with residents" and, "There are evenings when I go home and I have not spent any time just talking to residents. All my time is spent on personal care. There is no time left over." Following the inspection, we were told the staffing had been increased. This would help staff to spend quality time with people.

From our discussions and from the records maintained we could see that some people had participated in activities such as, walks to local shops and cafes, looking at photograph albums, baking, colouring and sitting in the garden. We saw games, books and craft items available around the home and we were told 'rummage bags', containing various tactile items, were available for people to engage with.

Over the two days of our visit, we observed people participating in communion, one to one and group chats, walking in the garden and enjoying a visiting musical entertainer. We did not observe people helping with everyday tasks such as folding laundry and clearing and setting tables. People were supported to maintain local community links and visited local shops, pubs and cafes either with staff or their visitors. Staff also gave up their own time to take people out.

We looked at how the service supported people at the end of their life. The registered manager told us staff followed guidance from specialist professionals and ensured that anticipatory medicines were in place to keep people comfortable; training had been provided for staff. Where possible, people's choices and wishes for end of life care were being recorded, kept under review and communicated to staff. Where people's advanced care preferences were known, they were shared with GP and ambulance services. There were systems in place to ensure staff had access to appropriate end of life equipment, training and advice.

We looked at how technology and equipment was used to enhance the delivery of effective care and support. We noted the service had internet access to enhance communication and provide access to relevant information for staff. E-learning formed part of the staff training and development programme. Sensors or pressure mats were used to alert staff when people were at risk of falling and pressure relieving equipment was used to support people at risk of skin damage. We were told one person had been able to watch a family wedding on a laptop.

We checked if the provider was following the Accessible Information Standard. The Standard was

introduced in 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. We noted information was displayed on notice boards and some of the information was in larger print. The registered manager confirmed information could be made available in different font sizes to help people with visual impairments. We discussed how the provision of information in pictures and symbols could improve people's understanding and accessibility to information such as with the results of surveys, meetings and menus. The registered manager gave assurances this would be reviewed. We found there was information in people's initial assessments about their communication skills to ensure staff were aware of any specific needs.

Good

Is the service well-led?

Our findings

During the last inspection, we found the provider had failed to effectively operate systems to assess, monitor and improve services and assess, monitor and reduce risks to people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection, the provider sent us a monthly action plan which set out the action they had taken and intended to take to improve the service.

During this inspection, we found improvements in the way the service was being monitored. We found there were systems in place to assess and monitor the quality of the service in areas such as medicines management, staffing, accidents and incidents, care planning, infection control and the environment. We noted shortfalls had been identified, timescales for action had been set and actions were monitored by the provider.

People were encouraged to share their views and opinions about the service by talking with management and staff, by completing feedback forms and by attending meetings. An annual satisfaction survey had been undertaken in July 2018; the results had been analysed and shared with people so they knew what action was being taken to respond to their comments.

People, relatives and staff spoken with told us they were satisfied with the service provided at Arrowsmith Lodge Rest Home and with the way it was managed. People said, "The staff and management are very kind", "I am happy that the home runs well" and, "Things have improved."

The registered manager had responsibility for the day to day operation of the service and was visible and active within the service. She was regularly seen around the home, and was observed to interact warmly and professionally with people and staff. All staff spoken with made positive comments about the registered manager and the way the home was managed. They said, "[Registered manager] is very helpful and you can always go to her for help" and, "[Registered manager] is lovely to work with." The registered manager was described as approachable, kind and friendly.

The registered manager told us she was committed to the continuous improvement of the service. She could describe her achievements over the last 12 months and the planned improvements for the year ahead. The registered manager was supported by the provider who regularly visited the service to monitor the quality of the home and the effectiveness of the registered manager's practice. This meant that the provider had oversight of the service. The registered manager was supported by managers from other homes within the organisation; this enabled her to discuss good practice.

Staff said they worked well as a team and felt supported to carry out their roles and felt they could raise any concerns or discuss people's care with the registered manager. There was a clear management structure. Staff were aware of the lines of accountability and who to contact in the event of any emergency or concerns; there was always a senior member of staff on duty with designated responsibilities.

Regular staff meetings had taken place and records showed they discussed a range of issues and had been kept up to date. Staff said, "We get the chance to speak up and sometimes things change for the better" and, "We have ideas but they are not acted upon." Staff were provided with job descriptions, contracts of employment, a staff handbook and had access to policies and procedures which would make sure they were aware of their role and responsibilities.

There were procedures in place for reporting any adverse events to the Care Quality Commission (CQC) and other organisations such as the local authority safeguarding and deprivation of liberty teams. Our records showed that the registered manager had appropriately submitted notifications to CQC and other agencies. We noted the service's CQC rating and a copy of the previous inspection report was on display in the home and on the provider's website. This was to inform people of the outcome of the last inspection.

We saw evidence that the service worked in partnership with a variety of other agencies. These included community nurses, GPs, podiatrists, dieticians, speech and language therapists, hospital staff and social workers. This helped to ensure that people had support from appropriate services and their needs were met. The registered manager had also developed links with the local commissioners to access appropriate guidance and training.