Angel Healthcare Limited

Arden House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Arden House Residential Care Home is a care home and accommodates up to 30 people in a purpose built building. The service supports a wide range of people who need support. This includes, people who live with dementia, mental health disorders, general frailty and addiction to alcohol. At the time of our inspection there were 23 people living at the service.

We undertook this targeted inspection to follow up on specific concerns, which we had received about the service.

We inspected using our targeted methodology developed during the Covid19 pandemic to examine those specific risks and to ensure people were safe.

People's experience of using this service and what we found:
Care and treatment was not consistently provided in a safe way. People 's specific health needs were not identified and planned for. People's health therefore was at risk and this had not been addressed by the manager or provider. There was a lack of management plans for supporting people with their mental health needs which had the potential to impact negatively on peoples' overall health and social care needs.
People were not protected from potential harm and abuse. Some people had been subject to abuse and this had not always been escalated and investigated to prevent further occurrences. Abuse or improper treatment was not always reported, investigated or acted on.
An infection prevention control audit was carried out by CQC during the inspection. It was found the provider was not meeting government guidelines in regard to Covid-19. People had not been self -isolating safely in the home. There was a lack of zoning and cleaning of high traffic areas.
Staff had not all received essential training and specific training to meet people's individual needs and there was minimal evidence of regular supervision and competency assessments.

The provider's systems failed to identify that care and treatment was not provided in a safe way. Audits did not always identify risks to people, safeguarding concerns and a failure to report incidents. Staff practice was not effectively monitored.

Staff were open and transparent during the inspection. Staff were kind to people and wanted to deliver good care.

Rating at last inspection:
The last rating for this service was Good (published 12 September 2018).

Why we inspected:
We undertook this targeted inspection to check on specific concerns we had about peoples' safety and well-being and the management of risk in the service. We inspected and found there was a concern with staff training, accident/incident management so we widened the scope of the inspection to become a focused

inspection which included the key questions of safe and well-led.

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 coronavirus and other infection outbreaks effectively.

Enforcement:
We are mindful of the impact of the Covid19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the Covid19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified breaches in relation to safe care and treatment and good governance at this inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.
If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Arden House Residential Care 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. This was a targeted inspection due to concerns we had about people's safety, staffing levels, delivery of safe care and the governance framework to support people and staff safely.
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 and managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of two inspectors.

Service and service type
Arden House Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed the information, we held about the service and the service provider. We sought feedback from the local authority and healthcare professionals that are involved with the service. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection, however one

had been completed in March 2020. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

Due to the COVID-19 pandemic we needed to limit the time we spent at the home. This was to reduce the risk of transmitting any infection. Therefore, we had calls with the nominated individual for the organisation. We discussed how we would safely manage an inspection without announcing the date. We also wanted to clarify the providers infection control procedures to make sure we worked in line with their guidance.

To minimise the time in the service, we asked the provider to send some records for us to review prior to and following the inspection. This included records relating to the management of the service, audits, training and supervision records and staffing rotas. However, at the time of writing this report, we had not received the majority of records requested.

During the inspection
We spoke with eight people who used the service. We spoke with six members of staff including the nominated individual. We spent a short time in the home. This allowed us to safely look at areas of the home and to meet people, the providers and staff whilst observing social distancing guidelines. It also gave us an opportunity to observe staff interactions with people.
We reviewed a range of records. This included a sample of people's care records, medicine records, and fire risk assessment.

After the inspection
We continued to seek clarification from the provider to validate evidence found, however we did not receive any of the documents requested. We received feedback following the inspection from two staff members and two health professionals.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate.

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.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from harm. We were aware that there had been allegations of financial abuse which were discovered in July 2020 and were currently being investigated. There were new on-going concerns about the management of peoples' finances and property, which meant that systems at present were not sufficiently robust to prevent financial abuse occurring.
- Staff and people told us of incidents of behaviours that were challenging and of actions during these incidents that placed staff and other people at risk. For example, people who were intoxicated became confrontational and verbally aggressive. Not all these incidents had been raised to the local authority safeguarding team or CQC. People told us, "It is frightening sometimes, hearing the shouting, it's upsetting, it has made my anxiety and mental health problems worse."
- The manager and provider had not recognised the impact of verbal abuse and physical threats on people who lived at the home. A staff member said, " The home has changed so much over the past year, people aren't happy. People are scared of [person] who shouts and threatens and they get upset. This affects everyone in the home. We have raised our concerns with the manager, but it's not been dealt with. " Appropriate action had not been taken to effectively reduce risk and this placed people at continued risk of abuse. Peoples care plans did not have guidance for managing peoples' behaviours.
- We spoke to staff about safeguarding training. 40% of staff have not had training in safeguarding. Two staff told us they had not had training but felt confident in identifying and reporting safeguarding issues to managers. Whist three other staff we spoke with were not clear about the different types of abuse and of the steps to take when they identified possible abuse.
- There is currently a safeguarding investigation following a medicine error. A person had taken their anxiety medicine from an unattended and open medicine cabinet. It was not identified by senior staff for 12 hours. The manager had conducted an internal investigation into the error and a plan for improvements had been made. However, it had not included checking the medicine trolley which does not always close securely. This was found by the provider following the inspection 14 days after the incident.

From the information gathered, the above evidence shows that the risk of harm to people had not always been mitigated as incidents and accidents were not consistently reported, recorded and investigated. Action plans to prevent further incidents were not in place. This meant that people were not always protected from the risk of harm and is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were aware of the service whistleblowing policy. Whistleblowing allows employees to raise issues of concern whilst protecting their anonymity.

Assessing risk, safety monitoring and management

● Risks to people had not always been assessed and their safety had not been monitored and managed

● Risk assessments had not been completed for people who may become anxious or distressed. There was no information in the care plan to guide staff on how to support people at this time, and staff had not received appropriate training.

● People with behaviours that may challenge did not have a care plan or risk assessment to guide staff in managing their behaviours. Behavioural charts were not used therefore there was no information about when an incident occurred, what action staff had taken to de-escalate the situation. There was also no guidance as to how to distract the person and reduce risk to them, other people of staff, or if any action taken had been successful.

● Risks of self-harm and low mood of people, whilst known to staff, had not been reported to the manager or documented within the daily notes or care plans. This meant there were no management strategies in place to keep people safe from harm and no referral had been made to the GP and mental health team for support.

● There were people who lived with life threatening and specific medical problems. These had not been risk assessed or included in the care plan to provide staff with guidance on how to manage it should it occur. For example, one person had a history of gastric varices due to cirrhosis of the liver. Staff had no knowledge of this life threatening condition and therefore would not know how to deal with it.

● Fire risk assessments had recently been introduced along with Personal Emergency Evacuation Plans (PEEPs) to ensure they were supported to leave the home safely in an emergency. However, these were not correct and had not been updated with recent changes to people who lived in the service.

● Risk of smoking had not been fully explored. Staff said that it was unsafe at night as people smoked in their rooms whilst intoxicated. There was no documentation available to evidence that this had been assessed for risk and action taken to protect people and staff from fire.

Using medicines safely

● The management of medicine was not undertaken in a safe way which put people at risk. There were multiple gaps in people's Medicine Administration Records (MAR); there was a risk that people had not received their medicine, and this could impact on their health. For example, anti-hypertensives to control their blood pressure.

● There were also people who did not receive their prescribed essential medicines. The reason was coded as asleep. There was no evidence that this was re-offered or that the GP was informed. Staff had not reflected on the health impact on the person of not receiving their essential medicine. For example, medicines for alcohol management and anxiety.

●Staff had a system for putting dispensed medicines in a small plastic bag and labelling the bag with the person's name, date and time. However, this was not consistently undertaken by staff. It meant staff were dispensing the medicine without seeing the person first and ensuring they were ready for their medicines.

● Where people required 'as and when' medicines, such as pain relief (analgesia) and mood calming medicines, there was no guidance in place for staff on when this should be given and staff were not recording whether the medicine was effective.

● Medication has been going missing, but not all had been reported or investigated. In all cases opportunities for learning lessons from these incidents had been missed. For example, introducing checks to ensure all medicines were accounted for.

● There were other aspects of the management of medicines that were not adequately managed. For example, medicines were not always stored safely and ordered in a timely way. Examples of this were

discussed with the provider.

Preventing and controlling infection

● We were not assured that the provider was preventing visitors from catching and spreading infections. The home was not clean and hygienic in all areas and did not promote good infection control practice. For example, on arrival visitors were directed to a table with a thermometer and oximeter(for recording oxygen levels) and asked to take their temperature and record it. There was no hand gel or cleaning of equipment available after usage. There was no handwashing or hand gel for visitors to use as they entered the home.

● We were not assured that the provider was meeting shielding and social distancing rules. For example, people who should be shielding were not doing so, including those with serious underlying health conditions. No zoning had been implemented to prevent the spread of infection.

● We were not assured that the provider was using PPE effectively and safely. Staff were not changing aprons or gloves when entering and leaving positive Covid19 areas. There were no PPE stations outside Covid19 positive people's rooms and other PPE stations were not appropriately stocked. There were no pedal bins for the safe disposal of used masks, gloves and aprons.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Staff were disposing of used PPE with normal household waste. Laundry had not been segregated and staff showed minimal awareness of wiping down high traffic areas which people who had tested positive were using throughout the day.

● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. Not all staff had the Covid19 specific training, the only advice they had was on the WhatsApp staff group and videos sent. No competency checks had been undertaken to ensure the Government Covid19 guidance was being followed. There were no Covid19 care plans or risk assessments for each person in place and staff therefore did not have guidance to follow in keeping people safe.

● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was admitting people safely to the service.

We have also signposted the provider to resources to develop their approach.

Staffing and recruitment

● Comments from people and staff included, "The staffing levels seem okay" and "The staff work hard they seem to get it done." Feedback from staff was mixed. One staff member said, "We have enough staff," whilst another staff member said, "We need more staff at night as some people are unpredictable and it's not safe with just two staff."

● Rota's confirmed staffing levels had been adapted in the last three weeks and the evening shift extended until 10pm. However, this was not consistent over the week on the rota we were given. There were sufficient staff to support people on the day of the inspection.

● From talking to staff, viewing the training programme and meeting people with varied needs, we were not assured that staff had the necessary training to meet peoples' needs. Staff told us that they had not had training in managing behaviours that challenge, diabetes or in managing addiction and alcohol dependency.

● The training programme also evidenced that not all staff had undertaken essential training. The provider informed us that the training matrix provided on the inspection visit was not up to date and an accurate programme would be provided. We have now received an up to date training record, which confirms that staff have been given their training booklets.

● Staff competencies had not been undertaken following completion of the training booklets. This meant that the provider could not be assured that staff were competent in their roles.

The provider had not ensured the safety of people by assessing the risks to their health and safety and doing all that is practicable to mitigate any such risks and ensuring that staff had the skills and competence to support people. The provider had also not ensured the proper and safe management of medicines and had not appropriately assessed the risk of preventing, and controlling the spread of infections, including those that are health care associated such as Covid19. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

- We were told that accidents and incidents were documented and recorded. However, the records could not be located in the office. We requested prior, during and following the inspection the overview of accidents and incidents and these have not been produced.
- There was also no evidence in people's care plans and risk assessments that they had been updated following an incident or accident. For example, one person was on bed rest following a fall. However, there was no information regarding the rationale for bedrest or an injury. We could not confirm that all serious incidents resulting in harm to people were escalated to other organisations such as the Local Authority and CQC.
- We were not assured that learning from incidents and accidents took place. Specific details and follow up actions by staff to prevent a re-occurrence were not clearly documented. Action from incidents and accidents were not shared with all staff or analysed by the management team to look for any trends or patterns.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated 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

- The registered manager has been absent since July 2020 and has yet to be de-registered. An interim manager from one of the provider's other homes was in day to day charge. However, the manager was not available at the inspection visit.
- We found records relating to safe care delivery were incomplete and not up to date. Many care plans and risk assessments had not been updated since July 2020. For example, one person had left the service and then returned following a hospital admission and the care plan and risk assessments had not been updated to reflect this. This meant the person's specific needs were not being met in regard to their alcohol management.
- Alcohol management documents were in place, but the daily management charts were not completed and lacked insight of goals. There were also discrepancies in the amount of alcohol people were drinking. This had resulted in some people being very intoxicated and the cause of some incidents in the premises and altercations.
- Important health problems of people had not been recorded and there was no guidance for staff to follow to manage their health and safety. For example, one person suffered from a specific stress disorder and there was no management plan to support them safely. Staff could not discuss how they supported this person safely due to lack of training.
- Staff told us that supporting people with behaviours that were unpredictable and could challenge was stressful, especially at night. The provider had not ensured staff had received appropriate training to support them in this role. We were told that this was covered in their training programme, but staff told us they had not completed the training.
- The quality monitoring systems in place had not ensured the provider had oversight of the service. This had impacted on safe support for people within the service, medicine management, training and competencies and infection control procedures. For example, systems to monitor staff practice had not identified staff were not complying with government guidance in relation to PPE. We found concerns with regard to government guidelines for Covid19 not being adhered to. This has been referred to in depth in the safe section of this report.
- Systems to safeguard people's money and property were inadequate. These are currently being investigated by the Local Authority and police.
- Areas of fire safety shortfalls had not been identified through the organisational audits. A fire inspection

was undertaken by the fire service and the provider was working through their requirements.
● There were delays in information being sent to CQC, by the management team and provider, following the inspection. Telephone calls and emails had to be sent, some information requested was received and some information was not received. This meant there were delays in collating and corroborating evidence.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people: Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff told us that staff meetings had not been happening in recent months. A Whatsapp group had been introduced but no outcomes or actions from these meetings were recorded or taken forward. One staff member said, "I don't know what is going on, we don't get told things." Another staff member said, "It's all strange really as staff have left, new staff and different manager, all strange and unsettled."
● People told us, "I talk to staff if I need to, haven't been asked to fill in a survey," "Haven't a clue, I live day to day, place is falling down, no-one listens, needs to be better here."

The provider had failed to establish and operate effective governance systems to assess, monitor and mitigate the risks to people's health, safety and welfare. Some records were not in place, accurate or complete. Feedback form relevant people had not been sought and acted on. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection and letter of intent was sent to the provider on the 23 October 2020 requesting immediate and longer term assurances about people's safety. In response, an external nurse consultant had been employed to make needed improvements to the management and prevention of Covid19. We have also received updates of initial improvements made.

Continuous learning and improving care
● The provider stated they valued the opportunity to meet other providers and manager to share ideas and discuss concerns at meetings and forums.

Working in partnership with others
● The management team in the last month has actively looked for and took up opportunities to work in partnership with local health care and community services to improve people's health and wellbeing. This was on-going.
● Since the organisational safeguarding in July 2020, the service have worked with the local authority to improve governance and improve standards within the service. This work is on-going.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the safety of service users by assessing the risks to their health and safety and doing all that is practicable to mitigate any such risks. The provider had not ensured the proper and safe management of medicines. The provider had not appropriately assessed the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated such as Covid19; Regulation 12 12(1)(2)(a)(b) (g) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that systems and processes were established and operated effectively to prevent abuse of service users. Systems and processes had not been established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. Regulation 13 (1) (2) (3)

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 to assess and quality assure the service. Regulation (17) (1) (2) (a).

The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user.

Regulation 17 (2) (c).