Arden Manor Care Limited

Arden Manor Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Arden Manor Care Home is a care home providing personal care to 21 people at the time of the inspection. The home is registered for up to 23 people. Some of the people were living with dementia. People have access to their own bedroom along with communal spaces including lounges and gardens.

People's experience of using this service and what we found
People did not always receive safe care, as risks to people's safety were not always assessed and care plans were not always in place or followed. There was no evidence lessons were learnt when things went wrong. Infection control procedures were not always followed to ensure the spread of infection was reduced, some of the environment and equipment was unclean and in need of repair. There were safeguarding procedures in place however these were not always followed to ensure people were protected from potential harm.

People were not supported to have maximum choice and control of their lives and staff did not supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Staff did not always have the correct training, skills or their competency checked to ensure they supported people in a safe way. There were not enough staff to support people. Medicines were not always stored safely or administered by competent staff. Some people did not receive their medicines when needed.

The systems in place were not effective in identifying areas of improvement and audits completed were not identifying areas of improvement.

There was a choice of foods which people enjoyed. People received as required medicines when needed.

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 good (Published 22 March 2022)

Why we inspected
We received concerns in relation to safety and leadership. As a result, we undertook a 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.
The overall rating for the service has changed from good to Inadequate based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to regulation 11 capacity and consent, regulation 12, Safe care and treatment, regulation 13, safeguarding service users from abuse and improper treatment, regulation 18 staffing and the skills of staff and regulation 17, Good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

Arden Manor 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. 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.

Inspection team
The inspection was carried out by 1 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
Arden Manor 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.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post. A new manager had recently been employed and was in the process of applying to register with us.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since our last inspection, including notifications the provider had sent to us. We also gathered feedback from the local authority.

The provider was not asked to complete a provider information return prior to this inspection. 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. We used all of this information to plan our inspection.

During the inspection
We spoke with 10 people and 4 relatives. We also spoke with the manager, the deputy manager, the nominated individual, the provider, and 12 members of staff, including care staff, domestic and kitchen staff. We looked at the care records for 10 people. We checked the care people received matched the information in their records. We looked at records relating to the management of the service, including audits carried out within service.

The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Inadequate

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 good. At this inspection the rating for this key question has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management. Learning lessons when things go wrong

- Individual risks to people were not assessed, monitored and reviewed. When incidents or changes to people's care had occurred, care plans were not in place to reflect these changes. In some instances, they were not in place at all or had contradictory information recorded in them. For example, in part of 1 persons' care plan it stated they needed supervision to mobilise, yet in another plan it stated they were independent. We saw different staff support them in different ways. This placed people at risk of not receiving the support they needed.
- When people did have care plans in place, we saw these were not always followed. For example, 1 person was supported to move using a hoist when they could mobilise with a walking aid. They had not been assessed as needing a hoist and this was an unsafe practice which placed this person at risk of harm. The nominated individual confirmed this person should not be supported using a hoist.
- People were placed at an increased risk of choking. One person had been assessed by Speech and Language Therapist (SALT) as needing a specialist diet and thickened fluids. We saw they did not receive a diet or drink in line with this specialist advice. We had to intervene to stop the person eating these foods and unthickened drink. We observed the staff member telling the manager they were unaware of this person's diet.
- We saw another person was supported to eat their lunch in bed whilst lying down. This was an unsafe position to consume food which placed this person at significant risk of choking.
- Equipment people needed to keep them safe was not always in place. For example, 1 person's records showed they needed a bed sensor whilst in bed to alert staff if they got up. We saw this was not in place. Another person's bed bumper that was used to protect them from the bed rails was on the floor for over 2 hours, we alerted staff to this several times. This placed these people at an increased risk of injury or harm from falling out of their bed.

Preventing and controlling infection

- The provider could not be assured they were preventing visitors from catching and spreading infections or using Personal Protective Equipment (PPE) effectively and safely. The provider could not be assured that PPE was being effectively used in the home, in line with their own procedures and risk assessments. On several occasions we had to ask staff to stop removing their masks to talk with people. We saw on many other occasions staff adjusted their mask when we entered the room.
- The provider was not promoting safety through the layout and hygiene practices of the premises. We identified equipment and the environment posed a risk to people, this included ripped chairs and pressure cushions in communal areas. Damaged items made it difficult to ensure surfaces remained clean. A used commode remained in a person's bedroom for over 40 minutes whilst they were present, and faeces was on a toilet aid in a communal toilet for over 40 minutes. Staff were aware of these but did not take any action to

resolve.
● We also saw people sharing equipment such as slings for hoisting and a blanket that was passed between people in the communal area, placing people at risk of cross infection.
● We observed areas of the home that were unclean, including cobwebs in the corridors.

Using medicines safely
● Medicines were not always stored safely. We saw a trolley containing prescribed creams was unlocked for over 30 minutes. During this time people, some of whom were living with dementia, passed this trolley independently. This placed people at risk of harm should they have taken anything from the trolley.
● Staff told us only senior staff were trained to administer medicines to people. Staff told us all care staff administered creams to people and then signed the Medicine Administration Record (MAR) to show they had. Staff told us they had not received training to do this. Later we were showed records that some staff had received training. However, there was no evidence to show staff had their competency checked to ensure they were safe to administer prescribed creams to people. The provider had therefore not assured themselves staff were competent to do so.
● The staff member administering medicines to people on day 1 of our inspection had not received a competency check to ensure they were safe to do so.
● Not all people, received their medicines when needed. We saw on 1 person's MAR they had refused their oral medicines; we were told this was because they were unable to swallow these tablets and were waiting for their medicines to arrive in a liquid form. There had had been a delay of 8 days until they received this. It was unclear who was responsible for following this up and this had resulted in these medicines not being followed up in a robust way. For example, we saw an email had been sent to the pharmacy requesting these medicines, however, no further follow up had then occurred for a further 6 days. Staff we spoke with were unaware who was responsible for this placing this person at an increased risk of pain and harm.
● The provider took action during and after our inspection to resolve these issues. They sent us an action plan identifying the action they had already taken and the action they planned to take. We will review this as part of our next inspection.

Individual risks to people were not assessed, monitored and reviewed. Medicines were not always managed in a safe way and infection procedures were not always followed. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other people received their medicines when needed. Records we reviewed confirmed this. One person told us, "The staff give me my tablets, I have never had any problems".
● When people had 'as required medicines' there were protocols in place stating when these should be administered, and we saw people received these.

Systems and processes to safeguard people from the risk of abuse
● There were procedures in place to identify and report safeguarding concerns, however these were not always followed to ensure people were protected from abuse. We saw 1 person had unexplained bruising, there had been no follow up of this incident and staff or the manager was unable to tell us what action had been taken.
● During our inspection on day 1 we observed a physical altercation between 2 people. We alerted staff to this incident and they separated the people. On day 2 of our inspection we found this incident was not documented or reported by staff or the manager who was made aware of this on day 1 of our inspection. Therefore, no action had been taken to ensure these and other people were protected from abuse.
● We had to ask the manager on day 2 of our inspection to raise a safeguarding referral around incidents we had observed on day 1, this demonstrated there was a lack of understanding around when safeguarding's

needed to be reported.
● It was unclear who had Deprivation of Liberty Safeguards authorisations in place as there was no system in place. We later found in people's files some authorisations were in place. Staff and the management team were unaware of these and therefore unable to tell us who these people were and what this meant for them. The restrictions placed on these people included not being free to leave the home and the use of bed rails. Furthermore, some people had restrictions placed upon them since these authorisations has been completed, no one was able to tell us how these new restrictions such as covert medicines and sensor mats had been considered. This placed people at risk of being unlawfully restricted.
● We saw a person who was independently mobile was in bed with their bedrails up. There was no care plans or risk assessments in place for this and the nominated individual confirmed they should not have had these up. The provider had not considered this could be restraint.
● Although records we reviewed showed staff had received training, some staff told us they had not or were not aware they had received training. Through our conversations with staff, it was clear they lacked an understanding of what safeguarding meant. For example, some staff were unable to tell us the type of abuse people might face or action they may take. This placed people at risk of abuse.

People were not protected from potential abuse. This placed people at risk of harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment
● There were not enough staff available to support people. Staff told us they were often short staffed. One staff member said, "Short staffed at times, usually mornings, we should have 4, its usually 2." Another staff member told us, "There is not enough staff on shift. Every day we are short. We should have 3 on night but only have 2 so it's hard to do double up clients."
● There had been an incident in the home where 1 person had fallen out of a chair. Staff told us this was because there were not enough staff and they could not be in the communal area as there were only 2 of them on shift and they were supporting someone else.
● We saw there were not enough staff and people had to wait for support. At lunch time the environment was disorganised and chaotic, people were becoming upset and unsettled as they had not received their meals and other people had finished theirs. Some people had to wait for staff to become available to support them with their meals, some people who needed support with their meal, did not receive any support at all.
● We were told by the manager the communal area needed to have a staff member present to ensure people were safe, we saw at various times over the course of our inspection there were no staff in this area and people were present, including people who needed support with mobility and who were at risk of falls. People were also shouting out for support and staff were not available as they were supporting other people. One person told us, "There's always a wait."
● The system for working out staffing levels in the home was not effective as the information recorded was not accurate. For example, people who needed support with mobility were documented as mobilising independently.

There were not enough staff available for people. This placed people at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff had received the relevant pre employment checks before they could start working in the home to ensure they were safe to work with people.

Preventing and controlling infection

● We were assured that the provider was admitting people safely to the service.
● 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
● There were no restrictions placed on visiting and visitors could access the home freely.

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. The rating for this key question 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.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support

- People's health needs were not always responded to in a timely manner. We saw a visiting health professional had documented in 1 person's notes they were displaying symptoms in line with a urine infection. We saw a GP had visited the home and this had not been discussed with the GP this meant important information about this person's health had not been shared.
- Eight days later a health professional had been contacted to follow this up [person displaying symptom of a urine infection], meaning a delay for this person. It was unclear who was responsible for this and why this had not been completed before. One staff member told us they believed the manager was responsible for this, however the manager was unaware until we showed them the documentation. The person was then seen by the health professional and prescribed medicines. Altogether there was a delay of 10 days before this person was treated for their urine infection. Due to the lack of communication this meant this person did not receive prompt medical treatment, placing them at risk of increased pain and harm.

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

- People were not always supported to have enough to eat and drink. One person had lost a significant amount of weight; this had been identified following a safeguarding referral from an external professional. Despite this, there were no up to date plans to identify how this person should be supported with this. We spoke with a member of staff who told us, "I don't think they have a special diet; they can eat independently." They were unaware of the concerns with this person.
- Furthermore, we saw this person was not encouraged or supported at mealtimes and inaccurate records of what they had eaten and drank had been made by staff placing them at further risk of weight loss.

People 's health needs were not always responded to in a timely manner. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- People's oral health care was considered and there were plans in place identifying the levels of support they needed.
- There was a choice of meals available for people. We saw people were verbally asked what they would like and when they chose different options this was made available for them.
- People had hot and cold drinks available on tables beside them.

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.

● The principles of MCA were not always followed. It was unclear from the documentation being used where people lacked capacity to make certain decisions. For some people capacity assessments or best interests' decision were not always in place. For example, 1 person had plans in place to receive covert medicines should they require them, there was no capacity assessment for this. This meant the correct process had not been followed.
● Capacity assessments that had been completed were not decision specific, there was no record to show the decision that was being made and often best interests of the person. Some people had capacity assessment in place despite the DoLS team assessing them as having capacity. This is not in line with MCA.
● We also saw relatives were signing consent forms on behalf of people, with or without capacity without the legal power to do so. This is not within the requirements of MCA.

The principles of MCA were not always followed. This placed people at risk of harm. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience
● Staff did not always have the skills or knowledge to support people. Although records showed staff had received training, the provider could not be assured they received adequate training to meet people's needs. For example, records showed staff had received safeguarding and MCA training, however when asked they were unable to explain what this was and what it meant for people.
● Staff competency was not checked after training was received to ensure they had understood and were able to apply the training received so that they were safe to support people, including in medicines management.
● Staff told us they had not received training to support people to eat and drink in a safe way and we found concerns with the diets people received. This placed people at risk of harm.

Adapting service, design, decoration to meet people's needs
● The home looked tired, and some areas were in need of repair. For example, seating in communal areas was ripped and needed replacing. The paint was peeling off doors and walls, there were also other areas where damage had occurred and no action had been taken.
● Further improvements were needed to ensure the home could be more dementia friendly. For example, there were limited signs or pictorial guidance to offer guidance or support to people with orientating themselves around the home.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were assessed before they started using the service. This considered people's gender, culture and religion. People's physical and health needs were also assessed and considered. This information was not always reflected in people's care plans, risk assessments or the care people received.

● It was unclear how people and those important to them were involved. On both days of our inspection despite raising concerns we saw staff writing care plans without involving people or those important to them. Staff we spoke with told us they had been asked to complete the paperwork and were unable to explain why people were not involved with this.

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 good. The rating for this key question 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;

- The systems the provider had in place had failed to effectively monitor and make improvements to the quality and safety of care people received.
- The systems in place to ensure staff were trained or competent to administer medicines to people were ineffective. We found the staff member administering medicines had not had a competency check to ensure they were safe to do so.
- The incidents and accidents audits had not identified reviews were not being completed after each incident or accident had occurred. The audit had not highlighted care plans and risks assessment had not been updated to ensure people's risks of continued harm were effectively mitigated.
- There was no system in place that identified which people had Deprivation of Liberty Safeguarding (DoLS) in place, to ensure they received the correct support.
- The daily walkaround had failed to identify people did not have the correct equipment in place. This system was therefore ineffective in identifying when people were not receiving care and support in line with their care plans.

Continuous learning and improving care

- There were no systems in place to ensure lessons had been learnt when things went wrong for example, an external infection control audit (IPC) recommended actions on 31 January 2023. These actions included, 'high level dust noted in some bedrooms', deep cleans were suggested. There was no evidence this had taken place and we saw the dust remained, placing people at a continued risk.
- An IPC audit dated 24 January 2023, had been completed internally. This identified areas of improvements such as 'some items need to be replaced'. This audit was not robust as it had not identified what items these were, and timescales for completion. This meant this audit was ineffective in making improvements to the service.
- Care plan audits had been introduced; however, they had not identified when care plans were out of date or not reflective of people's needs. When they had identified an area of improvement an 'X' was recorded with no clear action or timeframes as when this was going to be completed. This meant this audit was ineffective in making improvements to the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- It was unclear how people were involved with the service, as there were no systems in place for this. There

were also no systems in place to ensure people had their care reviewed when needed.
● The provider told us they completed a satisfaction survey with people living in the home, however this had not been completed since 2021. Therefore, this was not current. There was no evidence to show what action had been taken since the last surveys were completed and they were unavailable for us to review.

Systems in place were not robust to ensure people were protected from harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff attended supervisions and team meetings so they could share their views. Staff felt supported and listened to by the manager and provider and spoke positively about the support they received.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The home did not create a positive culture for people. We found there were themes of poor documentation and culture, when we requested information, for example the handover from the day of our inspection, it could not be found. Staff we spoke with told us they had attended handover, however they told us they were not aware of some of the incidents that had occurred on the first day of our inspection. This placed people at risk of not receiving good outcomes and the support they needed.
● We found when concerns were raised or incidents were reported, there was a tendency for these not to be documented or reported. When we spoke with staff about an incident that we observed between 2 people, they told us they had not reported as they were unaware, they needed to. This created a closed culture within the home.

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
● We could not be assured duty of candour requirements were understood and met, as incidents were not always documented, reported or investigated.

Working in partnership with others
● The was some evidence the provider worked in partnership with health professionals, professionals were involved with people's care, we saw people had access to and were referred to the GP and district nurse team. However, we could not be confident, GP or healthcare advice was followed.
● For other people it was unclear when other professionals had been involved and reports were often unavailable for us to review. The provider had not always acted on advice from health professionals visiting the home.

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 11 HSCA RA Regulations 2014 Need for consent The principles of MCA were not always followed.

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 People were not protected from potential abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to support people in a safe way.

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 12 HSCA RA Regulations 2014 Safe care and treatment Individual risks to people were not assessed, monitored and reviewed. Medicines were not always managed in a safe way and infection procedures were not also followed.

The enforcement action we took:

Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place were not effective in identifying areas of improvements.

The enforcement action we took:

Warning notice.