Care Quality Commission

Oldfield Residential Care Ltd

Arden Grange Nursing & Residential Care Home

Inspection report

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Ratings

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

Overall summary

This inspection was unannounced and took place on 8 and 9 February 2016.

Arden Grange Nursing Home provides accommodation and nursing care for up to 45 people. On the days of our inspection the home was fully occupied.

It is a condition of this provider's registration that they have a registered manager but there has not been one in post since August 2015. The provider had appointed a manager in November 2015. The manager told us they had not submitted an application to register with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not supported appropriately to take their prescribed medicines and they did not always receive their treatment. Staff were nearby to support people with

Summary of findings

their care needs. Staff had access to risk assessments to promote their understanding about how to care for people safely. People felt safe living in the home but not all the staff knew about external agencies to share concerns of abuse with.

Some parts of the premises were unsafe and fire safety systems had not been maintained to ensure the safe evacuation in the event of an emergency. Practices within the home did not always support people's privacy or dignity. People had a choice of meals but menus did not always reflect what was on offer and practices did not always ensure people had enough to eat.

People's privacy and dignity was not always promoted but the majority of staff were kind and caring. People were not involved in their care planning but were happy with service they had received.

People had access to healthcare services but services were not always obtained on their behalf in a timely manner. People were supported by staff who had access to routine training but staff were not regularly supervised. Best interest decisions were made on behalf of people who were unable to make a decision.

People were not supported to pursue their specific hobbies and interests. Complaints were not always managed appropriately to resolve concerns and to improve the service where needed.

There were no systems in place to enable people to have a say in the way the home was run. People were not supported to maintain links with their local community. Some people were unaware of who the manager was but those who did said they were approachable. Systems to monitor the quality of the service provided were not effective to identify the shortfalls we found and people were at risk of not receiving a high standard of care.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

People were placed at risk because parts of the environment were potentially unsafe and cold. People's medicines were not managed appropriately to ensure they received their prescribed treatment. Staff were nearby to support people when needed. Risks to people were managed and they felt safe living in the home. Not all the staff were aware of external agencies to share concerns of abuse with to protect people from the risk of further harm.

Requires improvement 

Is the service effective?
The service was not consistently effective.

People had a choice of meals but practices did not ensure everyone would have a meal. Healthcare services were available but were not always obtained on people's behalf in a timely manner. People were supported by staff who were trained but they were not regularly supervised. People who were unable to make a decision, their human rights were protected.

Requires improvement 

Is the service caring?
The service was not consistently caring.

People's privacy and dignity was not always respected and they were not always involved in planning their care. The majority of staff's approach was kind and caring.

Requires improvement 

Is the service responsive?
The service was not consistently responsive.

People were not always involved in their care assessment and were not supported to pursue their hobbies and interests. Complaints were not always managed to resolve the concern or to improve the service where needed.

Requires improvement 

Is the service well-led?
The service was not consistently well-led.

There was no registered manager in post and systems were not in place to ensure the service was delivered to a high standard. People were not supported to maintain links with their local community.

Requires improvement 

Arden Grange Nursing & Residential Care 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8 and 9 February 2016 and was unannounced. The inspection team comprised of three inspectors 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.

As part of our inspection we spoke with the local authority to share information they held about the home. We also looked at information we had about the provider to see if we had received any concerns or compliments about the home. We reviewed statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We used this information to help us plan our inspection of the home. Prior to our inspection we received concerns about the care and support people received, so we looked to see what action the provider had taken to address these concerns.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we spoke with ten people who used the service, five relatives, seven care staff, two nurses, the chef, the manager and the operational director. We looked at two care plans and risk assessments, medication administration records, accident reports and quality audits.

Requires improvement

Is the service safe?

Our findings

People were not appropriately supported to take their prescribed medicines. For example, one person had been prescribed a cream for the treatment of a skin condition. The medication administration record (MAR) had been signed 11 times to show the cream had been applied. However, the amount of cream remaining in the tube indicated it had not been given as directed. Staff could not confirm the cream had been given as prescribed. The person this cream had been prescribed for was unable to tell us if they had received their treatment. Another MAR showed that the person had been prescribed a medicine to prevent their blood from clotting. The direction on the MAR showed this medicine should be given every 12 hours but the MAR indicated that the person received one dose in 24 hours for six days. The manager was unable to tell us why the appropriate dosage had not been given. Another person had been prescribed a medicine to be taken on a regular basis to reduce the acid in their stomach. The MAR showed that medicines had been carried over from the previous month. However, this medicine should be taken daily and there shouldn't be any medicines left to carry over. The manager was unable to explain the reason for the discrepancy. Prescribed creams were not securely stored in people's bedrooms. The manager acknowledged that people living with dementia wandered into other people's room and had access to these creams. If these creams were eaten they could be harmful.

This is a breach of regulation 12, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had access to a written protocol that told them how to manage 'when required' medicines. These are medicines that should only be taken when required. For example, for the treatment of pain. We saw these protocols in place to promote the safe management of these medicines.

The home was being refurbished on the days of our inspection. People told us they were cold and one person said it was too cold to eat their meal. Another person said, "I feel like I am sitting outside." The communal area did not have suitable heating and portable heaters had been situated around the home but this was insufficient to ensure people were comfortable. The manager said that the heating would be restored within a week. However, there were no arrangements in place to ensure people would be warm enough during the refurbishment. We also found that the provider had not taken steps to repair holes in the fire doors and the automatic door closures were not working on every door. We were concerned that people may be placed at risk because of this. We shared our concerns with Shropshire fire safety service, they carried out a visit and agreed actions for the provider to take.

People had risk assessments in place to support staff's understanding about how to care for them safely. The staff we spoke with were aware of the level of support people required to mobilise safely. Risk assessments provided staff with information about how to support people with their mobility and the equipment required to assist them. We also saw risk assessments in place that would guide staff when using safety rails on people's beds to keep them safe from falling whilst in bed. We found that some cleaning chemicals had not been stored securely, we alerted the manager to this and they assured us that action would be taken to address this. People could be assured that actions would be taken to reduce the risk of accidents in the home. The manager said that accidents were recorded and monitored to find out if there were any trends. Where possible measures would be taken to prevent it happening again.

People told us there were not enough staff on duty during the night time. Two people said during the night they sometimes had to wait a long time for support. One person said they had been incontinent because they waited so long to be assisted to the toilet. The manager said that one nurse and five care staff were provided during the night time. The manager said that staffing levels were determined by people's needs and observations and since their appointment as manager, staffing levels had increased. The manager was confident that there were enough staff on duty to meet people's needs. People and their relatives told us they had no concerns about staffing levels during the day. We saw that staff were nearby to support people when needed. One person said, "I like that there is always someone about." Another person said, "Staff always check to see if I am alright." One person told us they required two staff members to assist them with their care needs and confirmed that this level of staffing was always provided.

Staff told us and records confirmed that the provider's recruitment procedure ensured safety checks were carried

Requires improvement

Is the service safe?

out before they started to work at the home. This ensured staff's suitability to work with people. A relative said, "I think they are recruiting to a higher standard because the care standards have improved."

One person told us they felt safe living in the home and said, "I have a nice room and all my things are safe." A relative said, "I look to see how people are treated and I think my [relative] is safe here." Staff told us they knew the signs of abuse and what to look for, they also told us they would inform the manager of any poor care practices or abuse. Not all of the staff understood that they could refer potential abuse to external agencies but the manager did. The manager said safeguarding was discussed during staff induction and handover sessions.

Requires improvement

Is the service effective?

Our findings

On the days of our inspection we saw that some people did not have the support they needed to eat their meals. One person ate their meal with a fork; most of their meal fell onto the table. Staff did not recognise this person may have needed extra support to eat the whole of their meal. Another person had to wait for staff to help them. Two people did not have a meal at all because the system currently in place had failed to recognise this. We alerted staff to this who then provided the people with a meal.

We saw that not everyone ate their meal and one person told us the food was awful. However, other people told us, "The food is normally very good," and "The food is tasty and we have plenty." Not everyone was provided with a drink during mealtimes and the water dispenser in the lounge did not have any cups available. Staff told us that cups were available upon request. We saw that staff offered people drinks frequently throughout our inspection.

The manager said that when they have concerns about how much a person eats or drinks a dietician or a speech and language therapist would be requested on their behalf. This was also confirmed by the staff we spoke with.

One person told us they enjoyed reading, doing puzzles and watching the television but couldn't do these things without their glasses. They added their glasses had gone missing for a few weeks and they had not been supported to obtain a new pair. The staff and the manager were aware that the person's glasses had gone missing but had taken no action to help replace them. We shared this information with the manager who took action on the day of the inspection and assured us that the person would be supplied with a new pair of glasses that week. We spoke with another person who confirmed they had access to their GP when needed. Another person said they would like to see a physiotherapist to help them to walk again. A staff member said that action had been taken to refer the person to a physiotherapist to assist them with their mobility. One visitor said their relative had access to a chiropodist and the GP when needed. Discussions with the manager confirmed that where people had a specific health condition they had access to a specialist health practitioner to support them. We also saw evidence of this in the care records.

People could be confident that they would be supported to maintain healthy skin. The manager said that prior to their appointment a number of people had developed pressure sores. However, with care planning and the development of risk assessments to support staff's understanding about pressure care management no one in the home had a pressure sore. Staff were aware of the support and equipment people required to maintain healthy skin and to ensure their comfort.

People felt staff had the skills to care for them. A relative said, "The staff are fine." The manager said staff had access to regular training and this was confirmed by staff. On the day of the inspection we saw infection prevention and control training taking place. Staff we spoke with told us their induction had given them an introduction to the service and to their role and responsibilities. Discussions with staff, manager and the records we looked at confirmed that supervision was not carried out on a regular basis to support staff in their role to provide people with a safe and effective service.

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The manager and the staff we spoke with had a good understanding of MCA. Staff knew when a MCA assessment should be completed to find out whether the person was able to make a decision. The manager told us that where a person was unable to make a decision about their care and treatment a best interest decision would be made. We saw that best interest decisions were in place for some people. For example, one person was receiving end of life care. A best interest decision was in place in conjunction with a 'do not attempt cardio pulmonary resuscitation' for the person not to be admitted to hospital for further treatment.

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

Requires improvement

Is the service effective?

deprive a person of their liberty were being met. The manager knew when to apply the DoLS and told us that a DoL application was in place for a few people. Staff were aware of who had a DoLS in place and the reason why the person's liberty had been deprived.

Requires improvement

Is the service caring?

Our findings

People's dignity was not always respected. Staff gave good examples about how they promoted people's right to privacy and dignity but this was not always put into practice. We heard a staff member discuss a sensitive matter with one person and this was not done in a quiet or discreet manner. These actions did not uphold the dignity and privacy of the person. Some people's privacy had been compromised because their bedroom door had been propped open and meant that people walking past bedrooms could see people in their bed. A staff member said that doors had been propped open to enable them to supervise people who were unwell more closely. Due to people's health condition they were unable to tell us if it was their choice to have their door open at all times.

Whilst in the lounge where other people were present we saw that a person's medicines had been placed on a spoon and put into their mouth in a rushed manner. They were also not given the opportunity to take their medicines them self or when to have a drink. Another person didn't want their medication. One staff member held the person's hand whilst another staff placed the tablets in the person's mouth.

A visitor informed us that every time they visited the home their relative's finger nails were unclean. They said that they had raised concerns with staff but no action had been taken to address this. Prior to our inspection another relative contacted us to raise concerns about their relative's personal care needs not being met. We shared these concerns with the manager who assured us this would be addressed. At this inspection people told us that staff did support them with their personal care needs. People told us staff were kind and caring. One person said, "They look after us very well." One relative told us, "The staff are approachable and caring." We saw that one person was distressed and unsettled and a staff member provided them with reassurance. One person said when they first moved into the home they were anxious and upset and said, "The staff have been very good to me."

People told us they were not involved in planning their care but they were satisfied with the care they received. One person said if they didn't receive the support that suited them, "I would tell them and staff do listen to me." A visitor told us that they were involved in their relative's care planning because their relative was unable to tell staff how they would like to be cared for. The manager acknowledged that people's involvement was not reflected in their care plans but said that people were involved as much as possible.

Requires improvement

Is the service responsive?

Our findings

People did not have access to systems to enable them to share their concerns with the provider. A relative told us they were unaware of how to make a complaint but would speak to a staff member if they had any concerns. The manager told us that action would be taken to ensure people knew how to share their concerns. Prior to our inspection we had received a number of complaints about the care and support provided to people. We shared these concerns with the manager at the time so they could investigate the concerns and respond to them. At this inspection the operational director said they were unaware of these complaints. The complaints had not been recorded to show what action had been taken to resolve them or to improve the service where necessary. A relative said, "On the odd occasion the personal care has not been so good." They told us they had raised concerns with the manager and things had improved. Before our inspection one person contacted us to raise concerns about the lack of support provided to ensure their relative's personal care needs were met. The records we looked at showed that the manager had responded to this complaint. The operational director said that informal complaints would not be responded to in writing. Without a criteria to inform people what an informal or formal complaint was, this could lead to confusion.

People we spoke with told us they were happy with the support they had received. However, the records we looked at did not demonstrate how people had been involved in planning their own care and support. People were not always supported to pursue their individual hobbies and interests. One person said, "There's nothing to do but watch television." They told us, "I get up and then go back to bed and that is it." A visitor said, "I never see activities taking place, it's depressing watching them just sat there." One staff member said people had access to a variety of activities, such as making salt dough, puzzles and watching movies. We did not see any activities take place during our inspection. One staff member told us that activities did take place but they were infrequent. However, the provider had taken steps to find out what people's preferences were in relation to their hobbies and interests. The provider was also in the process of recruiting to the post of activity coordinator for the home. People told us they were able to maintain contact with people important to them. A visitor told us they were able to visit their relative at any time and we saw people visiting the home during the inspection.

Requires improvement

Is the service well-led?

Our findings

The manager was enthusiastic to improve the service and said they were aware of some of the shortfalls we had found. They told us they had developed an action plan to make improvements. However, the provider's quality assurance monitoring systems were not effective to identify the shortfalls we found or to ensure people received a safe and effective service. We looked at a monitoring audit that identified that the home was warm. However, it wasn't when we carried out the inspection. We acknowledged that the home was being refurbished but the provider did not have suitable arrangements in place to ensure sufficient heating would be provided so people would be warm and comfortable. We looked at a monitoring audit that showed the provider's complaint policy was in place but people were unaware of how to make a complaint. Appropriate arrangements were not in place to monitor that people received their prescribed treatment and this placed their health at risk. Monitoring systems were not effective to ensure staff received regular supervision to support them to provide a high standard of care.

One person told us they were unaware of who the manager was. However, another person was aware of who was running the home and said the manager was approachable. This was also confirmed by a visitor who said they would recommend the home. The home was run by a manager who was supported by the operational director. The manager had been in post since November 2015. The manager told us that had not submitted an application to be registered with the Commission but assured us this would be done. A staff member said, "The new manager has worked hard to improve the service." They told us, "We don't have any empty beds now and the staff turnover has dropped."

People were not involved in the running of the home. One person said that staff never asked for their views about the service they had received but they were happy with the service provided. We were unable to determine how people's views were obtained to ensure the service reflected their needs. We saw a comments book located in the corridor and this contained positive comments from visitors about the care provided to their relative. A staff member said people were not supported to maintain links with their local community. The manager also confirmed this but assured us this would be addressed. The manager said that monthly meetings were carried out with staff and this was confirmed by staff. One staff member said, "The manager is very good and does listen to us and act on things." For example, they requested a new bed for a person to ensure their comfort and safety and their request had been granted.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This is a breach of regulation 12, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. Medicines were not managed appropriately and people did not always receive their prescribed treatment.