Auckland Care Limited

Auckland House

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

About the service
Auckland House is a residential care home for people living with a learning disability, autistic spectrum disorder or mental health need. The service was a large home, bigger than most domestic style properties. The care home is registered to accommodate 8 people. There were 8 people living at Auckland House at the time of the inspection. The building design fitting into the residential area and the other large domestic homes of a similar size.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

Based on our review of the safe and well-led key questions the service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right Support: People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.
Right Care: People were at risk of harm because staff did not always have the information, they needed to support people safely. Medicines were not managed safely.
People did not receive consistent person-centred care that was empowering, of a high-quality and achieved good outcomes. Improvements were needed.
People had privacy for themselves and their visitors. The service was located so people could participate in the local community.

Right Culture: Ethos, values, attitudes and behaviours of leaders and care staff did not fully ensure people using services led confident, inclusive and empowered lives.

Leadership was poor, and the service was not always well-led. Governance systems were ineffective and did not identify the risks to the health, safety and well-being of people or actions for continuous improvements.

The provider did not have enough oversight of the service to ensure that it was being managed safely and that quality was maintained. Quality assurance processes had not identified all the concerns in the service and where they had, enough improvement had not taken place. Records were not always complete. People and stakeholders were not always given the opportunity to feedback about care or the wider service. This meant people did not always receive high-quality care.

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

Rating at last inspection
The last rating for this service was requires improvement (published 1 August 2019).

At our last inspection we recommended that the provider sought current guidance on the application of the Mental Capacity Act and medicines management. At this inspection we found the provider had not acted on these recommendations and improvements were still required.

Why we inspected
This inspection was prompted by a review of the information we held about this service.
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement and Recommendations
We have identified breaches in relation to risk management, medicines management, managing infection control, following the principles of the mental capacity act, recruitment of staff, good governance, failure to notify CQC of significant events and person-centred care at this inspection.

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 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 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 act 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 their 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.

Auckland House

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by 2 inspectors on site and a third inspector making telephone calls off site.

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

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

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 3 people who used the service and 2 relatives about their experience of the care provided. We looked at 4 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed. We spoke with 5 members of staff including the registered manager and care workers.

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 requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

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 Mental Capacity Act (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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At the last inspection we recommended the provider seeks advice and guidance from a reputable source on the application of the Mental Capacity Act (2005) and takes action to update their practice accordingly. At this inspection we found the provider was still not working within the principles of the MCA.

- Where people lacked capacity to consent to their care mental capacity assessments had been carried out however, we found no evidence to suggest best interest meetings had taken place. We spoke to the registered manager about this who told us they had not held any best interest meetings because these people had DoLS in place. Where mental capacity assessments have taken place and it has been decided the person lacks capacity a best interest meeting must take place in order to ensure any decisions made are in the persons best interest.
- Mental capacity assessments had taken place for all people even when capacity was not in question. The registered manager did not understand the mental capacity act or the processes they should follow.
- We spoke with staff who were not clear on the principles of the mental capacity act. A staff member told us, "I am aware of the act, I am not really sure." They also told us they had not heard of DoLS. Another staff member told us no-one at the home had a DoLS authorisation in place when in fact two people had DoLS authorisations in place.
- Staff had attended training on the MCA, this takes place every three years. The training appeared to have been ineffective.

Failure to act in accordance with the requirements of the Mental Capacity Act was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
At the last inspection the provider had not considered current guidance on supporting people to make informed decisions about the self-administration of medicines. We made a recommendation about this. At this inspection no-one was self-administering medicines, there was no evidence to demonstrate people were supported and assessed to consider this option. This is important to enable people to have as much independence, choice and control as possible in line with current best practice guidance.

● Medicines were not managed safely. Not all people who were prescribed 'as required' (PRN) medicines had a PRN protocol in place to guide staff when and how to use these medicines. For example, some people were prescribed variable doses of their medicine however, there was no guidance for staff to say how much should be given and why. This meant people were at risk of receiving the wrong dose of medicines for their needs.
● Topical creams were not managed safely, and MAR charts were not always signed to evidence if they had been administered. This meant there was a risk people were not having their topical creams administered or were at risk of it being administered too many times due to the lack of documentation.
● Some people had PRN protocols in place for medicines that were not on their MAR charts. If these medicines were prescribed there was a risk staff would not administer them and any administration would not be recorded.

The failure to have the proper and safe use of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The registered manager had a good system in place for ensuring regular oral medicines were counted and administered in line with prescriptions.

Assessing risk, safety monitoring and management
● The provider had failed to ensure the safety of people. Risks to people were not managed and mitigated effectively.
● Robust and detailed risk assessments were not always in place to provide guidance to staff on how to mitigate and manage the risks relating to people's needs. This meant we could not be assured people's needs were appropriately managed.
● When care plans and risk assessments were in place they had not been dated and signed by the author. A lot of the care plans and risk assessments appear to have been written in 2019 and 2020 judging by the dates staff signed to say they had read them. This meant if people's needs had changed records had not been updated which could put people at risk of receiving the wrong support and put them at risk of harm.
● A person had a positive behaviour support strategy document in place however, this was written by the intensive support team (IST) and staff at their previous home, dated January 2019. No changes had been made. This was reviewed in September 2022. Some support plans and risk assessments were last reviewed in 2021. This meant the information was not accurate or up to date and could put this people at risk of harm if staff did not know how to support them safely.
● There was a risk assessment in place guiding staff to wedge fire doors open. The registered manager told us they now had magnets on all fire doors linked to the fire alarm system however, this risk assessment had not been removed. There was a risk staff would follow this risk assessment and put people at risk of harm in the event of a fire.
● People had COVID risk assessment in place however, these had not been updated to consider the latest guidance.
● During the inspection we identified areas of the environment which could pose a risk of harm to the people living at Auckland House. Such as, broken furniture, items stored in carboard boxes on the floor, fire

risks, excessive electrical wires on the floor, holes in stair carpets and radiators which were scalding hot to touch. We spoke with the registered manager about these concerns., the registered manager was responsive however, had not identified most of these concerns themselves. This meant risks to people were not being identified and put people at significant risk of harm.

The failure to ensure people were provided with safe care and treatment and risks were assessed, monitored and mitigated was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● Infection control was not managed safely. We were not confident the practice in the service was in line with their policy and people were not always protected from risks of infection.

● The providers infection prevention and control policy was dated 29 September 2021 and did not include any reference to COVID-19. Following the inspection, the registered manager informed us they had a separate COVID-19 policy however, this was not provided.

● Bedrooms were unclean. We observed in peoples bedrooms several concerns such as open bin bags not in bins, one of which had a malodour, some bins without lids, items stored on floors making bedrooms difficult to clean, dirty bedding, stains and spillages on floors and carpets and water stains on some walls and ceilings, some of which had gone black.

● We spoke with the registered manager who told us people were supported once a week to clean their rooms however, this did not appear to have been effective. He also told us people were supported to wash their bedding weekly however, some of the sheets and bedding observed were very dirty and stained.

● Cleaning schedules had been ticked to say completed however, the cleanliness of the home did not corroborate this. Cleaning schedules were largely ineffective.

● Food cupboards contained 2 food packets which were 5 months past their best before date, one of which was opened, this did not have the opening date recorded on it and had not been sealed following being opened.

The failure to assess the risk of and prevent and control the risk of the spread of infection was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● PPE was available to staff and this was observed to be used appropriately.

Staffing and recruitment

● Recruitment practices were not robust, and staff were not always recruited safely.

● For example, gaps in the employment history of staff were not followed up to ensure there was a satisfactory written explanation for this. This meant the provider was not always able to consider whether the applicant's background impacted on their suitability to work with people who were vulnerable.

● References obtained for staff did not always include details of employment dates. This meant the provider was unable to check the dates provided by candidates matched those of their previous employer.

The failure to establish and operate recruitment procedures effectively was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● There were enough staff to support people's needs. People told us they thought there were enough staff.

● All staff had a DBS check in place. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Visiting in care homes

● There were 2 signs on the front doors advising visitors to only visit if really necessary and to ask management first. There was also guidance for visitors to wear masks. We spoke with the registered manager about this who told us he had forgotten to remove them. After prompting he did remove both signs.

● Relatives we spoke with told us they could visit when they wanted and no longer had to wear masks and do COVID-19 tests which was in line with current guidance.

Systems and processes to safeguard people from the risk of abuse

● People told us they did not always feel safe. Of the people spoken with 3 people told us they did not always feel safe and provided us with their reasons. We talked to the registered manager about their concerns. The registered manager was aware of some of these concerns and had put processes in place to reduce people's concerns.

● Relatives told us they thought their family members were safe and the staff did a good job.

● There were systems in place to report safeguarding incidents to the local authority safeguarding team however, these were not always notified to CQC. The registered manager told us he did not know they had to be notified to CQC. This meant CQC had been unable to effectively monitor the service.

● Staff had attended safeguarding training however, not all the staff we spoke with understood what safeguarding was or how to report concerns. For example, 1 staff member told us, "I have heard of safeguarding but do not know how to contact them or CQC," and a second staff member told us, "I haven't heard of the safeguarding team." All staff we spoke with did tell us they would report any concerns of abuse to their manager.

Learning lessons when things go wrong

● The provider has a history of not achieving the required standards. This is the second consecutive inspection where a rating of good has not been achieved in safe and well-led.

● When things went wrong, lessons were not always learnt to support improvement, and this was evident from our findings at this inspection and the previous inspection. This meant the service did not demonstrate learning, reflective practice and improvement.

● Although safeguarding events were recognised CQC had not always been notified. The registered manager was unable to demonstrate if accidents, incidents and safeguarding events were analysed to identify if any themes or trends were occurring. We could therefore not be assured if action would be taken to address any recurring 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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The service was not well managed.
- Some quality assurance systems were in place to assess and monitor the service. However, where they were in place, they were not effective and had failed to identify the concerns we found during the inspection. For example, systems and processes failed to identify care plans and risk assessments did not reflect people's current needs and did not contain all the necessary guidance for staff to support people safely. We have reported more about this in the safe key question of this report.
- The provider had an audit system in place. However, the process was ineffective at identifying concerns, when action was needed or evidencing if any action had been taken. Monthly medicine audits were in place but had failed to identify the significant concerns we found in the safe management of people's medicines as reported on in the safe key question of this report.
- There was no infection control audit in place, a monthly environment audit was completed however, had not picked up all the concerns we found during our inspection. For example, dirty bedrooms and bed linen, refuse bags without bins and unprotected radiators. You can read more about this in the safe domain of this report.
- There were no care plan or risk assessment audits, the management team did not have a robust oversight of care plans and risk assessments and had not picked up concerns we found during this inspection. We could not be assured people were receiving safe care and support in line with their assessed needs. The registered manager told us they were in the process of transferring all their documents onto an online system and as this was being done the care plans and risk assessments would be fully reviewed.

The failure to operate effective systems to assess, monitor and improve the service, was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Providers are required to act in an open and transparent way when people come to harm and to notify CQC of significant events without delay. The provider had failed to notify CQC of significant events that happened in the service as required by law. This included safeguarding concerns. For example, we identified from records, 3 occasions where a safeguarding alert had been raised with the local authority however, CQC had not been notified of these safeguarding concerns. This meant CQC were not able to effectively monitor the service or ensure appropriate action had been taken in relation to these incidents.
- We discussed the requirements of this regulation with the registered manager who told us he hadn't realised safeguarding concerns needed to be reported to CQC and said he would do this going forward. We

asked for retrospective notifications for these 3 incidents. These had not been received at the time of writing this report.

The failure to notify the Care Quality Commission of significant events was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People did not receive consistent person-centred care that was empowering, of a high-quality and achieved good outcomes. Improvements were needed. These have been reported in the safe domain of this report.

● Care plans did include person centred information; however, most were written approximately 2 years ago and had not been updated to reflect people's current needs.

● Some people spent a significant amount of time in their bedrooms which resulted in a lack of engagement. A staff member told us, "Some [People] stay in their bedroom 24 hours a day…It's been going on for some time so don't think it will change."

● There were no activity plans in place however, on the day of inspection one person had been supported to do their Christmas shopping which they told us they were very pleased about. One person told us they wanted to go out more. The registered manager told us they were aware people wanted to go out more however their funding did not allow for this.

● We asked staff if people had a choice of food and drink and how the menus were decided. A staff member told us, "No, people don't get asked…They do the menu on a Sunday, staff do it. People are not really involved on day to day decisions [around] food [choices] only breakfast they get asked." We spoke to people about food, 1 person told us, "[Food] is not so good…We only get pudding for Christmas." Another person talked about a food they don't like and told us they had been given that food on the day of inspection. They told us, "I didn't say anything." A third person told us they did make food choices and said, "We take turns to cook at teatime."

● One person had an end of life plan in place. It was detailed throughout the plan that the person did not participate however, the plan was fully completed. The registered manager was unable to say how the decisions were made for this person.

The failure to provide person centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Systems in place to enable people using the service to have the opportunity to give feedback, were not consistent or clear however, people we spoke with told us the registered manager was approachable and went out of his way to support them.

● Relatives were not always engaged and involved, and any feedback was not always followed up on. For example, relatives told us communication was not always effective and they were not kept fully informed. Relatives comments included, "There are no surveys or questionnaires, they stopped a long time ago. We do not have any meetings about our relative," and, "There have been no questionnaires for a long time and no meetings for a long time, sometimes they keep us updated." Relatives did tell us they could speak to the registered manager when needed and he was available and responsive. They also confirmed if something significant happened he would contact them to let them know.

● A staff member we spoke with told us they had not had supervision since they started working at Auckland House over 3 months ago. Another staff member told us, "Communication is horrible here sometimes."

However, staff felt they could receive support from the registered manager if needed.

We recommend the provider seeks current guidance and best practice on systems and processes for engaging people and seeking feedback and update their practice accordingly.

● We saw evidence of people being supported with their individual equality characteristics. The registered manager and staff worked in partnership with local GP's, community nurses and businesses within their local community.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had a duty of candour policy that required staff to act in an open and transparent way when accidents occurred.
● We did not see any evidence of duty of candour being followed however, relatives told us they were informed if something went wrong and the registered manager would apologise.
● We asked the registered manager for evidence of duty of candour being followed however, this was not received.

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 18 Registration Regulations 2009 Notifications of other incidents The failure to notify the Care Quality Commission of significant events was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The failure to notify the Care Quality Commission of significant events was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Failure to act in accordance with the requirements of the Mental Capacity Act was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The failure to establish and operate recruitment procedures effectively was a breach of Regulation 19 of the Health and Social Care Act 2—8 (Regulated Activities)

Regulations 2014

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to have the proper and safe use of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 The failure to ensure people were provided with safe care and treatment and risks were assessed, monitored and mitigated was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 The failure to assess the risk of and prevent and control the risk of the spread of infection was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We are planning to issue warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to operate effective systems to assess, monitor and improve the service, was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We plan to issue warning notice