Advinia Care Homes Limited

Arncliffe Court Care Home

Inspection report

147B Arncliffe Road
Halewood
Liverpool
Merseyside
L25 9QF

Tel: 01514866628

Date of inspection visit:
19 January 2021

Date of publication:
28 April 2021

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
Arncliffe Court Care home is a care home providing personal and nursing care to 97 people aged 65 and over at the time of the inspection. The service can support up to 150 people over five separate units each of which has separate adapted facilities. At the time of inspection four units were being used. Two of the units specialised in providing care to people living with dementia and one unit is specifically for nursing care.

People's experience of using this service and what we found
The majority of people we spoke with told us that they felt safe living in the home. However, we identified concerns in relation to people's safety and the leadership of the home.

The management of medicines was unsafe. People were placed at risk because they did not always receive their prescribed medicines due to them being out of stock. Staff had failed to report these omissions to managers and medication audits had failed to identify them.

Staff did not follow safe medication guidelines and infection prevention and control procedures despite evidence which showed they had completed training and had undertaken competency checks in both areas.

Checks carried out on the quality and safety of the service failed to identify a lack of effective planning and monitoring of people's care. Monitoring records were incomplete and did not always reflect the care people received or needed.

We identified that there was a lack of cohesive working and poor communication across the home. This led to risks not being recognised and mitigated.

Safe recruitment processes were in place, however these were not always followed by the provider. People we spoke with and relatives indicated there were issues regarding staffing levels. We saw that there was a high use of agency staff and that this had not had robust oversight. We also received feedback from families that communication with them was poor.

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 requires improvement (published 05 December 2019). At this inspection improvements had not been made and the service had deteriorated to inadequate.

Why we inspected
The inspection was prompted in part due to concerns received about care delivery and governance. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this full report.

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

The provider is taking action to mitigate the risks and is closely working with the local authority and others.

Ratings from previous comprehensive inspections for the key questions we did not inspect were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Arncliffe Court 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 medication, risk management and overall governance of the service at this inspection.

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

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our safe findings below.

Arncliffe Court 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 Care Act 2014.

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
This inspection was carried out by two inspectors, a medicines 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
Arncliffe Court 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.

The service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

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. 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.

During the inspection
We spoke with three people who used the service and seven relatives about their experience of the care provided. We spoke with five members of staff including the manager.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at six 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 reviewed. We spoke with one professional who regularly visit the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at recruitment information, policies, training data and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely; Systems and processes to safeguard people from the risk of abuse

- Medicines were not managed safely.
- A significant number of people living in the home had not received some of their prescribed medications over the six week period we looked at. The omissions of medication were because the items were not in stock. This had not been acted on by staff, and the management in home had not been made aware of this.
- The potential impact of not having these medications may reduce the effectiveness of the medicine, increase the risk of withdrawal symptoms or have a detrimental effect on people's mental or physical health.
- Medicines competency checks were provided by the manager but when questioned by the inspector, staff were unable to demonstrate that they knew how to use the system safely, how to order medicines when out of stock or how to use safeguarding procedures to report these failings.
- One person had medicines administered by a Percutaneous Endoscopic Gastrostomy (PEG) tube. The manager and staff had not obtained guidance from a pharmacist or doctor to guide them on how to administer medicines in a safe manner via the PEG. This may have increased the risk of the tube becoming blocked (preventing medicines being administered properly) or staff administering a medicine that is unsuitable for a PEG tube. Records showed staff were not following specialist fluid advice, which may have increased the risk of harm from either dehydration or over hydration.

Systems were either not in place or robust enough to demonstrate medicines were effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- People's needs and risks had not been properly identified and so staff did not have guidance on how to mitigate these risks in the delivery of care. For example, some people had a health condition (epilepsy) that had not been identified in risk assessments.
- The quality of risk assessments and reviews was inconsistent throughout the units of the home. One person's nutrition plan stated that they needed to be weighed weekly, however there was no evidence of weight monitoring since their admission two months previously.
- One person's records stated that the staff were to monitor diet and fluid intake, however no evidence was provided of this.
- Additionally, notes made by other professionals held at the back of one person's file stated the person had been tested as COVID-19 positive, this was not recorded anywhere else in the persons file and there was no care plan or risk assessment in place. This was also noted in other people's care files.

● Recording on people's health and wellbeing was not consistent throughout their care files. For example, one person had body maps that were clear and showed skin breakdown and subsequent healing, however there were body maps for other people that had no information other than the injury.

Systems were either not in place or robust enough to demonstrate risks were effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Regular health and safety checks of the environment had been completed. Service agreements and safety certificates were all in date.

Staffing and recruitment
● The manager told us that staff files had been audited, however records we reviewed during the inspection visit identified missing information that was required in line with safe recruitment processes.
● We saw that staff had added information to records after the inspection that explained gaps of employment. This indicates that the audits were not effective as the information was added retrospectively.
● The service had a high usage of agency staff, however there was no evidence to show the practice of agency staff had been closely monitored as required.
● During the inspection there appeared to be an appropriate number of staff on duty. However, feedback we received from some people and their relatives indicated that this was not always the case. One person told us "They're always understaffed. We can't do things. There aren't enough people [staff] to help me."

Preventing and controlling infection
● We were not assured that the provider was preventing visitors from catching and spreading infections. We identified infection control concerns regarding the COVID-19 pandemic.
● Staff failed to follow the safe procedures as set out by the provider in their COVID-19 contingency plan. When inspectors arrived at the reception area, they were told to take their own temperatures. Following the inspection, we were sent copies of risk assessments previously completed for visitors however, no one checked inspectors' temperatures or asked for the results. This indicated a lack of oversight of visitors to the home as inspectors arrived at two different times during the day.
● We were not assured staff were using personal protective equipment (PPE) effectively and safely. We observed staff with their masks under their chin's whist working on the units.
● We were told that staff had undergone training regarding infection prevention and control (IPC) and had had their competencies checked. However, practice observed during the inspection and in light of our findings we questioned the effectiveness of these.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

Learning lessons when things go wrong
● Due to the lack of records we could not be certain that mistakes that had happened had been identified and acted on. This meant there was no evidence to suggest that the service had taken any action to learn from incidents or mistakes.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- There had been a lack of consistency in the management of the service. The provider had employed a new manager who had been in post for a short period prior to the inspection, the home had had several managers over a two-year period.
- There had been a significant lack of leadership within Arncliffe Court Care Home and a lack of understanding about roles and responsibilities. There was a lack of scrutiny by the provider to ensure that their systems for assessing and monitoring the quality and safety of the service were implemented.
- The systems in place for checking on the quality and safety of the service was ineffective. Audits failed to identify the concerns highlighted on this inspection such as with medications, risk assessments, care plans and recruitment. This was highlighted to the manager during the inspection and to the provider following the inspection.
- Audits also failed to identify a lack of effective monitoring of people's care plans, risk assessments, nutrition and fluid charts.
- The oversight of infection control processes regarding the COVID-19 pandemic were not effective.
- There was a lack of communication between management and staff resulting in the concerns not being identified and appropriately actioned. For example, appropriate action was not taken in notifying the relevant agencies of allegations of abuse in relation to medication errors and omissions, this was due to the poor lines of communication.
- The findings of the inspection identified a lack of cohesive working across the home. We identified that there was some disconnect between the four units in the home concerning how each of the units work and also regarding staff knowledge.

We found systems were either not in place or robust enough to demonstrate the service was safely and effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) 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

- We identified throughout the inspection where information had not been passed on within the home.
- Due to the inadequate reporting systems we were not assured the provider had worked in partnership with other professionals.

● Care plans did not hold relevant information from external professionals such as a GPs or dietetic services to guide staff on how to provide people with safe and effective support in relation to their nutritional needs.

Continuous learning and improving care

● The lack of effective audits led to mistakes not being identified, therefore lessons were not learnt and improvements made.

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

● No official survey had been completed to gain people, relatives or staff views about the quality of care being provided. The new manager explained this had been delayed due to the pandemic.

● The feedback we received from people and their relatives was mixed. Comments included, "They're always understaffed. We can't do things. There aren't enough people [staff] to help me." We were also told that the communication was at times insufficient. We were told "They don't always keep me informed no" and "We have missed visits because they are so disorganised." However, we also received positive comments regarding some of the care received by people, for example "Yes, I feel safe apart from the COVID situation. The staff are nice."

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance We found systems were either not in place or robust enough to demonstrate the service was safely and effectively managed. This placed people at risk of harm.

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
Treatment of disease, disorder or injury	Systems were either not in place or robust enough to demonstrate medicines were effectively managed. This placed people at risk of harm. Systems were either not in place or robust enough to demonstrate risks were effectively managed. This placed people at risk of harm.

The enforcement action we took:

Condition imposed on provider registration