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?	**Inadequate**
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**

Summary of findings

Overall summary

About the service
Arden Grange Nursing and Residential Care Home is a residential care home providing personal and nursing care to 42 people aged 65 and over at the time of the inspection. The service can support up to 45 people across two wings of one purpose- built building. One of the wings specialises in providing care to people living with dementia.

People's experience of using this service and what we found
Since our previous inspection the quality and safety of the service provided for people had deteriorated. People's safety was not always effectively assessed and managed at the home; and there was a pattern of not always reporting events that would reasonably be thought to be a safeguarding concern to the local authority. The provider had not always had effective oversight of the safety of people living at the home.

The provider had not always ensured that new staff had robust checks of their previous conduct in health and social care; as they are required to do so. The administration of medication at the home was mostly safe. However, the guidance available for staff on how people receive their medication was not always up to date.

The services and equipment used in the building had been regularly checked for safety; and there were plans and systems in place to help keep people safe in the event of a fire. However, there were areas of the environment that needed attention to improve the safety and experience of people living at the home.

The home had very few points, or areas of interest for people and very few adaptations to help people find their way around. There was evidence that the lounges, in which some people spent a lot of time were not meeting people's needs and preferences.

We recommend the provider look at the environment of the home and how this met people's needs; including the storage of waste and the use of CCTV.

Each person had their needs assessed using a recognised model. This helped staff establish the level of support that each person needed. People were supported with their healthcare needs. When people had a particular health need, they had a care plan covering that health need which gave guidance for nurses and care staff.

Each person had an individualised care plan which was regularly reviewed, if appropriate with people's family members. We saw times when this method of care planning had helped staff to support people to achieve positive outcomes. We also saw times when care planning had not helped staff to provide responsive care and support.

We recommend the provider looked at how care planning and information was used to ensure that care

provided was responsive to people's needs and wishes.

We saw that people were consulted with and asked their opinions in day to day matters; if appropriate people's families were involved by the home to help support people to make decisions. People's family members told us that they felt involved and consulted with about the care of their relative. People were consulted about their likes, dislikes and preferences of food choices. The feedback was that people at the home liked the food provided.

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

For most of the time we saw kind, caring and respectful interactions between staff and people at the home; however, at other times staff seemed indifferent towards or unable to meet people's needs or wishes. We saw that people were usually treated with dignity and respect.

There were enough staff at the home to meet people's needs in a timely manner. Staff told us that they received training and support to help them be effective in their roles. The provider had a program of training and training refreshers. However, records still showed that there were gaps in the training provided to staff.

The provider had recently recruited two activity co-ordinators to help increase the responsiveness of the service in supporting people to engage in meaningful activities. They had recognised that this was an area that needed improving.

The providers assessing of the quality of the service provided had not been robust. The systems in place had not been effective in ensuring that the provider could assess, monitor and then use this information to improve the service. This had allowed the quality of the service to deteriorate.

During the inspection the provider, the area manager and newly appointed home manager were candid, open and keen to make improvements at the home. They were candid with staff members during a team meeting and they were immediately responsive to the concerns raised and recommendations made during our inspection.

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 good (published 17 March 2017).

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
At the inspection, we have identified breaches in relation to; safeguarding people from the risk of abuse, assessing and mitigating risks, fit and proper persons employed, governance of the service provided and failing to notify the CQC of events they had a legal responsibility to do so.

The provider immediately started to address many of these concerns.

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-Led findings below.	**Requires Improvement**

Arden Grange Nursing & Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. 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.

Inspection team
This inspection was completed by two inspectors.

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

The registered manager for the service had resigned prior to our inspection. There was a newly appointed home manager who during our inspection started the application process to register with the Care Quality Commission.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and Healthwatch. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our

inspections. We used all of this information to plan our inspection.

During the inspection
We spoke and interacted with eight people who used the service and three relatives about their experience of the care provided. We spoke with 13 members of staff including the provider, an area manager, an interim manager, the home manager, nurses, care staff, maintenance staff and the chef. 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.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at four staff files in relation to safe recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider about their response to the concerns raised during our inspection. We were also provided with additional information on staff training following our inspection of the home.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse

- People's safety was not always effectively assessed and managed at the home.
- There was a pattern of not always reporting events that would reasonably be thought to be a safeguarding concern to the local authority. This meant the local authority was not able to fully exercise their duty, to investigate safeguarding concerns and ensure people were safe.
- Information and knowledge about people was not always used, investigated or analysed to look for patterns that may highlight an area of concern about a person's safety.
- The systems in place had not always ensured that all reasonable actions had been taken to ensure that people were safe. Reviewing safeguarding investigations was not part of the providers assessment of the quality of the service provided at the home.

This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; learning lessons when things go wrong

- People had individualised risk assessments which were often scored to reflect the level of risk and these had been regularly reviewed. However, these risk assessments were not taking into account all available information. For example, information of concern on body map charts was not being addressed in the risk assessment process. The systems the nurse and area manager told us should ensure people were safe were not always being used. This meant that assessing and mitigating risk at the home had not always been effective.
- When medication errors had occurred, important actions to ensure people were safe had not always been taken in a timely manner. There had been no checks by senior staff to ensure these important actions had taken place.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The services and equipment used in the building had been regularly checked for safety. There were plans and systems in place to help keep people safe in the event of a fire, these had been regularly tested. There had been a fire safety audit on the building by an independent professional; progress was being made on implementing required improvements in the recommended timeframes.

Staffing and recruitment

- One of the checks providers are required to make before employing a person is their previous conduct in

health and social care roles; and why that employment ended. Usually this is done using references. This helps providers ensure that they make safe recruitment decisions.
● We checked four people's recruitment records and found that their conduct in previous social care roles had not been sufficiently explored; even when there was reason for concern.
● The area manager was not able to show us what information was held about one member of agency staff. This meant they could not be sure they were suitable to work at the home.

This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were enough staff at the home to meet people's needs in a timely manner. We saw that there was a good response to people's alert mats and call bells.

Using medicines safely
● The administration of medication at the home was mostly safe. However, the guidance available for staff on how people receive their medication was not always up to date. This meant that any unfamiliar staff may not administer medication in the best way.
● Checks to ensure that the administration of medication was safe had not been effective. There was nothing in place to check that staff had all necessary information on people's as and when required (PRN) medication and nothing to check that people received their medication in the right manner.

This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● There were areas of the homes environment that needed attention. For example, there were commercial bins which were very close to the kitchen, one of the lounges and one of the dinging areas. The bins could not be closed because they were over full. One member of staff told us, "They are like this nine times out of ten." The bins were emptied every two weeks and there was evidence they were attracting flies which were coming into the home.
● There was a plastic barrel containing used cooking oil outside the kitchen. Staff told us that it had been there since the deep fat fryer was removed in 2018.

We have recommended that the provider reviews how waste is stored at the home.

● The kitchen was clean and had been awarded by the local authority the highest rating of five for food safety.

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Adapting service, design, decoration to meet people's needs

- Areas of the home's décor and maintenance of the building looked in need of refurbishment. There were very few points, or areas of interest for people; and very few adaptations to help people find their way around the home.
- Each wing of the home had one lounge area; with chairs around the outside of the room. One of the lounges was a busy and noisy thoroughfare for the outside patio area. There was evidence that these lounges were not meeting people's needs and preferences.
- The outdoor space that people used had no points of interest and a very uneven lawn with tree stumps and raised grids that posed trip hazards for people. The outdoor patio was used as a smoking area, this looked uninviting with cigarette stumps, a bin bag and discarded gardening supplies and a broken lounge chair. Four industrial bins dominated the view from the window of one of the dining rooms.

We recommend the provider look at the environment of the home and how this met people's needs.

Staff support: induction, training, skills and experience

- Staff told us that they received training and support to help them be effective in their roles. The provider had a program of training and training refreshers and there had been a lot of training recently provided for staff. Nursing staff received additional clinical training and clinical supervision.
- However, records still showed that there were gaps in the training provided to staff; for example, only about 60% of staff had received training in dementia awareness or redirecting people and deescalating potentially risky situations. These are areas of care and support that the service specialises in.

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 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.

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

● Senior staff at the home had ensured that an application for a DoLS was in place for people who needed this legal protection. These were reviewed and conditions on them were met.
● When needed staff had worked within the principles of the MCA when supporting a person to make a decision or when a decision needed to be made on a person's behalf.
● However, in some cases this process was confused and the documents in people's care plans were not clear. For example, at times it was unclear in what capacity a person was making a decision or signing a document, and if that person had the legal right to do so. Also, on some best interest decision and mental capacity assessment documents it had not been identified what decision needed to be made.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Each person had their needs assessed when coming to the home using a recognised model. This helped staff at the home establish the level of support that each person needed.

Supporting people to eat and drink enough to maintain a balanced diet
● People were consulted about their likes, dislikes and preferences of food choices. The feedback was that people at the home liked the food provided.
● Each person had a nutritional care plan; people with poor food intake were encouraged to eat snacks in-between meals and people who did not drink enough fluids were encouraged to eat snacks containing a lot of fluids such as jellies and ice cream. We saw that some people were benefitting from this support and were gaining weight.

Staff working with other agencies to provide consistent, effective, timely care
● Staff at the home worked alongside and in co-operation with social workers and health professionals.
● One social worker praised the staff at the home and told us that they had been, "Brilliant and responsive in a difficult situation." They also told us that they had worked closely with them to help ensure a person remained as safe as possible and to receive the care and support that they needed.

Supporting people to live healthier lives, access healthcare services and support
● People were supported with their healthcare needs. Each person's care file had a record of referrals to and visits made by health professionals involved in their care. Nurses at the home worked alongside health professionals to help ensure that people were as healthy as possible.
● When people had a particular health need, they had a care plan covering that health need which gave guidance for nurses and care staff. We saw there was a daily handover and a staff regroup each day; during these meetings people with significant health needs were discussed and their care assessed.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- More attention needs to be given to people's meal time experience. Many people had their meals on trays, whilst in their chairs that they had spent the morning sitting in. Very few people used the dining room or sat at a table. The main meal of the day was not promoted as an enjoyable event or used as an opportunity to help people engage and interact. Also, because of how close people's chairs were together many times staff were standing over and had to lean across or in front of people to help them eat. The room had a very busy and distracting environment.
- For most of the time we saw kind, caring and respectful interactions between staff and people at the home; however, at other times staff seemed indifferent towards or unable to meet people's needs or wishes.
- One person's family member told us they felt their relative was well looked after. They said, "She's like a different person here; she's happy. We are really pleased with the home." Another person's family had written a thank you note for supporting them to celebrate their relative's birthday. They wrote, "It was lovely to walk into her room and see it decorated."

Supporting people to express their views and be involved in making decisions about their care

- We saw that people were consulted with and asked their opinions in day to day matters; if appropriate, people's families were involved by the home to help support people to make decisions.
- Staff were kind towards people, however at times they became task rather than person focused. For example, wiping a person's mouth without asking them whilst they were eating; and missing opportunities to engage with and dignify a person; for example, by giving out drinks without asking.

Respecting and promoting people's privacy, dignity and independence

- We saw that people were usually treated with dignity and respect. Staff respected people's privacy in their rooms and knocked before entering. People's private and confidential information was stored securely.
- There were some areas needing improvement. For example, one person had multiple signs relating to their care needs on the wall behind their bed in their bedroom, this looked undignified.
- The home had not set out the purpose for using CCTV and how these recordings will be used.

We recommend the provider looked at the guidance on what they need to consider when using CCTV in care homes.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Each person had an individualised care plan which was regularly reviewed, if appropriate with people's family members.
- The method of care planning used had, at times, helped staff to support people to achieve positive outcomes. However, this was not always the case and staff had not always provided responsive care and support. Information was often out-of-date contradictory and not being followed by staff.
- At times care plans did not provide appropriate guidance for staff and mentioned things like "diversion techniques" when a person was "agitated"; without highlighting what diversion works for this person or what they are likely to do when they are agitated.
- It was not clear how information gathered on charts impacted people's care planning. Some of the charts did not contain enough guidance for staff on what care people needed or what was important to record.

There was no evidence that people had suffered harm as staff were familiar with people's needs. However, people were at risk of receiving inappropriate care that did not meet their needs.

We recommend the provider looked at how care planning and information was used to ensure that care provided was responsive to people's needs and wishes.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- The provider had recently recruited two activity co-ordinators to help increase the responsiveness of the service in supporting people to engage in meaningful activities. They had started exploring with people what they may enjoy doing based upon their previous occupations.
- Some staff told us there had been a recent improvement in the opportunities made available for people to get involved with activities of interest to them. We saw a few people engaging playing dominos and were told that some people read and embroidered.
- However, during our inspection we saw limited life enriching interactions between staff and people.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- We saw that people were provided with information in both a printed format and relayed personally to

them on a one to one basis if required. We also saw that a pictorial method was used to help people with food choices.

Improving care quality in response to complaints or concerns

● The provider had a system in place for recording and responding to complaints.

End of life care and support

● If appropriate people had an end of life care plan in place. Care planning helped ensure that people received responsive end of life care that met their wishes. We saw written feedback from people's families that praised the care their relatives had received during the end of their life.

● Staff received training on how to be effective supporting a person at the end of their life. Some staff had recently refreshed this training; one staff member told us they felt more prepared and enjoyed the training.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The registered manager of the home had recently resigned after not working at the service for nine weeks. In that nine-week period the providers area manager, a manager from one of the providers other homes and the deputy manager had been providing oversight of the service. We saw that during these nine weeks some areas for improvement had been identified and improvements made.

- On the first day of our inspection the provider announced to staff that the deputy manager had been appointed as the home's manager.
- Most staff told us that there had been a poor culture amongst the staff team; they told us that they had felt intimidated and not able to speak. Feedback was that this had recently improved.
- This inspection showed that the use of the systems and the management of the home had not always enabled staff to provide the best possible care and support experience for people.

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

- The providers assessing of the quality of the service provided had not been robust. The systems in place had not been effective in ensuring that the provider could assess, monitor and then use this information to improve the service. This had allowed the quality of the service to deteriorate.
- Quality audits at the home were in part assessed as a percentage score. These audits had all scored very high in recent months and had not addressed the concerns and improvements required that this inspection highlighted.
- The area manager was still in the process of becoming aware and investigating areas of the home that required improvement.

This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 is required in law to ensure that specific events that happen at the home are reported to the Care Quality Commission. There were a number of times over the previous 12 months when they had failed

to do so.

This is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Continuous learning and improving care
● The inspection showed that the provider had not always used available information to learn and improve the quality of the service provided at the home.
● During the inspection the provider, the area manager and newly appointed home manager were candid, open and keen to make improvements. They were immediately responsive to the concerns raised and recommendations made during our inspection.
● Since our inspection, information sharing with the CQC and the local authority has improved. The provider has updated us on actions they have taken during and immediately after our inspection to help ensure that people's experiences had improved, and they were safe.
●The provider has five other homes that are rated good by the CQC and they have the capability and resources to address the concerns raised in this report.

Working in partnership with others
● The service worked in partnership with health and social care professionals. However, working in partnership with the local authority and the CQC was not always effective as appropriate information had not always been shared. This had recently improved.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● On the first day of our inspection the provider held a staff meeting providing updates on changes that have happened at the home and future plans. The provider took questions from staff and gave staff the information they required.
● People's family members told us that they felt involved and consulted with about the care of their relative.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not always ensured that statutory notifications had been provided to the CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The assessing and mitigating of risk at the home had not always been effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The systems in place had not always ensured that all reasonable actions had been taken to ensure that people were safe.

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 The providers assessing of the quality of the service provided had not been robust. The systems in place had not been effective in ensuring that the provider could assess, monitor and then use this information to improve the service. This had allowed the quality of the service to deteriorate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Applicant conduct in previous social care roles had not been sufficiently explored; even when there was reason for concern.