Whitelodge Alveley Limited

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

Arden Grange Nursing and Residential Care Home provides nursing and personal care for up to 45 people including people with dementia. At the time of the inspection there were 39 people using the service.
The home is an adapted building with all care provided on the ground floor. People have access to lounges, dining areas and accessible outdoor spaces. Bathrooms and toilets are situated near to all communal areas.

People's experience of using this service and what we found

Governance systems were ineffective at identifying and correcting failures at the home.

People could not be assured they would be cared for safely. People were not fully protected from the spread of infections. People were not protected from the risk of abuse from inappropriate and unauthorised restraint. People could not be assured that lessons would be learnt if things went wrong.

People did not have detailed care plans and risk assessments which meant staff may not have the information to support people safely. People were not supported in a timely manner at mealtimes meaning their meals could go cold. People could not be assured that action would be taken in response to concerns around food and fluid intake.

People could not be assured they would receive person centred support as care plans lacked detail about the people they were written for. People may not receive information in a format they understand.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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
This service was registered with us on 29 October 2021 and this is the first inspection.
The last rating for the service under the previous provider was requires improvement, published on 1 July 2021.

Why we inspected
We received concerns in relation to the use of restraint at the home. We decided to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive 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

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 monitor the service and will take further action if needed.

We have identified breaches in relation to regulation 9, person centred care, regulation 12, safe care and treatment and regulation 17, good governance 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 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 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
Three inspectors carried out the first day of the inspection. One inspector returned on the second day to complete the inspection.

Service and service type
Arden Grange Nursing and Residential Care Home 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. Arden Grange Nursing and Residential Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection the registered manager had been on extended leave and the provider advised us they would not be returning to their role.

Notice of inspection
The first day of the inspection was unannounced. However, we telephoned the provider from outside the home because of the risks associated with COVID-19. This was because we needed to know of the COVID-19 status in the home and discuss the infection, prevention and control measures in place. The second day was announced.

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 professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with nine members of staff including the nominated individual, the nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke to the acting manager, nurses, senior care assistant, care assistants and domestic staff. 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 four people's care records and medicines administration records. Quality monitoring systems and a variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated 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

- The provider's systems and processes in place did not fully protect people from the risk of abuse.
- During the inspection we found the provider had failed to assess the risks to people who may require restraint to protect themselves or others. There were no plans of care for staff to follow that identified ways of avoiding the use of restraint or what types of restraint could be safely used. This placed people at risk of having unnecessary or inappropriate restraint used.
- The provider failed to ensure staff completed accurate records of when restraint was used on people. This meant incidents of restraint were not always reviewed and opportunities to learn lessons to avoid reoccurrence were missed.

Systems had not been established to assess, monitor and mitigate risks of inappropriate or unnecessary restraint. This is a breach of regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff received training in safeguarding people from the risk of abuse. However, we found staff did not always recognise what abuse was.

Assessing risk, safety monitoring and management; preventing and controlling infection

- Risks to people were not fully assessed. During our inspection, we found risk assessments had either not been put into place or reviewed when needed. For example, one person had left the home unsupported which was a risk to them. The provider had failed to assess this risk or put any risk management into place for staff to follow.
- Fire safety at the home was not effectively managed. The homes fire risk assessment was 12 months overdue for review. The acting manager told us it had been arranged to be carried out a week before the inspection, but the assessor had been unable to attend. On the second day of the inspection we saw it had been carried out.
- The provider had failed to ensure delegated fire safety checks were undertaken as required. Records showed multiple gaps where important safety checks had not been completed.
- People and staff had not been given the opportunity to practise evacuating the home in an emergency. Records showed it had been over 12 months since the last evacuation drill. This placed people and staff at a higher risk of harm should an emergency occur resulting in the evacuation of the home.
- The providers systems to manage and minimise the risk of Legionella were not effective. We found shower heads were not being de-scaled as instructed by guidance from the Health and Safety Executive.
- We were not assured the provider was promoting safety through the layout and hygiene practices of the premises.

● During the first day of the inspection we did not see cleaning of the home taking place. Cleaning records were incomplete and showed some weeks cleaning had only taken place on two occasions. We saw areas of the home were visibly dirty with dust and cobwebs. We discussed this with the acting manager who investigated and advised us that the cleaner had been assigned to other duties in error and took action to ensure these areas were cleaned immediately.
● Systems in place to prevent the spread of infection were ineffective. For example, where people shared equipment such as hoists, we observed that staff did not clean these between different people's use of the hoist
● We were not assured that that the provider was preventing visitors from catching and spreading infections. Ineffective cleaning and maintenance meant that the spread of infection posed a risk to everyone at the home.

The failure of the provider to assess, monitor and manage risks and infection control at the home place people at an increased risk of harm. This is a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider was allowing visiting at the home in line with government guidance.

Learning lessons when things go wrong
● The provider was not identifying ways to make improvements to the service after adverse incidents to prevent re-occurrences.
● Although records of incidents were kept there was no evidence that lessons were learnt. For example, after a incident where inappropriate restraint was used, the provider failed to identify that there was no plan for staff to follow to avoid the use of restraint.

Staffing and recruitment
● The home had a high number of vacancies across its staff team. These voids were being filled by agency staff. The provider and manager told us about the difficulties they were experiencing in filling the vacancies and were trying new incentives to resolve this.
● Health professionals who visited people living at the home told us they felt the high use of agency staff impacted on people's care. For example, where healthcare professionals had asked staff to record important information for them, they found inconsistencies in the quality of this.
● We checked staff records to see whether appropriate checks were made to ensure they were of good character. We found the home was not obtaining full employment histories. We shared this with the provider and manager who said they would take immediate action to obtain them.

Using medicines safely
● People received their medicines as prescribed and were administered by trained staff. Protocols had been drawn up considering people's preference as to how and where they would like to have them administered.

● Where people were prescribed PRN (as required) medicines, guidance was in place for staff on when and how to administer these.
● Medicines administration records (MARS) were correctly completed with no gaps.
● Medicines were stored securely and at the right temperature and we evidence temperatures were checked regularly.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People's needs were assessed prior to moving into the home. This information was used to form the basis of their plan of care. However, care plans and risk assessments did not always reflect people's initial assessment information. Care plans lacked detail and did not provide staff with the information they needed to support people effectively or safely.
- For example, an initial assessment identified that a person could attempt to leave the home unsupervised which would place them at risk of harm. This was not recorded in their plan of care and there was no guidance for staff to follow to manage this risk.

Staff support: induction, training, skills and experience

- Staff completed a training programme to give them the knowledge and skills for their role. However, our findings showed numerous shortfalls in staff's knowledge and skills and some staff had not completed important training such as 'de-escalation' techniques for when people became anxious.
- The provider kept a record of staff training. However, they had not always assessed whether the training gave staff the knowledge and skills needed for their role.

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

- People did not always receive the support they needed from staff at mealtimes. We observed people requiring support were given hot food before staff had time to support them. This meant their meal became less appetising.
- Some people had an identified risk of malnutrition and / or dehydration. Records lacked detail of what a person had been offered or consumed making it difficult for staff to determine whether sufficient food or drink had been consumed or whether any concern should be shared.
- Where people required modified diets, we saw they were provided.
- The provider had employed the services of a dietician who maintained oversight of people's weights and diets and provided specialist input when required.

Staff working with other agencies to provide consistent, effective, timely care

- Communication with healthcare professionals that worked with the home was not always timely. For example, a healthcare professional told us that it had taken 11 hours on one occasion for a call to the home to be answered.
- We also received feedback that the information collected by staff to aid diagnosis and treatment was not consistent and that these inconsistencies extended to when referrals for external support were made.

● The home was visited by a local GP weekly and we saw evidence of their involvement in peoples care plans.

Adapting service, design, decoration to meet people's needs
● Signage and information at the care home had not taken account of peoples' different communication needs.
● All of the accommodation and communal facilities were on the ground floor of the property and there were gardens that were accessible.
● We saw that people were able to decorate their rooms to their personal taste.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
● The provider met the requirements of the MCA. MCA assessments had been carried out, where required, in relation to care provided which meant people's rights were protected.
● Where people lacked capacity to make certain decisions, best interest meetings had been held and the person, carers, family members and healthcare professionals had been consulted.
● Where a person living at the home had passed responsibility for making decision on their behalf to someone else, the home had ensured that correct legal paperwork was in place.
● We heard staff asking for people's consent throughout the inspection

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.

This is the first inspection for this newly registered service. This key question has been rated 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

- People were not always well treated or cared for in a compassionate way. For example, the provider had failed to develop plans of care for staff to follow when people became anxious or upset.
- Staff did not always demonstrate a caring approach toward people. Where we saw drinks and hot food placed in front of a person, staff did not communicate with the person or give them the support they needed.
- Some people were not well treated or supported at mealtimes as staff were placing drinks and meals in front of them when they were not ready to assist the person. These delays meant people could have cold food and drinks.
- The provider did not consistently demonstrate a caring approach as people's care and support needs had not always been considered or recorded in their plans of care.
- People's spiritual and cultural needs were respected, and we saw people were asked about this during their assessment and it was recorded in their care plans.

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

- People and their relatives were not supported to express their views or be involved in making decisions about their, or their loved one's care. For example, no meetings had been offered to people or relatives to share their views, ideas and suggestions on the service as a group.
- During our inspection we were informed 'feedback surveys' had been sent to people, but there were no results shared with us to review. This meant we could not be assured people, or their relatives were always invited to give feedback or that this was acted on.

Respecting and promoting people's privacy, dignity and independence

- The absence of information in accessible formats meant some people were not fully supported to make choices or decisions independently.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated 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

- People's plans of care did not contain important information about how staff should support them. For example, where people were likely to become anxious or upset, the care plan gave no information to staff as to how they could help the person to feel calmer.
- We found care plans were not always personalised and lacked the voice of the person they were written for. People's care plans did not demonstrate they had been involved in the planning or review of their care.
- People were not given the opportunity to express their preferences as to how their care was provided or how the home was run. This was because the provider did not involve them when planning the care.
- People's communication needs had not been considered when information was displayed around the home which took away their choice and control.

People could not be assured that their care would be person centred. This was a breach of regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We spoke to the provider and manager during the inspection about the care plans and they told us that they had identified the need for improvements and had employed somebody to assist the home in reviewing and updating the care plans.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The home was not meeting the Accessible Information Standard. Improvements were needed to the way the provider and staff presented information and communicated with people. For example, menu and activity information was not in a format accessible to people. Pictorial information had not been given consideration as an alternative to written words.
- We discussed this with the provider who showed us that they had the resources to provide pictorial menus and activity timetables but they had been stopped during redecoration of the home and it was an oversight that they had not been re-introduced and would be taking immediate steps to do so.

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

● People were not supported in activities and hobbies that met their needs.
● On the first day of the inspection we saw no activities taking place and we were told that this was due to there being no activity co-ordinator working that day. On the second day we saw people engaged in activities in the garden.
● We saw activity timetables in communal areas of the home. These showed only one activity planned per day and the range of activities was poor.
● 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. Our evidence showed us staff did not take opportunities to engage with people unless this was task orientated communication, such as asking if the person wanted a drink.

Improving care quality in response to complaints or concerns
● The provider had responded to concerns and complaints in a timely manner. Concerns had been raised by the local authority about the home and they told us the provider and manager were making improvements.
● The provider kept a log of complaints and recorded the response to them. We saw people were satisfied with the responses.

End of life care and support
● People or their friends and relatives had been consulted about what they wished for their end of life pathway and this was recorded in their care plan.

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.

This is the first inspection for this newly registered service. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The providers governance systems had failed to identify where improvements were needed.
- Quality checks on peoples' plans of care had failed to identify important information was missing and risk management was not always in place to inform staff how to keep people safe.
- The provider had failed to identify the home was not fully meeting the guidance for the control of the risk of Legionnaires disease.
- The provider's oversight had failed to ensure delegated tasks were completed as intended. For example, fire safety checks on equipment had not always been completed by staff.
- The provider had failed to ensure people were given the opportunity to be consulted and involved in the planning of their care.
- The provider had failed to identify aids for communication had not been re-introduced after decoration at the home which meant some people would not be able to independently make choices.
- The provider had failed to identify that people were not being protected from the risk of abuse because of the absence of risk assessments and plans of care on how to support people who became anxious or upset.

The providers governance and oversight of the service was not effective. This was a breach of regulation 17 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

- People were not engaged or involved in how their care was planned or delivered.
- Although the families had been given the opportunity to provide feedback about the care their relatives received at the home, this information had not been used to plan improvements. the manager was unaware of the outcome of the surveys and the results were not at the home.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Discussions with the acting manager demonstrated they understood their responsibilities under the duty of candour.

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 9 HSCA RA Regulations 2014 Person-centred care Care plans were not person centred. People were not given the opportunity to take part in planning their care. Information was not in accessible formats.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Lack of appropriate risk assessments and management plans for people where there is an identified risk. Lack of regular or appropriate checks to safety equipment and the environment – increased risk of fire and legionella Lack of regular cleaning – increased risk of the spread of infections. Lack of updated risk assessments – increased risk of harm.

The enforcement action we took:

Issued a warning notice

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 Lack of clear information around managing people when they become anxious or upset. This increased the risk of inappropriate restraint causing injury or further upset.

The enforcement action we took:

Issued a warning notice

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 Failure to ensure effective governance of the service to ensure safe care and treatment. Failure to take effective and timely action when governance systems did identify issues

The enforcement action we took:

Issued a warning notice.