Abbey Healthcare (Aaron Court) Limited

Aaron Court

Inspection report

17 Ramsey Way
Leicester
Leicestershire
LE5 1SJ

Tel: 01162415552
Website: www.abbeyhealthcare.org.uk

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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
Aaron Court is a care home providing personal and nursing care to up to 91 people in one adapted building, across four floors, each of which has separate adapted facilities. Some people were also living with dementia. On day one of our inspection 85 people were using the service and on day two, 84 people were using the service.

People's experience of using this service and what we found
Risks associated with people's individual care and treatment needs had either not been assessed, or risk plans were insufficiently detailed or not followed. A new electronic system had been introduced in December 2021. Not all staff had received training, and information had not all migrated from the previous electronic system. Following the inspection, the provider forwarded details of training key staff had received. Staff were using a combination of records; the new electronic and previous electronic system and paper records. This increased the risk of people not receiving the care and treatment they required.

People's prescribed medicines were not consistently managed safely. This included the administration, ordering, storage and recording of medicines.

The service was not consistently clean and hygienic. Infection prevention and control practice was not consistently followed, increasing the risk of infection and cross contamination. Personal protective equipment, including hand sanitiser, had not been replenished when required. Kitchenettes were found to be dirty.

Health and safety checks on the environment were not sufficiently robust and put people at risk of fire or injury. Combustible items were found in a stairwell. Action was not taken to remove a trip hazard in a timely manner resulting in near misses.

Staff deployment did not consider staff skill mix, experience and competency. The largest and most complex unit had the greatest amount of agency staff. Observations of staff engagement with people was not consistently good.

Staff recruitment procedures were not sufficiently robust. Shortfalls were identified in risk management, employment and reference checks. Interview procedures had not been consistently completed.

Incident management procedures were not consistently followed. Complaint investigations completed were not readily available, to understand how outcomes and decisions had been made. Concerns received were not logged to track for themes and patterns to help develop the service.

The provider's systems and processes to assess, monitor and mitigate risks were not sufficiently robust. Staff communication, oversight, accountability and leadership required improvements to ensure people received

the care and treatment they required.

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 comprehensive rating inspection for this service was Good (published 25 September 2019).

Why we inspected
We received concerns in relation to staff deployment and people receiving poor care and treatment. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from Good to Inadequate based on the findings of this inspection.

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.

Enforcement and Recommendations
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 safe care and treatment, staffing, governance and recruitment procedures.

Following our inspection, we issued a Letter of Intent to the provider in relation to urgent and extreme risks we identified during the inspection. We reviewed their response and were sufficiently assured the provider had taken immediate actions to mitigate those risks.

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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
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 well-led findings below.

Aaron Court

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 included checking the provider was meeting COVID-19 vaccination requirements. 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 undertaken by three inspectors, a specialist nurse advisor and an Expert by Experience. The specialist nurse advisor had experience of working and caring for people who required nursing care. The Expert by Experience had personal experience of caring for someone living with dementia.

Service and service type
Aaron Court is a 'care home' with nursing. 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. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we had about the service. This included statutory notifications received. A notification is information about important events the service is required to send us by law. 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.

We sought feedback from the local authority and professionals who work with the service, including the Fire and Rescue Service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection and make judgements in this report.

During the inspection
We spoke with 10 people who used the service, four relatives and a person's friend about their experience of the care provided. We completed observations of staff engagement with people using the service. We spoke with the registered manager, assistant manager, operations regional director, the clinical lead, two nurses, one senior care worker, four care workers, one domestic, the house-keeper and two maintenance staff members.

We reviewed a range of records. This included twelve people's care records and multiple medication records. We looked at eight staff files in relation to recruitment. A variety of records relating to the management of the service, including staff allocation, staff handover, accidents and incident records analysis and complaints.

After the inspection
We continued to seek clarification from the provider to validate evidence found. This included but was not limited to the provider's training data, policies and procedures and meeting 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 our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● People's individual care and treatment needs had not been fully assessed, or guidance for staff was insufficient in detail, missing or not followed by staff. This included a person who was at risk of choking. Recommendations made by a speech and language therapist of the modified diet they required was not recorded. Agency staff were frequently used at the service and new staff were being recruited. Up to date written care records and risk assessments, were essential in maintaining people's safety.

● A person's mobility care plan stated they were at high risk of falls. However, guidance for staff in the support required was contradictory. One part of the risk assessment stated one staff was required, whereby another part said two staff. A person who was at high risk of developing pressure sores repositioning chart, showed they were not repositioned at the frequency they had been assessed as required. These examples demonstrate people were put at increased risk of not having their needs met safely.

● Health and safety risks put people at increased risk of harm. Combustible items were found in a lower ground floor stairwell. Cigarette butts were found outside near an oxygen cylinder. A trip hazard causing near misses was passed 64 times by staff before it was removed. Two communal bathrooms were unlocked and used for storing wheelchairs and other equipment, despite notices on the doors stating not to be used as a storeroom. These hazards posed a significant risk to people and had not been identified by the daily health and safety checks completed.

● Personal emergency evacuation procedures (PEEP) were not on the electronic care record system. The Registered Manager advised this information was stored in the emergency 'Red Bag' on entry to the service, and said this information was being updated. Following our inspection, the provider forwarded confirmation of when the PEEP records were reviewed and updated. Up to date information is essential to ensure should people be required to evacuate, staff and the fire and rescue service had the information they required.

Using medicines safely

● Medicines were not managed safely. Handwritten Medication Administration Record (MAR) were not consistently signed by two staff. This is important to ensure accurate transcribing. The administration of as and when required, 'PRN' medication had not been consistently recorded on the back of the MAR, the reason for administration. This is important to monitor the use of PRN.

● The administration record of a controlled drug for one person, had not been signed by a second staff member to confirm they had witnessed the administration to ensure this was completed safely. Pain relieving patches were not consistently checked to ensure they remained in situ. This was important as some people were living with dementia and were unable to express pain. MAR and care plans did not provide staff with consistent and sufficient guidance on the safe administration of medicines or followed correctly. For example, a person who required their blood glucose levels checking pre meals, had this completed post meal on eight occasions. This was incorrect practice and increased the risk of harm.

● MAR for seven people were found to have missing staff signatures. We were therefore not assured people

had received their prescribed medicines. We saw examples of when people had not received their prescribed medicines due to it being out of stock. This showed a lack of oversight and organisation and put people at increased risk.

Preventing and controlling infection
● Poor infection prevention and control practice put people at increased risk of infection. On day one of our inspection, we were advised by the Registered Manager there was a suspected Diarrhoea and Vomiting (D&V) infection outbreak on the First Floor Unit. Staff were observed not to be using full personal protective equipment (PPE) when supporting people despite signs saying they should.
● Staff were observed not to consistently follow national guidance in the wearing of face masks. We observed four staff on several occasions wearing the mask under their chin and below their nose. This meant the PPE was not fully effective and there was a risk infection could be more transmissible. PPE dispensers and hand sanitiser containers across all four floors had not been consistently replenished.
● The service was not consistently clean and hygienic. We did not observe regular cleaning of touch points throughout the home during either of our visits. This was despite the suspected D&V infection outbreak and ongoing risk of COVID-19. Kitchenettes on units were found to be dirty including examples of cereal boxes in open containers and milk left on the side uncovered. This placed service users at increased risk of acquiring infections and ill health.

The failure to ensure people's individual care needs, the administration of medicines and infection and prevention control measures were effectively managed increased the risk of harm. This was a breach of Regulation 12 (Safe care and treatment) (Regulated Activities) Regulations 2014.

Visiting in care homes □
● The provider was following national visiting guidance and supporting people to receive visitors and maintain contact with friends and family.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.

The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

● Feedback from people who used the service and relatives, told us people were positive their bedrooms were kept clean and hygienic. Comments included, "Yes, it's clean enough for me."

Staffing and recruitment
● Staff deployment did not adequately consider staff skill mix, experience, and competency. There was a lack of management oversight of how staff were deployed.
● We identified significant concerns in relation to staff deployment on the First Floor Unit. This unit was the largest, and for people with the greatest and complex level of care and treatment needs. There was high use of agency staff used at the service of which the majority were deployed to the First Floor Unit. Agency staff did not all have access to the electronic care records and staff communication, oversight and leadership were poor, increasing the risk of people not receiving safe and consistent care and treatment. Following the inspection, the provider forwarded us information to advise agency staff received training and had access to the electronic system.

● Feedback from people and relatives raised concerns about staffing levels and competency. Comments included, "There is not enough staff, they have to rush when they are busy." Another person said, "Agency staff are not experienced, you have to tell them what to do." A relative said, "I have walked up and down the corridor looking for staff, sometimes there's no one around."
● We observed concerns in relation to staff's care and approach that demonstrated a lack of staff competency and understanding in caring for people living with dementia. For example, we saw two staff on separate occasions lead a person living with dementia briskly down the corridor. One staff member grabbed the persons wrist, and neither communicated or offered a leading hand to guide or support the person.

The failure to ensure staff deployment was sufficient in meeting people's needs and safety placed people at increased risk of harm. This was a breach of Regulation 18 (Staffing) (Regulated Activities) Regulations 2014.

● Staff recruitment procedures were not sufficiently robust or completed. The provider's recruitment policy did not include any reference to the expected frequency DBS checks. 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. Where staff had a criminal conviction on their DBS, a risk assessment had not been completed.
● Staff recruitment files showed examples of missing interview notes, gaps in employment history, lack of suitable reference checks, and checks on staff's residency rights.
● Where staff had a health-related need, a risk assessment had not been completed to support the staff in their role.

The failure to ensure recruitment procedures were robust and adhered to, put people at increased risk of harm. The provider had also failed to support staff with reasonable adjustments in relation to health needs that may have impacted on their work. This is a breach of Regulation 19 (Fit and proper persons employed) (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● At the time of our inspection, we aware of ongoing safeguarding investigations being completed by external agencies. We will monitor these.
● The procedure for staff to complete accident and incident reports were not consistently completed in a timely manner. For example, a person's daily notes recorded a fall whereby the person sustained an injury. Another incident involved a person living with dementia entering an unlocked room that stored electronic equipment. Incident reports had not been completed. This meant no action had been taken to consider actions required to mitigate reoccurrence and risks.
● Bedroom sensor monitoring was used to monitor some people at risk of falls. However, the position of the monitor meant it was incorrectly placed for people in a low bed position. One person had received an injury because the sensor had not activated due to the position it was in.
● Incidents were analysed monthly by the registered manager for themes, patterns and required actions to mitigate further risk. However, this was not fully effective. For example, a safeguarding incident that occurred between two people resulted in a person having additional monitoring for their safety and others. However, staff were not completing checks at the frequency expected.
● Staff had received safeguarding training and were aware of their responsibilities to protect people from risks and avoidable harm. However, there was a lack of staff communication and accountability and this impacted on people's safety.

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 Good. 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;

- The concerns and breaches to regulation identified during this inspection had not been identified by the provider. This is despite the Registered Manager and maintenance team daily walk around checking health and safety and hygiene and cleanliness of the service. This meant risks relating to the health, safety and welfare of people and others were not identified or mitigated.
- The current electronic care record system used, replaced a previous electronic care records system in December 2021. This was ineffective. Staff had not received training on the new system before it was implemented. Staff were using both electronic systems and paper records. Many care plans and risk assessments had not migrated over from the old electronic system and there was no clear timescale for this to be completed. This put people at increased risk of staff not fully knowing their current care and treatment needs.
- Frequent gaps were found in people's additional records that monitored care delivery such as repositioning, food and fluid and personal care. There was a lack of staff accountability and management oversight, to ensure people received care and treatment to meet their individual needs and safety. This increased the risk of harm and receiving consistent care and treatment.
- The provider's policies in relation to recruitment, the use of CCTV and accident and incident were found to be insufficiently detailed, robust or followed. The provider's CCTV policy required an Impact Assessment being completed; however, one had not been done. These examples increased the risk of people not receiving safe care and treatment.

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; Continuous learning and improving care

- Complaint management and oversight were ineffective. Complaints had been investigated and closed. However, there was no evidence of the investigation actions to show how the investigation had been conducted and the outcome reached. The Registered Manager told us they had not recorded concerns raised but assured us they had acted on any concerns received and these had been resolved. This lack of openness and transparency impacted on any leaning and the ability to monitor for any themes and patterns to concerns and complaints received.
- Incidents were analysed monthly by the Registered Manager for themes, patterns and required actions to mitigate further risk. However, this was not fully effective. For example, a safeguarding incident that occurred between two people resulted in a person having additional monitoring for their safety and others. However, staff were not completing checks at the frequency expected. Staff advised that this was not

allocated to a named staff member and staff completed the checks when they could. Neither was it clear from both person's care records and risk assessments of the actions taken to reduce further risks.
● Action was not consistently taken to reduce incidents from reoccurring. There was an ongoing external investigation involving agency staff. Whilst the Registered Manager said the learning from this was to ensure agency staff were paired with a permanent staff member, there was no evidence of this happening. These examples show a lack of management oversight and leadership.

Working in partnership with others
● Recommendations by external health care professionals were not always recorded in people's care plans and risk assessments. For example, a person's nutritional and hydration care plan dated 1 December 2021 recorded they had a normal food and fluid diet. However, a Speech and Language Therapy (SLT) letter dated February 2022, reference the person's last SLT assessment dated July 2021 where recommendations had been made about the person receiving a specific modified food and fluid diet to reduce the risk of choking. Care records did not reflect this and put the person at risk of harm.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People had not received consistent effective and safe care and treatment to support them to achieve positive outcomes. There were no opportunities of activities, stimulation and occupation for people. The Registered Manager told us they were in the process of recruiting a new occupational therapist and activity staff.
● Poor staff communication, accountability and management oversight and leadership increased the risk of people not receiving the care and treatment they required.
● People's care plans lacked personalised and detailed guidance to support staff to provide person centred care. The new electronic care planning system was not supportive or accessed by all staff,

A failure to effectively and consistently assess, monitor and mitigate risks, and to maintain contemporaneous care records placed people at increased risk. This was a breach of Regulation 17 (Good governance) Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had a quality assurance procedure to seek feedback from people, relatives and others about their experience of the service. However, the management were unable to advise when the last survey was completed but told us they had plans to address this.
● People who used the service and relatives could not remember being invited to give feedback about their experience of the service. Whilst some people told us they did not know who the Registered Manager was, others did. Some people told us when they had raised issues and concerns they had been resolved. In the main people felt confident if they needed to make a complaint it would be responded to.
● The Registered Manager told us they held various meeting, this included regular heads of department meetings and staff meetings. Records confirmed what we were told.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed A failure to have robust and effective recruitment procedures increased the risk to people. Regulation 19 (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The failure to ensure staff deployment and staff skill mix, experience and competency was sufficient in meeting people's needs and safety placed people at increased 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 The failure to ensure people's individual care needs, the administration of medicines and infection and prevention control measures were effectively managed increased the risk of harm. Regulation (1) (2) (a) (b) (g) (h)

The enforcement action we took:

Warning Notice Served on the Registered Manger and Provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance A failure to effectively and consistently assess, monitor and mitigate risks, a lack of management oversight and leadership and a lack of accurate and complete records in respect of people's needs placed people at increased risk. Regulation 17 (1) (2) (a) (b) (c)

The enforcement action we took:

Warning Notice Served on the Registered Manger and Provider