Abbey Healthcare (Aaron Court) Limited

Aaron Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

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. The building is across four floors, each of which has separate adapted facilities. The service supported people with mental and physical health needs. At the time of our inspection, 80 people were using the service.

People's experience of using this service and what we found
Staff did not always have sufficient care plan guidance in place to meet people's needs. However, staff knew how to meet people's basic needs as they had worked with them for a while. Medicines were not always managed safely. There were enough staff, and staff were safely recruited. The service used agency staff as they had found it difficult to recruit permanent staff. However, these agency staff were booked on longer term contracts and deployed effectively around the home. Staff did not always record incidents that occurred. However, incidents that were recorded resulted in clear lessons being learnt and improvement made.

People were not always supported to have maximum choice and control of their lives as the mental capacity act was not always followed. The policies and systems in the service did not support good quality mental capacity practice. We have made a recommendation that the provider improves mental capacity record keeping, so staff have suitable guidance available on the administration of covert medicines . Staff were mostly well trained, but further training was needed for all staff to understand complex health conditions. National standards were not always met. There was good quality working with external health and social care professionals. The service was adapted to meet people's needs.

Improvements had been made to the service since the last inspection. However, the management team had not yet resolved all concerns. People, staff, relatives and visiting professionals spoke highly of the service.

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

Rating at last inspection and update
The last rating for this service was inadequate (Published 18 March 2022)

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider had made some improvements but remained in breach of some regulations.

This service has been in Special Measures since 18 March 2022. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We carried out an unannounced inspection of this service on 7 and 8 February 2022. We found breaches of regulation in relation to safe care and treatment, staffing, governance and recruitment. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. The inspection was planned to inspect the key questions Safe and Well Led. However, as we identified concerns with the application of the Mental Capacity Act, we made the decision on the day of the inspection to widen the scope of our inspection. We therefore also reviewed the key question of Effective.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.
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 Inadequate to requires improvement, based on the findings of this inspection.

While the provider has improved, we have found evidence that the provider needs to make further improvements. Please see the safe, effective 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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Aaron Court on our website at www.cqc.org.uk.

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, consent and good governance.
Please see the action we have told the provider to take at the end of this report.

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?

Requires Improvement

The service was not always safe.
Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.
Details are in our effective findings below

Is the service well-led?

Requires Improvement

The service was not always 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 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 completed by two inspectors

Service and service type
Aaron Court 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. Aaron Court 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 there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

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

During the inspection
During the inspection, we spoke with six people who used the service, and three relatives about their experience of the care provided. 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 completed observations of staff engagement with people using the service. We spoke with the registered manager, assistant manager, director, three nurses and five care staff members. We also spoke with four visiting health professionals. We reviewed a range of records. This included eleven people's care records and multiple medication records. We looked at three staff files in relation to recruitment. We also reviewed a variety of records relating to the management of the service, including staff rotas, incident records, audits and complaints.

Requires Improvement

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 inadequate. At this inspection the rating has changed to requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely
At our last inspection the provider had failed to ensure people's medicines were always safely managed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12 for medicine management.

- At the last inspection, staff did not always record that prescription pain relieving skin patches had been checked as still being in place. This risks the patch medicine coming off the person's skin and this removal not being recognised in a timely way. This removal of the patch would impact the person's access to their pain relief. At this inspection these recording concerns were ongoing.
- We observed a staff member give a person an insulin injection. The used needle was then carried through the service on a tray to be disposed of in the medicine room. This is a risk, as the used needle could cause injury to someone during the journey. We discussed this concern with the registered manager who took quick action to investigate whether a safer disposal option at the point of use could be considered.
- When people with diabetes experienced low blood sugar, they needed 'as needed glucose' to bring their sugar levels up to a safe level. There was not always clear guidance for when to recheck their blood sugar levels after having this glucose administered. We raised this with the registered manager who explained action would be taken to improve this recording.

Staff did not always record that they had checked the location of pain patches. Staff did not have a safe place to dispose of needles in a timely way. Staff did not have clear guidance on when to recheck blood glucose levels. This poor management of medicines, placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had guidance on when to administer 'as needed' medicines. They recorded when this 'as needed' medicine was given to people.
- People were supported to take their prescribed medicines by staff who had received the necessary training to do this. Staff spoken to during the inspection had good knowledge of people's medication needs.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to ensure people had clear care plans in place to guide staff. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12 for poor care planning.

● Care plans did not always provide good quality guidance on people's physical health needs. For example, there was contradictory details on a person's diabetic health diagnosis within the care plan. This contradictory guidance risks staff not understanding the person's health need. There was also a person with a serious pressure related skin wound. This wound was not described in the care plan, nor was there guidance on how to care for it.
● Care plans did not always provide guidance on how to support people's mental health needs. For example, staff explained that one person was known to become agitated during personal care tasks and could become aggressive towards staff providing this care. This care need, and how best to support, was not in the person's care plan to guide staff.
● While care plans provided poor-quality guidance, staff had good knowledge of people's care needs and were observed to provide skilled care. Relative's told us that staff knew people very well and responded effectively to people's care needs. This is an improvement on the last inspection. However, this poor care planning would still impact the ability for new care staff to provide safe care as they would not have developed this longer term understanding of the person's needs. It could also impact visiting professionals, who may use these care plans to understand a person's needs.
Systems were not in place to ensure care plans were of good quality. This place people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection, we gave the registered manager examples of care plans that needed improvement. Quick and effective action was taken to improve the care plans that we listed. We will review the effectiveness of improving all care plans at our next inspection.
● There were clear processes in place to support people to evacuate in an emergency. This is an improvement on the last inspection.
●The provider had recently started using an electronic alert system for people's individual care needs. For example, if a person had not drank enough this was flagged electronically to the registered manager. This up to date information was used in daily meetings to respond to risk and improve the safety of care.

Preventing and controlling infection
At our last inspection the provider had failed to ensure people were safe from the spread of infection. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● We observed several staff wearing masks below their nose or chin. This meant the personal protective equipment (PPE) was not fully effective and there was an increased risk of infection transmission.
●At the last inspection the service was not consistently clean and hygienic. At this inspection the service was cleaner. However, there were still issues with the standard of cleanliness in the communal kitchenettes. Open dates were not always written on perishable food, risking the food going out of date and still being used. Bins did not always have lids on, and one bin had a broken foot pedal where a staff member was observed lifting the bin lid after hand washing. We reported this to the registered manager, who took quick action to resolve these concerns.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider was responding effectively to risks and signs of infection.

Visiting in care homes

The provider's approach to visitors in the care home, aligned with government guidance.

Staffing and recruitment
At our last inspection the provider had failed to ensure there were enough, skilled staff suitably deployed around the building. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● People told us that there were enough staff and that staff attended quickly if their emergency buzzer was pressed.
● We saw there were enough staff to meet the needs of people living at the service. When people became emotionally upset, staff were around to notice this and respond quickly.
● Agency staff were used at the service. However, the agency staff were effectively deployed around the service to ensure they had permanent staff to support them as needed. Rotas demonstrated these agency staff were usually arranged on long term bookings. This meant these agency staff were used repeatedly, allowing some consistency for the people at the service.
● The agency staff spoken to, had good knowledge of the people they supported.
● The registered manager was working hard to recruit a more permanent staff team.

At our last inspection the provider had failed to ensure staff were safely recruited. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

● Staff were safely recruited. We reviewed three staff recruitment files and found appropriate checks such as Disclosure and Barring Service (DBS) had been completed prior to staff starting. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Learning lessons when things go wrong
● Accident and incident reports were not consistently completed by staff. A staff member told us her top was "grabbed and pulled" by a resident during personal care. Another staff member told us "[person] punched me in mouth a few weeks ago." These incidents had not been recorded in accident forms and the people's care plans had not been updated. The poor recording of incidents can impact lessons being learnt.
● Where staff had recorded an incident as occurring, the management team had acted to improve the person's safety. For example, after a person had fallen over, a motion sensor had been put in place. This motion sensor allowed staff to respond quickly in future if the person was identified as moving within their bedroom.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe at the service.
● Staff had received safeguarding training and demonstrated a clear understanding of how to identify if a person may be at risk of harm or abuse and how to report their concerns.
● Staff told us they felt confident that the management team would respond appropriately to any concerns. Staff were also confident in whistleblowing outside of the organisation if they felt the management team did not act on concerns raised.

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

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.

● Care plans described that some people 'lacked capacity' and that 'capacity assessments were needed'. These mental capacity assessments had not always been completed. The mental capacity act determines people's capacity should be established with a fully completed capacity assessment – and it should not be assumed that they cannot make decisions. It is poor practice to describe someone as lacking capacity without this assessment being done, as was done at this service.
● Without people's decision-making abilities being assessed, restrictions had been imposed on their daily freedom. For example, one person had hourly night-time checks to monitor their movement, and two types of motion sensor to alert staff if they moved. This imposed restriction on the person's freedom of movement, had not had a related mental capacity assessment.
● Staff described that one person repeatedly declined staff support with personal care. However, staff would continue to offer this support in the person's best interest. The person's mental ability to make this choice to decline care, had not been capacity assessed. Staff had no care plan guidance on how to respond if this person did not consent to care being given.
● Multiple people at the service had their medicines covertly hidden in their food and drink. The registered manager described that the prescriber of this medicine had completed a mental capacity which ascertained these people could not make decisions about their medicines, and this hidden administration was appropriate. The details of this mental capacity assessment, and details of how to complete the task in the person's best interest were not recorded at the service.

We have made a recommendation that the provider improves this record keeping so staff have suitable

guidance available on the administration of covert medicines. We have received evidence that this information gathering has started since our inspection. We will review this implementation when we next inspect the service.

Effective systems were not in place, to ensure all people had their mental capacity assessed before staff began making decisions for them. This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Appropriate legal authorisations were in place when needed, to deprive a person of their liberty. Any conditions relating to those authorisations were being met.

●Staff did have good knowledge of the principles of the mental capacity act. Staff were also seen asking people for consent when completing daily tasks (for example, asking consent when helping a person remove a piece of clothing).

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The National Institute of Clinical Guidance (NICE) recommends that care homes should have care plans, to guide staff on how to meet people's certain health conditions. The service had not followed this guidance as health sections of care plans were not good quality. This has been described in the Safe section of the report.
● While care plans did not always give clear guidance to staff on people's needs, staff had a good knowledge of how to support people effectively. We observed the staff respond effectively to people's needs.

Staff support: induction, training, skills and experience
● Staff had mostly received training to complete care effectively. The exception was that only senior care staff had training on complex health conditions. Nursing and senior care staff, mostly supported complex nursing care like catheters, enteral feeding and wound care. While we saw no issues with the quality of this care, we expressed concern that all staff should have basic training in these needs – so they could recognise issues and flag them to senior staff. We have been advised this training will be arranged.
● At the last inspection, we saw staff were not skilled in supporting people when they became agitated. At this inspection, staff were observed to be more effective in their support of people's anxiety. One staff member told us that they still lacked confidence in responding to complex mental health needs and would like further training in this. We raised this with the provider, who has since sent evidence that training has been arranged for all staff.

Staff working with other agencies to provide consistent, effective, timely care ; Supporting people to live healthier lives, access healthcare services and support
● Care plans did not always clearly describe people's health diagnosis and how staff could support them to live healthier lives. However, staff had good knowledge of people's health when asked. It is important that care plans are kept up to date in case new staff come to the service and need to rely on the care plans to understand a person's health needs.
● We spoke to four visiting health and social care professionals. They all spoke highly of the service and advised that communication with the service was good quality. They explained that care staff were aware of when to call for external health support and acted on any advice given. This created effective partnership working and allowed people to live healthier lives.
● Effective staff handover meetings reflected on which health professionals were due to visit, and what advice had been given. This information meant the whole staff team knew important professional updates.

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

● People were supported to eat and drink enough. The provider used an electronic system to record how much people ate and drank. The registered manager reviewed this system every day, and if there were any concerns about inadequate levels of food and drink, then they would take action with the staff team.

● People were weighed if they were at risk of weight loss and action taken if needed

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

● At the last inspection, we found the call bell system did not allow for an easy auditing process. This is because the manager could not easily identify how long staff took to respond to call bells being triggered. At this inspection, we saw that the call bell system had not changed. There was also still a poor auditing process. However, the manager advised that adaptations to their daily walk around checks would ensure the service met people's needs.

● People's bedroom doors had subtle information displayed. This meant staff would easily be aware of people's needs in the event of emergency evacuation. For example, bedroom doors identified a person's emergency evacuation needs with symbols. This picture design effectively met the needs of the service and person, whilst being respectful to the person's privacy.

● The service had undergone refurbishment since the last inspection. For example, a bariatric room had been created to meet the needs of future bariatric people who came to Aaron Court. Bariatric relates to the specialised treatment of people with obesity. These people often need specialised equipment to meet their needs.

●The service had an ongoing action plan to continue to improve the design of the service.

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 our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement.

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

At our last inspection, the provider's governance systems had failed to bring the service to a good quality standard. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider remained in breach of regulation 17.

● At the last inspection, we identified that care plans were not always available for staff, so staff did not have guidance on how to support people safely. Since that inspection, the management team had spent time ensuring that all people now had a care plan in place to guide staff. We reviewed eleven people's care plans and they all required some further quality improvement. The provider's audit had already recognised that further improvements were needed. We raised these care plan concerns with the registered manager and they quickly sent improved versions to us. We remain concerned that the care plans have not yet been fully improved in a timely way.
● The provider's systems had failed to ensure that mental capacity assessments were always completed, before decisions were made on people's care. This poor governance meant the service did not follow the Mental Capacity Act.
● The provider's systems had failed to ensure that improvements had been made to recording the location of topical medicine patches. We found that concerns from our previous inspection were ongoing.
● At the last inspection, we identified that staff sometimes wore face masks below their chins. Poor governance at the service meant this concern was ongoing and national guidance was still not being followed.
● At the last inspection, we identified that multiple areas of the service were unclean and cluttered. We observed the service was now cleaner. This excluded kitchenettes on each floor which needed further improvements. These cleanliness issues had not been recognised on cleaning schedules or audits. However, the registered manager explained they were addressed quickly after the inspection occurred.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People spoken to, advised that they were happy with the care provided and they would recommend the service to others. A relative spoke highly of the care provided to people with dementia. They said, 'They don't embarrass people. They treat them with humanity. They don't tell them off.'
● Staff were positive about working at Aaron Court. They described people's needs in a person-centred way,

and observations showed a caring culture towards people.
● The previous inspection identified a high use of agency staff, who were mostly deployed to one area of the care home. This risked these agency staff not knowing people's needs. At this inspection, rotas showed regular agency staff were booked on a block booking contract. These staff worked in set areas of the home and when spoken to, had good knowledge of people's needs.

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 has a legal duty to notify the Care Quality Commission when certain events occur at the service. They had notified us of events when appropriate.
● At the last inspection, people told us complaints were not always recorded and acted upon. At this inspection, nobody reported concerns to us about their care. A relative told us 'If I had any complaints they would listen and act. I'm so sure of that.'
● The few complaints that we know had been received, had been recorded and responded to by the management team. One person was recorded as unhappy with the complaint response, and the registered manager had correctly referred the person to the independent ombudsman for consideration.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Since the last inspection, the manager explained that they have re-considered where people's bedrooms might be best placed around the home. This is to ensure they are living near other people who do not impact their care. We spoke to relatives, who told us that they had been consulted in this move and felt moving to a new bedroom had positively impacted the person's wellbeing.
● We spoke with three relatives. They all spoke highly of the registered manager's communication and compassion towards them. One said "The registered manager listened to me when I said [NAME] had dementia behaviours. She didn't judge them for the person they had become- but understood who they were before. It meant so much to be listened to and for them to be understood."
● Staff told us that they felt they could report concerns to the management team and be listened to. Since the last inspection, there had been an additional senior staff member employed to the first floor. Staff explained that this employment of this staff member meant they had easier access to management advice which made their roles easier.

Continuous learning and improving care
● Record keeping had improved and the electronic recording system meant the manager could easily oversee that people were receiving suitable care. For example, if a person had not received a drink, this system would flag to the manager who could follow up with staff.
● The implementation of the electronic system was still at an early stage. The registered manager explained that this was why care plans were not fully up to standard. Where we flagged specific care plan concerns, we received improved copies of these care plans within a few days.

Working in partnership with others
● Visiting health professionals spoke highly of their involvement at the service. They explained that the manager knew people well and had good oversight of the running of the service
● Since the last inspection, the local authority have made repeated visits to the service to assess the quality of the care provided. They advised that the service has been receptive to their feedback.

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 11 HSCA RA Regulations 2014 Need for consent The provider did not follow the principles of the mental capacity act (2005)

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 Systems did not always keep people safe from harm. Care plans did not provide enough guidance to staff and medicines were not always managed safely

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 provider's governance systems had failed to bring the service to a good quality standard.