Aarondale Health Care Limited

# Aarondale House

## Inspection report

49 Eastgate
Hornsea
Humberside
HU18 1LP

Tel: 01964533306

Date of inspection visit:
23 August 2017
24 August 2017

Date of publication:
24 October 2017

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | **Requires Improvement** |
| 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

This inspection was carried out on 23 and 24 August 2017 and was unannounced.

Aarondale House is a care home which provides single and shared accommodation for up to 20 people. At the time of our inspection there were 19 people living there. The service supports older people, some of whom may be living with dementia and is located in Hornsea, in the East Riding of Yorkshire.

There was a registered manager who was present during our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The registered manager will be referred to as 'manager' throughout the report.

At the last inspection on 30 June and 1 July 2016 we found the provider was in breach of three regulations of the Health and Social Care Act 2008. These related to the need for consent, staff training and supervision and good governance. We rated the service as requires improvement. The manager sent us an action plan in August 2016 which stated what action the service would take to address the issues. At this inspection we found that the provider had made sufficient improvements to meet the requirements of Regulations 11 and 18.

During this inspection we found not all of the changes made to the processes and audits had been completed robustly and did not identify further issues highlighted during this inspection. For example, we found that people's medicines were not always managed safely; we found the balance of three people's medicines were incorrect and did not tally with the stock that was recorded. In one bathroom cupboard we found used hairbrushes, razors and opened soap. Staff were not always aware of people's care needs and people's records did not always clearly reflect these, risk of harm to people was not always assessed, managed and reduced and the manager had not informed the CQC of all significant events.

Although there were some audits in place these had not picked up the shortfalls and inconstancies of information in people's care plans, risk assessments, infection control and medicine practices, and the non-notification of incidents, therefore they were ineffective at driving improvements. These areas need to be strengthened to ensure people received a safe and consistent service.

We saw that overall people's access to activities had not improved since the last inspection and activities were low key both inside and out in the local community. The people we spoke with consistently told us they would like to go out more. We saw a singer performed at the service on the first day of this inspection.

This meant we found two continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the (Registration) Regulations 2009, in relation to good governance and notification of other incidents. We also found an additional two breaches in relation to safe care and treatment and person

centred care

People told us that they felt safe living at Aarondale House. Staff told us that they had received safeguarding training and showed an understanding of how to report safeguarding concerns.

The provider followed safe recruitment checks, to employ suitable people. There were sufficient staff employed to assist people in a timely way.

Safety equipment, electrical appliances and gas safety were all checked regularly.

The manager and the staff had knowledge of the Mental Capacity Act (2005) and their responsibilities linked to this. People's consent was recorded in areas of their care.

People spoke highly of the staff who cared for them and felt able to raise any concerns with staff.

We observed some positive, caring interactions and relationships between people living at Aarondale House and staff. Visiting relatives were welcomed at the service and we saw that they had a positive rapport with staff.

People we spoke with told us they were happy with the meals available to them.

People who used the service received additional care and treatment from health professionals based in the community.

There was a complaints procedure on display and people and their relatives felt able to complain.

You can see what action we told the provider to take at the back of the full version of the report.

## 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 consistently safe.

Risks of harm to people were not always assessed, managed and reduced through the effective use of risk assessments.

The safe management of medicines required improvement and people could potentially be at risk of not getting medicines as prescribed. Improvements were required to the environment and to ensure that appropriate infection control practices were applied and followed.

People said they felt safe living at the home. People were protected from abuse and staff were knowledgeable on procedures to follow if abuse was suspected. Suitable procedures were in place to recruit staff safely.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

Improvement was needed to maximise the suitability of the premises for the benefit of people living with dementia.

Staff received a range of training to meet people's care and support needs. Staff felt supported and staff had received regular supervision.

The service was compliant with legislation around the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS).

People spoke positively about the meals and drinks provided.

People had timely access to services to support them in maintaining their health.

### Is the service caring?

**Requires Improvement**

The service was caring.

Staff interactions we observed were kind and caring.

Staff respected people's privacy and dignity.

People told us the staff treated them with kindness and were considerate to their needs.

## Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

Staff we observed were responsive to people's needs. However, care plans did not always reflect people's current needs.

The provision of meaningful activities required strengthening. Further work was required to ensure that people had the opportunity to be offered regular access to the outside, activity and stimulation.

There was a complaints system in place.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well led.

People who used the service and staff were complimentary about the manager.

We found the CQC had not been notified of all significant events that occurred at the service. This meant we could not check that appropriate action had been taken.

We found repeated concerns in relation to the governance systems identifying the issues within the service, and quality checks had not reliably identified and resolved shortfalls in some aspects of the quality and safety of the service provided.

The provider and manager were open and acknowledged the need to improve in some areas.

# Aarondale House

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was carried out on 23 and 24 August 2017 and was unannounced. This meant the provider and staff did not know we would be visiting.

On the first day of our inspection, the inspection team consisted of one inspector, one assistant inspector and one Expert by Experience who had experience of older people and those living with dementia. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. During the second day of our inspection, the inspection team consisted of one inspector.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service, such as safeguarding information and notifications we had received from the provider. Statutory notifications are when registered providers send us information about certain changes, events or incidents that occur. As part of the inspection planning process we contacted the local council commissioners and safeguarding team for their feedback; they had no concerns about the service.

During our inspection, we spoke with six people who used the service and three relatives who were visiting people. We spoke with the provider, manager, five care staff and the maintenance person.

We completed a tour of the building and looked at communal areas, bathrooms, toilets and, with some people's permission, their private bedrooms.

We observed medicine administration, the support provided to people across two mealtimes, and interactions between staff and people who used the service.

We reviewed care records for five people who used the service and four people's financial records. We also looked at a selection of medication administration records, three recruitment and training records for staff and other records relating to the management of the service.

Following this inspection some concerns were raised with us by the registered provider. These are being looked at by the local authority safeguarding team.

Requires Improvement

# Is the service safe?

## Our findings

People told us that they felt safe. One person told us, "Yes, quite safe, no reason not to." We asked the person what made them feel safe and they said, "Lots of people being here and knowing there's someone around" and another said, "'Yes, staff are really, really good – do all the safety checks. I have got cot sides up in bed, if I need the commode in the night they always put the cot side back up while they (staff) get another member of staff. There are always two members of staff; especially in the morning."

A visitor told us, "I think she (relative) is (safe), she's zero risk. I've seen them (staff) do things (moving and handling) with proper equipment, they have people's needs sussed."

People were protected from the risk of harm and abuse. Staff had received training in safeguarding vulnerable adults and were able to describe to us how they would recognise abuse. Staff were aware of the correct processes to follow in order to report abuse, including how to report concerns about poor practice. One member of staff told us, "I have just done training. I would go to the manager or ring safeguarding."

Care plans contained assessments for areas such as mobility, moving and handling, eating and drinking and pressure care. We saw that risks to people from behaviour that was challenging to themselves and others were assessed and managed. We looked at one person's care plan which provided clear guidance to staff about what were the early behaviour indicators and how best to support the person to reduce their anxiety and stress.

Despite this, not all risks to people were managed effectively. Information about the risks to people were not always recorded to help staff understand people's support needs.

We saw one person's daily records had an entry stating their food needed to be blended. We saw there was no risk assessment present to guide staff in relation to the risks in terms of food and drink for the person. We asked staff about the persons needs in relation to food and we received inconsistent information about what texture of food staff thought the person required. This meant the person was at risk of harm to because staff were not clear about how people's food should be textured. If people are given food with the incorrect texture they may be at risk of choking.

One person had a catheter fitted and we saw an adequate plan of care was in place for this. However, there was no corresponding risk assessment to guide staff in identifying and reducing the risks to the person. We were informed by the manager after this inspection that a risk assessment for the person's catheter had been implemented.

Another person had been assessed in June 2017 as being at 'high risk' of developing pressure ulcers. The person had no risk assessment in place. This meant that staff had not assessed the risk for this person and may not be providing appropriate support at the level required. This put the person at risk as effective guidance to staff was not in place. The person did not have any pressure damage at the time of this inspection and so there had been no immediate impact.

We looked at the systems in place for medicines management. We assessed five medication administration records (MARs) and looked at ordering, storage, recording and stock. We found that appropriate arrangements for the safe handling of medicines were not always in place.

There was a monitored dosage system (MDS) in place. The pharmacy pre packed people's medicine to assist staff to dispense medicines safely. Medicines were stored securely and the keys were held by a senior member of staff. Some medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD's). We found controlled drugs in use at the service and appropriate storage facilities and recording was in place.

Medicines were administered by trained senior staff members. We observed a member of staff administering medicines during our visit. Medicines were administered safely and documentation signed appropriately. The arrangements for the ordering of medicines were discussed with staff. We were told that the senior staff ordered peoples medicines. The majority of Medicine administration records (MARs) were printed by the community pharmacy. However, we saw one person's MARs had been handwritten; this had not been signed by the person who had completed it.

We saw several examples where the medicine recorded at the service did not correspond with the tablets held in the service and the amount of signatures recorded on the MARs. For example, we checked one person's pain relief and saw from records they had 238 in stock. When we counted the tablets there were only 204. Another person's tablets we checked did not correspond with how many had been signed as given on their MARs. This meant we could not be sure if people's medicines had been administered as prescribed. We asked the manager and provider to investigate these concerns and provide us with an outcome.

The manager was undertaking medication audits; however the last one had been completed in April 2017. This meant none of the issues we found had been identified or addressed.

We looked at how the health and safety of the building was maintained. There were current maintenance certificates in place for the fire alarm system, portable electrical appliances, gas safety, the electrical installation and hoists. The manager told us the service employed a maintenance person who worked four days each week.

We saw that external fire safety checks had been conducted as planned. However, the home's internal environmental checks had failed to identify that an automatic door closer to a lounge door required re-locating. We saw this was hanging over a wall mounted fire extinguisher and the lounge door was held open with a door wedge. We discussed this with the manager and maintenance person and spoke on the phone to the external company who completed repairs. We were informed after this inspection that the door closer had been re-located and fixed.

The manager's monthly audits checked various aspects of the service which included the presentation of bathrooms, toilets, people's bedrooms and the cleanliness and appearance of furniture. We saw the last recorded check was completed in April 2017. From the records we reviewed we saw these checks had not identified environment and maintenance issues we found. For example, we saw a broken radiator cover, three chipped over chair tables, a broken bathroom wall light and a damaged sink cabinet in a person's bedroom.

We entered a first floor room via a small lock on the top of the door and found this was significantly cluttered with boxes of incontinence aids, mops stored head down and large shelves which were dirty and held large bottles of chemicals on them. We discussed this with the provider and manager who told us this

room was used for storage whilst some reconfiguration of the service was on-going. After expressing our concern that this area could be accessed by people who used the service we received an update after this inspection that the door had been fitted with an appropriate lock.

In one person's bedroom we observed brown deposits on the toilet seat of a commode and in a downstairs bathroom we found a dirty bath lift with a slightly damaged seat and cupboards that contained a large quantity of items including a hairbrush and comb with hair on them, toiletries, razors, toothbrushes and a bar of opened soap. A downstairs toilet had a large split in the flooring behind the toilet. This meant that any water spillages would be able to leak under the floor and therefore the floor could not be cleaned effectively.

We discussed our findings with the manager who told us the service employed three domestic staff who worked over every day of the week (one of those was currently absent). They showed us cleaning schedules for the service and we saw these were blank and had not been completed. They also told us they did not complete any infection control audits in the service. Environment checks of the service required further development in order to promote people's safety at all times and improvements were required to ensure that appropriate infection control practices, policies and procedures were applied and followed.

The above information demonstrated a breach of Regulation 12 (1) (2) (a) (b) (d) (g) (h) of the Health and Social Care Act (Regulated Activities) Regulations 2014, safe care and treatment.

There was evidence of recent investment in the interior of the building by the provider and we saw the dining area had new flooring and dining tables and chairs. On the first floor a wet room has been installed and the provider shared with us their long term plans to update and refurbish the whole of Aarondale House.

People's personal money was managed safely. We checked the personal finances held at the service for four people and found monies were stored safely in a lockable drawer in the main office. Transactions were clearly recorded and money was checked regularly to ensure balances were correct.

Overall people told us there were sufficient staff on duty to care for them and call bells were answered promptly. Comments included, "Staff are all very good, seem to manage ok. I sometimes think another pair of hands would be useful" and, "At night my call bell is possibly answered within two minutes; – five minutes probably the longest I had to wait. They (staff) do hourly checks on you anyway." Visitors told us, "It's hard to tell, they (the service) haven't got too many people" and, "Don't think there are ever enough staff in these places. If there were enough staff you wouldn't be able to afford it. If someone is off sick Dad says it's rushed in the morning, but he's never complained about it."

At the time of our inspection 19 people were living at the service, five of those required two staff for transferring. People were supported each shift by three staff including a senior member of staff. There was a team of ancillary staff to cover domestic, kitchen and maintenance areas. Throughout the inspection staffing levels were judged to be appropriate.

We checked three staff files and saw that staff had been recruited safely in line with the registered provider's recruitment policy. Before prospective staff were offered a role within the service an interview took place, references were requested and a Disclosure and Barring Service (DBS) check was undertaken. A DBS check is completed during the staff recruitment stage to determine whether an individual has a criminal conviction which may prevent them from working with vulnerable people. This, as far as reasonably practicable helped to ensure people were supported by staff that had not been deemed unsuitable to work with people using

the service.

Requires Improvement

# Is the service effective?

## Our findings

At our previous comprehensive inspection to the service on the 30 June and 1 July 2016, we found that staff had not completed training that would enable them to safely carry out physical restraint and were not receiving regular supervision. There was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found these improvements had been made.

We reviewed the training records and saw improvements had been made to staff training. Staff had been provided with essential training to enable them to meet the needs of people. We saw copies of some training certificates which set out areas of training. Topics included fire safety, medicines, infection control, safeguarding, dementia and first aid. One person using the service told us, "The staff are very good, very professional and all qualified carers".

After this inspection we were provided with a copy of the service training matrix which showed that 22 of the 23 staff had completed training in Non-Violent Crisis Intervention (NVCI). NCVI focuses on prevention strategies for safely managing anxious or physical behaviour. One member of staff told us, "We have accessed training for NCVI; he (the trainer) showed us how to stop a person hitting out at you. It's made it easier for us" and another said, "We looked at how to hold people without hurting them." We asked staff how they supported people who may become anxious and distressed. One member of staff told us, "We talk to [Name] about her doll, we will back off and leave [Name] and come back again later."

Staff confirmed they received supervision with a senior member of staff. One member of staff told us, "I've had two supervisions in the last six months – the owner did mine." We looked at the supervision records for six staff and saw that improvements had been made and staff were receiving supervision more frequently.

At our previous comprehensive inspection on the 30 June and 1 July 2016, we found examples where the Mental Capacity Act 2005 (MCA) guidelines were not being followed which was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found these improvements had been made.

We looked at records in relation to the MCA and Deprivation of Liberty Safeguards (DoLS). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the DoLS. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Records we looked at confirmed staff had received MCA and DoLS training. One member of staff told us,

"You always have to ask the person and always give them their choices." Care plans we looked at showed that the person had their capacity to make decisions assessed. For example, one person's care plan stated, "I can make all my own decisions on my daily care and routine. Any major financial decisions I will discuss this with my family." Where people were deprived of their liberty, for example, due to requiring support with care and treatment for personal care tasks, appropriate applications had been made to the Local Authority for DoLS assessments to be considered for approval. This meant that people's ability to make some decisions, or the decisions they may need help with and the reason as to why it was in the person's best interests had been recorded. This meant the provider had acted in accordance with legal requirements.

People's likes, dislikes and preferences in relation to nutrition formed part of their care plan and their weight was routinely recorded if required. People told us they enjoyed the meals provided to them. Comments included, "Its edible, I used to be a chef, I don't think all the veg are fresh but you can't be too critical. I am diabetic and have to be careful – they check every night that my levels are ok. There's no choice but I eat most of it anyway" and, "Excellent, had chicken and leek pie yesterday and I saw her (cook) doing the chicken from scratch and rolling the pastry, also had homemade parsnip and apple soup. If you don't like what is going to be for dinner you could have an omelette or jacket potato I think."

A visitor told us, "'He (relative) enjoys his diet, and he complained yesterday that he was given ginger beer instead of his usual shandy. I think it would be nice to have more salads and fresh fruit but he is of a generation that think salads are the work of the devil. He likes the food – raves about it, never hungry. They (staff) are aware of people who need extra drinks; they come round and insist they drink their drinks. The linen napkins are a lovely touch." The visitor went on to tell us their relative had put on weight since living at Aarondale House.

The breakfast and lunch experience within the service was noted to be positive during the inspection. For breakfast porridge or cereals were offered and/or toast and marmalade. Drinks were also offered. At lunchtime the menu was written on a whiteboard in the dining room and showed cottage pie with cabbage and cauliflower, followed by yoghurt or iced cream was on offer. No other choice of main course was listed and there were no pictures of the food which may have assisted those people who were living with dementia.

We observed the cottage pie was homemade and the overall lunchtime meal looked and smelled appetising. We spoke with the cook and it was clear they knew people's individual likes and dislikes in relation to food. For example, we saw one person did not like ordinary mashed potatoes and the cook had made a portion of mashed sweet potatoes to top the person's cottage pie. The main course was plated on either white crockery with a design around the rim or on red plates with 'guards' for those residents who required that adaption. Primary colours are recognised for longer by people as their dementia progresses.

People were able to choose where they ate their meal, for example at the dining tables, whilst others remained in their lounge chairs with tables placed in front of them. Where people required assistance from staff to eat and drink, this was provided in a sensitive and dignified manner. For example, we observed staff assisting two people to eat. This was done in a caring, unhurried manner with staff talking to each person as they did so. We saw staff asking questions such as, "Are you ready for a bit more?" One person required support to eat their porridge but was encouraged to eat their toast themselves after it had been placed in their hand. At lunchtime the person was encouraged to feed themselves after being given a spoon. The member of staff regularly came over to the person to turn their plate as they would always go to the same part of the plate for the food.

People were supported to maintain good health and had access to appropriate healthcare services. Their

records showed they had regular appointments with health professionals, such as community nurses, dentists, and GPs. People who used the service told us they were able to see community health professionals when required to help ensure their health needs were met. Comments included, "Staff ring up for me and make appointment" and, "I tell [Name of manager] or one of the girls (if needs GP)."

The manager told us that approximately 16 people currently living at Aarondale House were living with dementia. The provider needed to review the environment to maximise the suitability of the premises for the benefit of people living with dementia. There was limited signage available to help people to orientate themselves and the environment did not reflect best practice and up-to-date guidance to support people living with dementia. There were few clear signs, symbols or colours to help people to recognise their own bedrooms. There was a lack of sensory stimuli, for example, orientation boards and information for people in an easy to understand format. In addition, there were no memory boxes or objects of reference to help aid reminiscence or provide a stimulating environment.

We saw the provider had some sensory stimuli items in the service such as twiddlemuffs, stress balls and various games. However, during this inspection these items were held in the manager's office and not readily available for people to pick up and use. A twiddlemuff is a double thickness hand muff with bits and bobs attached inside and out. It is designed to provide a stimulation activity for restless hands for patients living with dementia.

Requires Improvement

# Is the service caring?

## Our findings

Overall we observed the staff at the service to be caring. However, people were not provided with regular opportunity to access the garden areas of the service or to go out into the community. We have reported on this further in the responsive section of this report.

People we spoke all said the staff were very kind and caring at Aarondale House. One person stated, "All (staff) are very good; definitely caring. I need someone with me when having a shower, we have a good laugh. All the carers are really, really friendly" and another person told us, "Very good, they (staff) always do what you want if you ask them. They treat me very well usually."

One visitor told us, "It's really good (the care)." We saw that visitors came to the service throughout the day and were made welcome by staff. It was apparent that these were regular visitors. All of the relatives we spoke with told us they were made welcome by the service and able to visit at any time. One person who used the service was observed to receive a phone call from their daughter during the inspection.

Staff we spoke with understood the importance of maintaining people's privacy and dignity and gave examples of how they would implement this which included, knocking on doors and closing curtains. We observed that staff put this into practice during the inspection and were seen to knock on doors before they entered people rooms or bathrooms. One person told us, "Yes" when we asked if their privacy and dignity was preserved. They went on to tell us, "They (staff) have to wash me and everything." A visitor told us, "Really good, doors are always shut to the toilet when they are with them; they don't open the door before they are appropriately dressed again."

Throughout the inspection we heard and observed kind, friendly and appropriate interactions between all levels of staff employed at Aarondale House and the people who lived there. Staff spoke with people as they passed them and as they entered communal areas such as the lounge or dining area. People looked well cared for; they were tidy and clean in their appearance which was reached through good standards of care. People were dressed appropriately and staff ensured people were wearing appropriate shoes/slippers.

The cook told us there was no-one currently living at the home that required specific food or meals to meet their cultural or religious needs. We saw as part of the care planning process equality and diversity information was included such as the person's gender, religion and marital status. The manager told us that a local church visited to provide Holy Communion once each month. This meant people's cultural and religious needs were assessed and considered to ensure their individual needs and preferences were supported and maintained.

People's care plans recorded the skills and tasks they were able to complete themselves. For example, one person's care plan read 'I can eat independently if my food is cut up' and, 'I can communicate my needs with good encouragement'. Our observations showed that some people at lunchtime were supported to maintain their independence to eat their meal. Care plans confirmed that some people were able to manage some aspects of their personal care with limited staff support.

People's wishes and choices around end of life care were documented in their care files. Care plans clearly recorded when people had a 'Do Not Attempt Cardiopulmonary Resuscitation' order (DNACPR) in place. We noted that one person's DNACPR had been put in place in December 2011 and no recorded reviews had been held. We discussed this with the manager and provider during the inspection and we received an update after the inspection that a review had been completed.

Despite the majority of our observations and feedback being positive one relative told us , "A basic level of care is given, she's (relative) warm, gets food and they make sure she eats something. It's not wonderful but I'm sure there are a lot worse." We also identified that improvements were required to support people living with dementia.

Requires Improvement

# Is the service responsive?

## Our findings

People's needs were assessed prior to their admission to Aarondale House, and these assessments were then used to develop their individual care plans. Care plans we checked covered different aspects of people's health care needs such as, personal support, eating and drinking, mobility and communication, and how they preferred to have those needs met.

We found care plans were person centred and explained how people liked to be supported. For example, entries in the care plans we looked at included, 'I like to sit in the dining room looking out of the window' and, 'I like watching western films, musicals and the company of others'. This helped staff to know what was important to the people they cared for and helped them take account of this information when delivering their care. One member of staff told us, "The care plans have improved. We have spoken to people and got more detailed person centred information." This is important as some of the people who lived at Aarondale House had memory impairments and were not always fully able to communicate their preferences.

We saw examples that care plans and risk assessments were not always reviewed or updated when people's needs changed. For example, we saw one person had been assessed for the use of a hoist and the assessment should have been reviewed every three months. We saw this had last been completed in May 2017. Another person had been assessed as a high risk of developing pressure ulcers. We were unable to see any care plan for this area of care for the person. Care planning had not always provided clear guidance to help inform staff of people's needs and how these should be met safely. We discussed these finding with the provider and manager who agreed to address this. The provider informed us after this inspection that a 'read and acknowledge' book had been implemented to ensure that all staff are aware of any changes in a person's needs.

At the last inspection on 30 June and 1 July 2017 we made a recommendation to the service to seek advice and guidance from a reputable source on the delivery of an activity programme.

During this inspection, we found that people did not have regular opportunity to access the outside space at the service or to go into the community. We discussed the programme of activities with the manager and staff. The manager told us a painting group came to the service every month and a programme of activity was offered during the week. The manager told us people did not go out of the service very often.

There was a notice board in the hallway that included an activity programme for the week which included board and ball games, reminiscence afternoons, pamper days and music afternoons. There was no dedicated activity worker employed at Aarondale House and staff provided activity for people. One member of staff told us, "We don't stick to planned activities as not everyone wants to participate." We did not observe any activities in the service, apart from an outside entertainer who visited in the afternoon.

We asked people about the activity programme at Aarondale House. One person said that they had recently "Had a go" at drawing/sketching. They told us that the "TV is on all day" and said "No" when we asked if they ever went out to the shops. We noted there was a small parade of shops very close to the service. They went

on to tell us, "Quite a few of us are in wheelchairs and it must be difficult with only three staff. The hairdresser comes once a week – I have it done once a fortnight." Other comments included, "I am not used to the TV being on but I can switch off and read my kindle" and, "Yes, I would like there to be more activities as I get bored." During the morning a curate and reader from a church came and gave the person communion and stayed and chatted for a while. The person told us, "I would like a communion service more often." Another person described their life to us as "Boring" as they just "Sit here all day". They added, "I think we have a singer coming this afternoon."

Visitors told us, "That's an awkward one; I don't think there are any (activities). The Lions paid for a drawing person to come in but that only lasted two weeks. There is hymn singing on a Tuesday afternoon but my father is an atheist. He has his Times (newspaper) delivered here every day; he shares it out after he has read it. He stays in the quiet room but occasionally he'll ask if he can watch TV" and, "I usually come at weekends, I have never seen any entertainment before. I think there is a lack of stimulation."

There was a garden area at the front of the property with two wooden seats adjoining the car park which had a pleasant outlook. However, this was not secure which meant people did not have the opportunity of a safe environment to go out and walk or sit in the fresh air. We were told this was not used very much. Comments included, "I have only been in the garden when we had a fete. I haven't sat outside in the garden this summer", "No, I never go in the garden" and, "I would like to go out more often." We saw one person had some teddy bears next to them on a table however these were not in use. We did not see any activity used to stimulate people living with dementia.

The above information demonstrated a breach of Regulation 9 (1) (3) (a) (b) (e) of the Health and Social Care Act (Regulated Activities) Regulations 2014, Person centred care.

People we spoke with told us they knew how to complain. Comments included, "I have complained only once, I can't remember what it was about, I prefer to deal with someone on my own and sort it out", "No, not up to now, (had cause to complain) – presumably I would speak to [Name of manager] or speak to my husband and he would take it up and, "No I've never had any complaints but I would go to the manager if necessary". A visitor told us, "I've never had to complain and they apologise if they do something wrong – they once put a knitted jumper in a hot wash and it shrank – very apologetic." We saw a copy of the provider's complaints procedure displayed in the hallway of the service and the records we checked showed the service had not received any formal complaints in the last 12 months.

Requires Improvement

# Is the service well-led?

## Our findings

At our previous comprehensive inspection to the service on 30 June and 1 July 2016, we found that quality assurance systems were not effective or robust and there was a lack of managerial oversight by the management team. As a result of our concerns a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was made. The manager confirmed that following our last inspection to the service, improvement and development had been undertaken.

At this inspection we found repeated concerns about the notification of incidents to the Care Quality Commission (CQC). We found the service had not notified the CQC of a significant injury sustained by one of the people using the service. This notification was submitted retrospectively after this inspection. Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. This meant we could not check that appropriate action had been taken.

This was a continued breach of regulation 18. Notification of other incidents, of The (Registration) Regulations 2009. We are considering our regulatory response to this breach.

Since our last inspection the quality assurance processes in the service had been reviewed and an increase in service audits had taken place. The manager had overall responsibility for monitoring the quality of service. We reviewed a selection of these audits which involved the manager's monthly checks of the environment and its cleanliness, and medication. These were last completed in March and April 2017, therefore had not highlighted any of the issues we found during this inspection. We judged that a robust system was still not fully in place.

Further areas that required improvement and related directly to the management of the service in terms of oversight included, the management of risk, safety of the environment, medicines management and infection control practices.

We found there were no systems in place for consulting with people living at Aarondale House and their relatives about the service delivery. We saw a list of dates in the hallway which displayed dates for residents/relatives meetings. However, we were only able to see the minutes from one meeting held in May 2017 which recorded that 13 people had attended. We saw the subjects discussed at this meeting included any concerns that people had with the service, the menu and laundry.

No one we spoke with during this inspection had attended a meeting. One person told us they had lived at Aarondale House for two years and said, "I haven't been to one so far, they probably have them in the dining room. I wouldn't want to go" and another person told us, "No, not up to now" when we asked if they had attended a meeting. Visitors told us, "I try to avoid those – I don't know if they take place, I know there is a sign" and another said, "No" they were not aware of or had attended any meetings.

The manager told us they had not carried out any satisfaction surveys with people, their relatives or other stakeholders and professionals since the last inspection. When we asked the manager about how they

consulted with people and their relatives they told us that people did not respond well to meetings and people were spoken to regularly about the service delivery. The manager told us they intended to start recording the discussions they held with people who used the service.

We rated the service as requires improvement at our last inspection in June and July 2016 and identified three breaches of the regulations. At this inspection we found that improvements in all areas had not been made. This meant compliance with the regulations was not sustained.

The provider and manager did acknowledge these shortfalls during our discussions with them during the feedback of this inspection.

The above findings demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider is required to have a manager as a condition of their registration. There was a manager in post on the day of our inspection. They had been in post for eight years.

People spoke positively about the manager of the service. One person said, "I don't see (the manager) very often, she pops in; has a lot of office work I expect." The person went on to tell us they thought the service was, "Well run as far as I can see – nothing to compare it with" and another person told us, "Yes I know the manager but can't remember her name – she comes in most days, she's been talking to me this morning. If I can't be in my own home I'd rather be here, I was always falling about, that's why I came in."

We saw staff meetings were held infrequently. We reviewed the minutes from staff meetings held in March and April 2017. The manager told us the next planned staff meeting was in September 2017. Despite this, the staff we spoke with were positive about the support they received and the culture of the service. One member of staff told us, "[Name of manager] is really approachable. She is fair and I can just go to her" and another told us, "I came back to work here after leaving as I like it."

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 9 HSCA RA Regulations 2014 Person-centred care<br><br>Care plans and risk assessments were not always reviewed or updated when people's needs changed.<br><br>We found that people did not have regular opportunity to access the outside space at the service or to go out into the community. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The risk of harm to people was not always assessed, managed and reduced through the effective use of risk assessments.<br><br>The safe management of medicines required improvement and people could potentially be at risk of not getting their medicines as prescribed.<br><br>Environment checks of the service required further development in order to promote people's safety at all times and improvements were required to ensure that appropriate infection control practices, policies and procedures were applied and followed. |

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 17 HSCA RA Regulations 2014 Good governance<br><br>Quality assurance systems had not picked up the shortfalls and inconstancies of information in peoples care plans, infection control and medicine practices, and the non-notification of incidents, therefore they were ineffective at driving improvements. |

**The enforcement action we took:**

A warning notice was issued.