Mr Salim Adam

Aadamson House Care Home

Inspection report

Peel Hall Street
Preston
PR1 6QQ

Tel: 07931586770

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Aadamson House is a residential care home providing personal care to 13 people at the time of the inspection. The service can support up to 19 people.

People's experience of using this service and what we found
People were not always protected from avoidable harm. The provider failed to ensure people's care and treatment was adequately assessed and planned in line with their needs and preferences. For example, risks associated with choking, mobility, bedrails, falls and nutrition.

The provider failed to ensure people were consistently protected from transmission of infectious disease including Covid-19.

People's medicines were not always managed in a safe and effective way. The provider failed to ensure robust systems were in place for the storage, administration and recording of people's medicines. This placed them at risk of avoidable harm.

Accidents and incidents were not always adequately investigated, and the provider failed to ensure lessons were learnt. Duty of candour processes were not consistently followed, and this meant people's representatives were not always updated when they were involved in an accident or incident.

Staffing levels were not always sufficient to keep people safe. At the start of the inspection the provider failed to ensure enough staff were deployed at night time to enable timely support for people. Five people needed two members of staff to support them to move and reposition at night time, only one member of staff was deployed. The provider took action when we told them people were not safe at night time and increased staffing levels.

Staff recruitment processes were not always safe. The provider failed to ensure staff were checked for good character before they were employed to work with vulnerable adults. Safeguarding processes were not always followed and we found incidents had not been reported to the Local Safeguarding Authority.

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

There was a lack of information for staff to follow in relation to best practice standards in care homes and the guidance available throughout policies and procedures was outdated. People were not assessed in an effective way to ensure they reached their goals and abilities.

Staff had not received sufficient training and support to enable them to carry out their roles and

responsibilities.

There was a lack of quality assurance processes, the provider and registered manager failed to identify the shortfalls as outlined in this report. During the inspection the provider employed an interim manager and the registered manager resigned. The provider acknowledged they had failed to understand requirements providers need to meet and told us they were committed to ensure improvements were made.

People and their representatives told us they were satisfied with the food and drinks provided. We observed people choose their preferred food and drinks. People told us they were supported in a kind and dignified way and had built trusting relationships with staff and managers. During Covid-19 people were supported to keep in touch with their close friends and relatives. We observed visitors engage with people using window visiting procedures and staff facilitated them to feel comfortable and welcome.

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

Rating at last inspection
This service was registered with us on 05/07/2019 and this is the first inspection.

Why we inspected
We received concerns in relation to the management of Covid-19 and staffing levels. We reviewed the information we held about the service and decided to undertake a focused inspection. Because of areas of concern were identified in the other key questions we widened the scope of the inspection to include all key questions. This also meant we could rate the service for the first time.

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 coronavirus and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, governance, staffing, staff training, person-centred care and consent to care and treatment at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Aadamson House Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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 team comprised of two inspectors, one medicines specialist and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience did not visit the service they contacted people's representatives by telephone to listen to their feedback.

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

The service had a manager registered with the Care Quality Commission. 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. The registered manager resigned and applied to deregister during the inspection process.

Notice of inspection

This inspection was unannounced. We did not tell the provider we were visiting across all three days of inspection.

What we did before the inspection
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 reviewed information we had received about the service since registration. We sought feedback from the local authority and professionals who worked with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and six relatives about their experience of the care provided. We spoke with eight members of staff including the provider, registered manager, senior care worker, care workers and the cook.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not consistently safeguarded from abuse, harm and improper treatment.
- The provider failed to ensure systems were in place to identify when an incident was reportable to the Local Safeguarding Authority.
- Staff had not received training in relation to local safeguarding procedures.

People had not consistently been safeguarded from the risk of abuse and harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People were at risk of avoidable harm because they were not always supported by staff with the skills or experience to keep them safe. For example, one person had sustained injuries from falling, they had not been adequately assessed and the risk of further falls had not been mitigated. Staff supporting them did not have training in basic life support, moving and handling or falls awareness.
- The provider failed to ensure people were assessed and monitored in relation to significant risk of harm. For example, the risk of choking, falling, weight loss and mobility. One person had developed a pressure wound whilst living at the service, their care records did not reflect assessment or monitoring of their skin integrity to prevent further damage to their skin.
- The provider failed to ensure people were protected from the risk of fire. On the first day of the inspection we found a fire escape had been blocked.
- The provider failed to ensure sufficient numbers of trained staff were deployed to carry out safe evacuation procedures in the event of an emergency at night time.
- Accident and incident analysis were insufficient. The provider failed to ensure people were properly assessed and known risk was not mitigated, this placed people at significant risk of harm.
- The provider did not evidence lessons learnt, staff told us they were not routinely involved in discussions post incidents to ensure the risk of harm was reduced. For example, one person had fallen from their bed, no review had taken place and staff failed to ensure alterative equipment was considered to prevent the accident happening again.

The above failings placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staff recruitment and deployment was not consistently safe. This placed people at risk of harm, as the provider did not always ensure staff deployed were of good character or had the necessary training and skills to keep people safe.
● Staffing levels were unsafe at night time because people were often supported by one member of staff when they required two. Staff told us they felt staffing levels in the day time were insufficient because the senior managers included in staffing numbers did not always carry out the role of support worker.

This was a breach of regulation 18 (Staffing) and regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● The system for management of people's medicines was unsafe. We found staff hand recorded people's medicines without proper reconciliation and this meant they were at risk of receiving medicines not in line with their prescription.
● The policies and procedures for medicines management were out dated and did not guide staff in line with best practice guidance. We found the storage of controlled and refrigerated medicines was unsafe. We asked the provider to take immediate action to ensure people's medicines were stored in a safe and effective way.
● The recording of people's as required medicines was insufficient. There were no protocols to guide staff around when people might need their medicines. Topical medicines were not always administered as prescribed and record keeping was insufficient.

We found evidence that people's welfare had not been significantly affected by unsafe medicines administration practices. However, systems were either not in place or robust enough to support safe medicines management. This placed people at risk of harm.

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

Preventing and controlling infection
● The provider failed to consistently protect people, staff and visitors from catching and spreading infections including Covid-19.
● People were exposed to the risk of harm because the provider failed to ensure a staff member who tested positive for Covid-19 isolated, they allowed the member of staff to continue working. Another member of staff worked one shift with symptoms of Covid-19.
● The provider did not ensure people social distanced when in communal areas including the dining room.
● Staff did not consistently wear Personal Protective Equipment (PPE) when supporting people and in the care home environment as per national guidance to prevent the risk of Covid-19 transmission. We observed staff fail to remove PPE before exiting people's bedrooms and bathrooms where they had been providing personal care. This increased the risk of cross-contamination of infectious disease.
● The provider's infection prevention and control policy and procedures were not up to date. Staff had not received training in Covid-19 and some staff had not received training in infection control.

We reported our concerns to the local infection prevention and control team and support was provided to ensure immediate safety mechanisms were implemented. We have also signposted the provider to resources to develop their approach.

People, staff and visitors were at serious risk of transmission of Covid-19 and other infectious disease. This

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

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- The provider failed to ensure staff had sufficient skills, training and experience to provide safe and effective support for people who lived at the service. The provider deployed staff to support people on their own without essential training courses including; moving and handling, safeguarding and fire awareness.
- Staff did not always provide effective support for people because they had not been adequately trained. For example, we found one person should have been supported to move position every two hours, because staff had not been trained in understanding the risks of damage to people's skin, they had not acted in line with the person's prescribed care plan.
- Staff were not adequately supported to undertake an induction process, staff were not sufficiently assessed for competency before being deployed to support people unsupervised. This placed people at risk of harm.

There was a failure to ensure that all staff had received appropriate support and training to enable them to carry out their duties. This was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People's needs and choices were not always assessed to ensure their care, treatment and support was delivered in line with current legislation, standards and evidence-based guidance to achieve effective outcomes.
- Significant short falls in the pre-admission assessment process meant people were admitted to the home without staff being fully aware of their needs or preferences.
- People's care records were not regularly updated. We found examples were people had not been assessed for areas of risk to their health and safety. Two people using bedrails had not been assessed and ongoing safety monitoring had not been undertaken, this placed them at serious risk of harm including entrapment.

We found people's welfare had been affected because their person-centred needs had not been effectively assessed. Systems were either not in place or robust enough to ensure person-centred support was consistently provided. This placed people at risk of harm. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible,

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The provider failed to ensure people's mental capacity was considered before asking them to consent. Restrictive measures such as the use of bedrails had not been assessed in line with principles of the MCA.

● The provider failed to ensure people were assessed in relation to DoLS. No DoLS applications had been made or considered. Staff told us three of the people we pathway tracked would not be able to leave the care home alone because it would not be safe for them to do so. Their care records did not reflect this.

There was a failure to ensure people were effectively supported in line with principles of the MCA and associated DoLS. This was a breach of Regulation 11 (Consent to care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People's care records showed inconsistent information about their nutritional needs and assessment of people's needs including; risk of malnutrition and choking. Staff told us they did not rely on people's care plans to identify people's nutrition's needs and preferences they relied on kitchen staff and asking the individual. This placed people at risk of harm.

● People told us they were satisfied with the meals, snacks and beverages provided. We observed people were offered various options at meal times. Comments included; "Yes, the food is nice", "The food is ok, could be better" and "Not bad food, lots of choice." A person's representative told us, "The food is wonderful, [name] has put weight on since being here, there is a variation of food."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● We received variable feedback from visiting professionals. One professional told us the registered manager was responsive to people's changing health needs, another told us the provider and registered manager lacked understanding of best practice standards.

● We found people were referred to external professionals including the falls prevention team and speech and language however, this was not always in a timely way. One person had a number of falls and they were not referred to the fall's prevention team in a timely way.

● During the Covid-19 pandemic people had been reviewed by their GP remotely, district nurses visited the service regularly.

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

● The environment design and decoration met people's needs. Adaptation aids were available in people's bedrooms and communal bathrooms which encouraged people to be independent. There was an accessible and secure garden area. We observed relatives undertake window visits during the inspection and used the garden area to facilitate this.

Requires Improvement

Is the service caring?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People were positive about the support they received. However, we were not assured people always received support in a person-centred way. There was a lack of information about people's current needs and preferences in care records to ensure staff had the right information to provide safe and effective care.
- People's comments included, "The staff are angels, so caring and attentive" and "It really is a great place to live." People's representatives also told us, "I noticed that residents are always well treated, and I have not witnessed anyone raising voices at residents, back answering or ill treatment, they are kind and sensitive" and "It seems very quiet and peaceful in the care home."
- People's ethnicity was respected and valued. A relative told us, "[Name] is fussy with food they give her what she wants. She has an Indian diet and once in a while she would eat European food. She is well looked after."
- We observed staff promote people's privacy and dignity. Staff spoke with people in a kind and sensitive way and respected their decisions.

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

- People's care records did not demonstrate how they had been involved in making decisions about their care and treatment.
- People told us they felt listened to and in control of their lives. Comments included, "The staff always asks what I think, and if there are any issues" and "I am fully involved."
- The registered manager had held some residents' meetings and people told us they felt involved in any decisions made about the running of the service. We observed the provider and registered manager engage with people and it was clear they had built trusting relationships.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

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

- People did not always receive personalised care that was responsive to their needs. The provider failed to ensure people were adequately assessed and their care plans were not always reflective of current needs and preferences. This meant people were at risk of not receiving care and treatment in a safe and effective way.
- Pre admission assessment processes were unsafe. We found one person was admitted without assessment. This meant the provider could not be sure their needs and preferences could be met. People's care records showed insufficient review of their needs to determine the best standards of care and treatment required.

We found people's welfare had been affected because their person-centred needs had not been effectively assessed. Systems were either not in place or robust enough to ensure person-centred support was consistently provided. This placed people at risk of harm. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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

- We found people's communication needs were not always assessed or considered. One person received support from specialist community professionals to improve their ability to communicate. However, the strategies provided were not understood or carried out consistently by staff. This meant the person's wellbeing was negatively impacted and they told us they felt very frustrated.
- During the Covid-19 pandemic visiting at the service had been restricted for many months. People and their representatives told us they were satisfied by the effort staff made to keep them in touch with each other. Video and telephone calls were used to ensure people could keep in contact and garden/window visits were facilitated. We observed a relative visit during the inspection and staff made sure they had a hot drink and umbrella whilst sat in the rain talking to their relative through the window.
- People had access to limited activities when they were scheduled. There was a lack of person-centred and meaningful activity provision, the provider acknowledged this and said they would work towards individual planning for people in line with their interests, hobbies and social inclusion preferences.

Improving care quality in response to complaints or concerns

● People's concerns and complaints were listened to. We found people and their representatives were satisfied with the way senior management responded to their concerns.

End of life care and support

● People's end of life wishes, and needs were considered when their health deteriorated. However, there was a lack of advanced care planning for people's end of life care decisions this meant it was possible people would not be able to express their end of life wishes in a timely way.

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.

This is the first inspection for this newly registered service. This key question has been rated 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; Continuous learning and improving care

- The provider and registered manager failed to ensure the service was well-led. There was a distinct lack of understanding about quality performance and regulatory requirements. The provider failed to quality assure the service therefore, shortfalls found at this inspection were not already known or acted on.
- Systems for learning from incidents and near misses had not been adequately implemented which meant staff could not demonstrate whether they had reviewed what could be learnt from incidents events to reduce re-occurrences . People were at serious risk of harm because their safety and welfare had not been adequately assessed.
- During the inspection the provider employed an interim manager and the registered manager resigned. The provider acknowledged they had failed to understand requirements providers need to meet and told us they were committed to ensure improvements were made.

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

- People did not consistently receive person-centred care. We found examples were people had not achieved good outcomes because staff lacked the knowledge and skills to be able to identify how to keep people safe. For example, the provider did not ensure bedrail use had been assessed and was in line with principles of the MCA, there was no policy or procedure to guide staff around bedrail safety standards.
- One person had sustained a number of falls which had not been communicated to their nearest relative. This meant the provider and registered manager did not always act on their duty of candour responsibilities. The provider failed to demonstrate transparent working with external professionals in relation to the management of Covid-19, two members of staff worked when they were symptomatic or known to be Covid-19 positive. This placed people, staff and visitors at serious risk of harm.
- Record keeping was inadequate and meant the provider could not evidence the support people had or had not been provided.

There had been a failure to assess, monitor and improve the quality, safety and welfare of service users and others who may be at risk. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider failed to submit statutory notifications after serious incidents had occurred. This meant that

CQC could not undertake its regulatory function effectively.

This was a potential breach of regulation 18 (Notification of other incidents) of Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- We received mixed feedback from visiting professionals. One professional told us they found the registered manager worked positively with them and was quick to report any concerns about changes in people's health. Another external professional told us the registered manager and provider failed to understand the fundamentals of good health and social care.
- People and their representatives in the main told us they felt engaged and involved in decisions made about the way the service was run. We observed the registered manager, provider and staff engage with people in a kind and inclusive way.
- People's representatives told us, "I know who the manager is, and the owners and they are approachable", "I know who the manager is and the owners and they are friendly and approachable, I feel that I can speak to them about anything", "The owners give me the impression that they care about everyone in their care" and "We have a Facebook page and can contact through on three phone lines, I can always get someone."

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to submit notifications of significant incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people consistently received person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure people were consistently supported in line with principles of the Mental Capacity Act.