Aaroncare Limited

Aaron Court Care Home

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

Summary of findings

Overall summary

Aaron Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 is registered to accommodate up to 73 people in one adapted building. At the time of the inspection there were 58 people using the service. The service consists of three units which provide a mixture of nursing care, and care for people living with dementia.

There was a registered manager in post within the service. 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 inspection was unannounced and took place over two days on the 21 and 22 March 2018. At the last inspection in February 2017 we identified breaches of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found some improvement had been made, however we identified a continued breach of Regulation 17 and an additional breach of Regulation 18. You can see what action we told the provider to take at the back of the full version of the report in response to these issues.

Quality monitoring systems were being completed, however they had failed to embed quality into the day-to-day running of the service. We identified that a sluice room had been left unlocked and the tap in this room was dispensing very hot water. Pull cords had been tied up in some bathrooms which meant they were not accessible should people need these. We also found that care records did not always include consistent information about people's needs.

We followed up on concerns raised by the local Clinical Commissioning Group (CCG) regarding the medication audit process used by the service. We found that this has been improved in response to issues they had raised.

Training was not being kept up-to-date within the service. Records provided by the registered manager showed that training was overdue in areas such as infection control, moving and handling. It is important that staff skills and knowledge are maintained to ensure they can carry out their role effectively.

Whilst people's personal care needs were being attended to, we noted that they were not always being given the option of having a bath, where this was their preferred choice. Baths within the service all contained a layer of dust which showed they had not been used, and this was confirmed by records which showed people were predominantly offered a 'wash'. We have made a recommendation to the registered provider in relation to the provision of person-centred care.

In a majority of cases the service was compliant with the requirements of the Mental Capacity Act 2005 (MCA); however we identified examples where mental capacity assessments had not been completed, and in one instance an application had not been made to deprive a person of their liberty as required. We looked into these examples and found that there had been no impact on the people being supported. We have made a recommendation to the registered provider in relation to the MCA.

We checked a sample of people's medication and found that these were being administered appropriately. Medication records were being filled in as required by staff when these had been given, and the quantities of those medications that we looked at were correct and all accounted for.

We looked at a selection of staff recruitment records which showed that a robust process was in place. Staff had been subject to a check by the disclosure and barring service (DBS) and had also been required to provide two references, one of which was from their most recent employer. This helped ensure staff were suitable to work with vulnerable people.

People were protected from the risk of abuse. Staff were aware of how to report any concerns they may have and were aware of the different types of abuse that might occur.

People had been supported to access health professionals where required. This helped to ensure that their health and wellbeing was maintained.

Positive relationships had developed between people and staff. We observed examples where people had felt confident and able to challenge staff which showed that they were comfortable in their company. We also overheard a lot of laughter and discussion between them.

People's family members commented that their relatives were well cared for during the end stages of their life. Where required people had appropriate paper work in place from their GP outlining their wish not to be resuscitated. This was clearly displayed at the front of their care records which ensured it was accessible.

Activities were in place for people using the service. During a recent meeting with people using the service and their family members a request had been made for further activities to be made available. In response to this issue an additional activities co-ordinator had been employed. During the inspection we saw people joining in activities as a group and in one-to-one sessions.

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.

A door to an unsafe area of the service had been left unlocked and call bells were not always within reach in bathrooms.

People were receiving their medication as prescribed.

Recruitment records were robust and ensure staff were of suitable character.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training was not always kept up-to-date.

Mental capacity assessments were not always being completed as required.

People were being supported to access health professionals where needed.

Is the service caring?

Requires Improvement

The service was caring.

Positive relationships had developed between people and staff.

Staff acted to prevent people from becoming distressed or upset.

People were treated with dignity when they came to the end of their lives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records contained conflicting or unclear information about people's needs.

Where people had a preference for having a bath this was not

always offered.

There was a complaints process in place for people to use.

Is the service well-led?

Requires Improvement

The service was not always well led.

Audits had not fully embedded quality into the day-to-day running of the service.

Meetings were held with people, their relatives and staff to ensure they were kept abreast of developments within the service.

The registered provider was displaying their rating, and notifying the CQC of specific events that occurred within the service as required by law.

Aaron Court Care Home

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 is 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.'

The inspection was prompted in part following feedback from the local Clinical Commissioning Group (CCG) who had raised concerns regarding the management of medicines within the service. During the inspection we followed up on these concerns.

This inspection took place on the 21 and 22 March 2018 and was unannounced. The inspection was carried out by an adult social care inspector, an assistant inspector and a nurse specialist advisor.

Prior to the inspection we contacted the local authority safeguarding and commissioning teams. They informed us of one safeguarding concern which we followed up on during the inspection. We also discussed findings in relation to medicines.

During the inspection we spoke with four people using the service and three people's family members. Following the inspection we also had a telephone conversation with another person's family member. During the inspection we spoke with one professional who was visiting the service who did not raise any concerns. We looked at the care records for six people and the recruitment records for four members of staff. We looked at records relating to the day-to-day management of the service such as audits and maintenance records. We also made observations on the interior and exterior of the premises.

Requires Improvement

Is the service safe?

Our findings

People's interactions with staff showed that they felt confident. In one example we observed a person challenging a member of staff, who subsequently made their apologies and offered their support to the person. In other examples we observed positive interactions which showed people felt safe in the company of staff members. One person told us, "Yes I feel safe here." People's family members also commented that they felt their relatives were safe.

During the previous inspection at Aaron Court we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because pressure reliving mattresses had not always been put on the correct setting. During this inspection we observed that a majority of cases this had been rectified. However, we found one person's bed to be on the incorrect setting. We raised this with staff and action was taken to rectify this. This person had not come to any harm as a result.

During the inspection we found one of the sluice rooms to be unlocked and accessible. The water temperature in there was scalding to the touch and measured well in excess of safe water temperatures. We asked that this room was locked which was done immediately. We check on this and other sluice rooms in the service throughout the two days of the inspection, and did not find these to be unlocked again. The risk to people was mitigated as most people were in the lounge area and this corridor was secured. However, there was a potential risk of people coming to harm if this room had been left unlocked whilst people were on the corridor.

We observed that pull cords in a number of bathrooms within the service had been tied up or had been placed on top of cabinets, out of reach. This meant that people who may have required assistance from a member of staff would not necessarily been able to reach these. We raised this with the registered manager for them to rectify. Action was not taken in all cases to rectify this straight away, however on the second day we observed that this had been done.

Opinions regarding staffing levels varied. One family member told us, "The staff are great, but they are always having to rush because there aren't enough staff" whilst another family member commented, "Staff cope quite well. There's always someone with them in the lounge." During the inspection in most cases we observed enough staff to meet people's needs. However, in one instance we were unable to locate any staff on one of the units. This was because two staff were attending to a person's needs in their bedroom whilst another member of staff had gone off the unit. Whilst another member of staff was available, they were specifically responsible for observing one person's wellbeing and limited their ability to respond to any issues that arose. We raised this with the registered manager and the staffing levels were rectified.

As part of this inspection we followed up on concerns that had been raised by the Clinical Commissioning Group (CCG) regarding the safe handling of medication. During this inspection we looked at a sample of people's medications to ensure that correct quantities were being stored, and found that they were. Controlled medication was being stored in line with legal requirements, and when administered this was being done by two members of staff as required. Medication administration charts were being signed

appropriately by staff to show this had been administered. We also observed staff administered medication to people and found this was being done safely.

People were protected from the risk of abuse. Staff had received training in safeguarding vulnerable adults and knew the signs that may indicate that abuse was taking place. Staff knew how to report their concerns and told us they would go to the registered manager, the local authority or the CQC with concerns.

There was a robust recruitment process in place which helped to keep people safe. We looked at the recruitment records for four members of staff which showed they had been required to provide two references, one of which was from their most recent employer. New staff had also been subject to a check by the Disclosure and Barring Service (DBS). The DBS checks whether individuals have a criminal record or are barred from working with vulnerable groups of people. This helps employers make decisions regarding the suitability of staff.

There were processes in place to ensure the environment was safe. Checks had been carried out on water systems to ensure it was free from harmful bacteria. The lift and other equipment such as hoists had been checked to ensure it was safe for use. Electrical equipment had also been checked to ensure it was in good working order. A fire risk assessment was in place and people had personal emergency evacuation plans (PEEPs) in place, outlining what support they would need in the event of an emergency.

Risk assessments were in place regarding people's needs. For example, where people were at risk of developing pressure ulcers a risk assessment was in place outlining what support they required to prevent this. In other examples where people were at risk of falls a plan was in place to help mitigate the risk of these occurring.

An analysis of accidents and incidents was being completed on a monthly basis by the registered manager. This looked at patterns and trends that were occurring, and where required action was taken to ensure people's continued safety, for example through increased observations following an incident or referring to another professional. We looked at the incidents for the past two months and found that there had been no significant injuries within the service.

Staff had received training in infection control procedures. During the inspection we observed staff using personal protective equipment (PPE) such as disposable gloves and aprons. This helped protect people from the risk of infection.

Requires Improvement

Is the service effective?

Our findings

People and their family members told us that staff were good at their job. One person told us that one member of staff was "amazing", whilst another person's family member told us, "Some of the staff here really have a way with [my relative]."

Staff had not always received the training they needed to carry out their role effectively. For example, records provided to us showed that the moving and handling training for 25 members of staff was overdue and the infection control training for nine staff was also overdue. During the inspection we did not observe any examples of bad practice in these areas; however processes need to be in place to support staff to maintain their skills and knowledge.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where people required DoLS these had been applied for or were in place.

People's capacity to make decisions about aspects of their care had been assessed for some people, but not others. In one example we identified a person who had bed rails in place, however a mental capacity assessment had not been completed around this. In another example one person who was under continuous supervision did not have a DoLS in place and a mental capacity assessment had not been completed. We spoke to the member of staff in charge of the unit who told us this would be actioned straight away.

We recommend that the registered manager seek advice and support from a reputable source around ensuring that the requirements of the MCA are met within the service.

There was an induction process in place for new members of staff which included a period of shadowing experienced staff members. During the inspection we observed an example where a new member of staff was carrying out a shadow shift. We identified that the induction process conformed to the requirements of the care certificate, which is a national set of minimum standards care staff are expected to meet. This helps ensure that new staff have the skills they need to carry out their role.

Staff confirmed that they had received supervision, and staff records showed that these were being completed. This gave staff the opportunity to discuss any training or development needs they may have. It also enabled management to raise any performance related issues with staff and set objectives for improvement.

People told us they liked the food that was available during meal times. We spoke to a group of people after their meal who told us that they had enjoyed the food, describing it as "nice". Another person nodded "yes" when we asked whether they had enjoyed their breakfast. Where people required softer food options or thickened fluids, this had been provided. In one example we observed a member of staff offering a person a glass of milk. This was thickened to the appropriate consistency before being given to the person. Kitchen staff maintained records of people's dietary requirements and were aware of people's needs.

The kitchen was clean and well maintained. A record of fridge and freezer temperatures was being maintained and these were being kept at the appropriate temperatures to ensure food was kept fresh. There was a good selection of fresh fruit and vegetables, along with fresh meat and tinned produce. Whole fat milk was available to support people with maintaining their weight.

The premises had been adapted to meet the needs of people using the service. Signage was used to help people find their way about the service. This included the use of images to support those people who were no longer able to read or understand words. Handrails lined the corridors, and were painted in contrasting colours to the walls to help make these more noticeable for people living with a visual impairment. Floors were clear of obstacles and were level to minimise the risk of falls.

People had been supported to access health care professionals such as their GP where appropriate. People's care records contained a professionals communication log where updates regarding their health needs were recorded.

Requires Improvement

Is the service caring?

Our findings

During the inspection we observed some positive examples of interactions between people and staff. People appeared comfortable in the company of staff who spoke kindly and acted to reduce any episode of distress. We spoke to people's family members who described staff as "nice" and "caring".

At the last inspection we identified that staff could be task focussed in their approach towards people. People had also described some staff as "sharp". We made a recommendation around ensuring people's dignity was maintained. During this inspection we found that improvements had been made with regards to staff approach. However, whilst we identified some areas of good practice we also identified some areas where improvements could be made.

We looked at records relating to people's personal care and found that people were receiving support with personal care tasks. However, we noted a layer of dust in all of the baths in the service which showed they had not been used recently. We looked at personal care charts for three people who were documented as preferring a bath and found that this was not always provided. In one example over a 23 day period a person had had a bath twice. In another example, over a 19 day period a person had had one bath. We raised this with the registered manager to ensure that people were provided with the option of a bath where this was their preference.

We recommend that the registered provider seek advice and guidance around ensuring that care is delivered in a person-centred manner.

Positive relationships had been developed between people using the service and staff. We overheard a lot of laughter and discussion between the two which helped generate a warm, friendly atmosphere. Staff presented as bright and chatty with people, asking people what they would like to eat and drink. We observed that people felt comfortable raising their concerns with staff if they were not happy and staff acted to address issues appropriately.

Staff acted to relieve and prevent people from becoming distressed. In one example a person started to become anxious and confused, however a member of staff managed to alleviate their distress by using distraction techniques to redirect their attention. In another example, a person's care plan stated that they did not like being alone. We observed a member of staff spending time sitting with this person when they started to become anxious. We overheard this person's mood change from being upset to happy and laughing because of this intervention.

People were treated with dignity and respect. We overheard staff speaking kindly to people, using a calm, level voice when communicating to help maintain a peaceful atmosphere. In examples where equipment such as a hoist was being used to help transfer people, staff remained focussed on the person, offering reassurance where needed. Where staff were attending to people's personal care needs we observed them ensuring doors were closed so that people's privacy was maintained.

In a majority of cases people's confidentiality was protected. However, in one example we found records containing personal information about a person dating back to 2013 in a bathroom. We asked for these to be removed to more appropriate storage. In other examples records were kept securely in locked offices which helped ensure personal information was kept safe.

People's relatives commented positively on the support that had been offered to their relatives during the end stages of their life. One family member told us, "I cannot fault the staff, they have been brilliant. [My relative] is being kept as comfortable as possible." A compliment had also been received from the family of a person who had passed away, which stated, "[Staff] made [our relative's] last few weeks and eventual death a period of calmness, safety and support."

Care plans were in place around people's future wishes and how they would like to be supported at the end of their life. Where people had chosen not to be resuscitated in the event of a decline in their physical health, the relevant paper work around this was contained at the front of their care record so this was easily accessible.

Requires Improvement

Is the service responsive?

Our findings

People were not always able to tell us if they received the care and support they needed. However we observed examples where staff displayed familiarity with people's care needs, and provided the correct level of support, for example through the appropriate level of support during meal times, or during moving and handling tasks.

People each had a personalised care record in place, however in some examples the information in these was not complete or was unclear. For example, one person required the use of Oxygen, however their care record provided conflicting information on how much needed to be administered. In another example, a person's care record advised staff to use the "best not approach" when attending to a person's personal care. It was not clear what this meant. In another example the care record one person who had recently been admitted into the service after sustaining a hip injury, stated that they could mobilise up the stairs with some assistance. This was queried with a member of staff who confirmed this was inaccurate. Another person's continence care plan stated that they needed to use the toilet every two to three hours, whereas elsewhere in their care record it stated this person needed to be supported every four to six hours. It is important that information contained within care records is accurate and up-to-date to ensure that staff know what level of support to provide.

Daily records were maintained in relation to people's presentation and the support they had been provided with. For example, records relating to people's dietary and fluid intake were being maintained to monitor people's diet. After meal times we followed up on people's monitoring charts to ensure these were being filled in, and found that they were. However, we identified examples where people's hydration charts did not record the total amount of fluid they required to prevent them from becoming dehydrated. Whilst it was included in their care plan, we identified two occasions where one person had received less than the required amount of fluid, however staff had not identified this. We asked that this information be recorded on fluid charts to prevent this occurring again.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care records included personalised information about them such as their likes, dislikes and preferred daily routine. For example, one person's nutrition care plan stated that they enjoyed porridge for breakfast and also enjoyed a glass of milk. During the inspection we observed that this person had been given both. Other care records contained details about people's life history such as their previous employment, or relationships that were important to them. We spoke with staff who had a good knowledge of people's personal histories. This information helped facilitate the development of positive relationships between people and staff.

Where people required hearing aids or glasses, this information was included in their care records. We followed up on this to make sure people were wearing these and found that they were. We observed staff speaking clearly to people and crouching down to people when talking to them, which helped ensure they

could hear. This helped ensure effective communication between people and staff.

There were mixed reviews regarding the activities that were available to people. One person's family member commented that they did not feel enough was done to support their relative to engage in activities, whilst another family member told us that staff spent a lot of time with their relative who spent a lot of time in their bedroom. Activities co-ordinators were in place and we observed them engaging with people over both days of the inspection. We observed people joining in a sing a long, whilst other people were having a dance. In other examples people were sat having one-to-one time with activities co-ordinators or other members of the staff team. We fed people's comments back to the registered manager for their consideration.

There was a complaints process in place and people told us they would feel confident making a complaint. At the time of the inspection, no formal complaints had been made to the service.

Requires Improvement

Is the service well-led?

Our findings

There was a manager in post within the service who was registered with the CQC. During the inspection we saw that they were visible throughout the service, talking with people and staff. Family members we spoke to told us they felt able to approach the registered managers with any issues they may have. Staff commented that they felt well supported by the registered manager and that they enjoyed working at the service.

At the last inspection in February 2017 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because quality monitoring systems had not identified issues with people's mattresses or parts of the service that were not safe. People were not always treated with dignity. At this inspection we identified other areas of concern that meant there was an on going breach of this Regulation.

Quality monitoring systems were in place to monitor aspects of the service. However, during the inspection we identified some issues which showed that maintaining quality had not been fully embedded into day to day practice. For example, one of the sluice room doors had been left unlocked which meant people were at risk of scalding themselves on the very hot water which was being dispensed from the tap. Training records also showed that this had not been kept up-to-date, and care records did not always contain consistent information. We identified one example where staff were not available on one of the units which showed poor co-ordination and placed people at risk if they needed support during this period.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A recent medication audit had been carried out by the local clinical commissioning group (CCG) which had highlighted a number of issues with the service's own auditing process. The registered manager was able to demonstrate that changes had been made to their auditing process to ensure it was more robust. We checked a sample of people's medications to ensure that those issues identified by the CCG had been resolved and found that they had been.

Monitoring was carried out in other areas such as the health and safety of the premises, and reviews of those people with pressure ulcers. The pressure ulcer reviews showed that where people had these, the appropriate support was in place and these had been healing over time. This demonstrated good oversight in this area.

A new registered provider had recently taken over the service. They had completed initial quality monitoring audits of the service to identify areas that improvement and oversight. We met with the new operations manager who had undertaken a number of checks within the service and was familiar was those areas that needed further development. A plan had been implemented with regards to making the relevant changes.

Meetings had been held with people using the service and their family members. During the most recent of

these the feedback about the service had been positive, however a request had been made for more activities to be made available. The registered manager informed us that an additional activities co-ordinator had been employed to try and make improvements in this area.

Meetings were held with staff on a regular basis. Minutes from the most recent staff meeting showed that this had been used as an opportunity to discuss a staff survey that had taken place and those actions that were being undertaken in response to the results. These meetings also gave the registered manager an opportunity to discuss developments within the service, and ensure staff were kept up-to-date.

The registered provider is required by law to display their most recent rating within the service. During the inspection we found that this was being done as required.

The registered provider is required by law to notify the CQC of specific incidents that have occurred within the service. This is so the CQC can ensure that appropriate action is being taken to keep people safe. Prior to the inspection we reviewed information that had been received by the service and found that this was being done.

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 Staff had not received the training they needed to ensure their knowledge and skills remained up-to-date.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality monitoring systems had failed to fully embed quality into the service. Records were did not always contain accurate and up-to-date information.