Aden House Limited

Aden View Care Home

Inspection report

Preseverance Street
Primrose Hill
Huddersfield
West Yorkshire
HD4 6AP

Tel: 01484530821

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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

This inspection took place on 23 August 2018 and was unannounced, which meant the home did not know we were visiting. This was a comprehensive inspection. At the last inspection on 5 and 6 June 2017 the home was rated Requires Improvement and we found care and treatment were not always provided with the consent of the relevant person and staff did not always act in accordance with the requirements of the Mental Capacity Act 2005.

Aden View is registered to provide accommodation and personal care for up to 46 people. There were 43 people living at the home on the day of our inspection. Aden View Care Home is a purpose-built building offering accommodation over two floors accessed by a passenger lift. All bedrooms have ensuite facilities. One floor is designated for people living with dementia. There are three communal lounges, dining rooms and bathrooms. Outside there is an easily accessible garden.
Aden View Care Home 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 home had a registered manager who was available throughout 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 provider's monthly quality reports showed effective oversight of the premises. The registered manager had systems to monitor quality throughout the home however this was not always achieved. Accidents and incidents were monitored. Fire safety and building maintenance were well managed.

Some feedback had been sought to engage people, relatives and staff in the running of the service. Information from this was used to develop the service.

People and their relatives told us they felt safe living at Aden View Care Home. Staff confirmed they had received safeguarding training and were able to describe how to identify and report any suspected abuse or incidents.

Standardised risk assessments were used in care plans so risks to people's health and safety could be effectively tracked and monitored.

People's dependency was monitored regularly however staffing levels did not always support people's needs. Recruitment processes ensured staff were employed who were suitable to work in a care home setting however induction records were not in evidence.

Medicines were administered safely and with due consideration to national guidance.

Staff were appropriately trained and knowledgeable about infection control procedures.

The registered manager had systems in place for monitoring accidents and incidents and ensuring learning from these was implemented and understood through regular staff meetings and supervisions.

Care plans contained some information about people's history, their preferences in relation to physical needs and some information about their social and leisure activities. Some consideration had been given to people's consent and their capacity to do so for a range of care and support needs. The registered provider was operating within the principles of the Mental Capacity Act 2005 and applications to lawfully deprive people of their liberty (DoLS) had been appropriately submitted to the local authority.

Training completion levels were generally good. The number of staff trained on fire safety was low. Staff supervisions were planned and taking place regularly. Communication between the registered provider, the registered manager and staff was good.

People were provided with a choice of food and drinks and some snacks were available at certain times during the day. People were not always supported to access this.

People were supported to receive access to healthcare which was demonstrated and recorded in care plans.

Dementia friendly signage was in evidence throughout the home. People's bedrooms were personalised.

Staff were aware of the need to ensure people's dignity and respect their privacy however this did not always take place. Staff were aware to support people's independence wherever possible however this did not always take place.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff demonstrated a good understanding of how to ensure people were safeguarded against abuse and were knowledgeable about the procedure to follow to report incidents.

The management and administration of medicines was sufficiently robust.

Recruitment practices were found to be safe however staff induction was not always undertaken or monitored. There were insufficient numbers of staff to meet people's care needs.

Is the service effective?

Requires Improvement

The service was not always effective.

The frequency of supervision and appraisal required improvement.

People received access to healthcare services.

People were complimentary about the food. The recording and meeting of people's dietary requirements needed improvement.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity and privacy were not always respected.

Staff were knowledgeable about people living at the home.

People had good access to advocacy support.

Is the service responsive?

Requires Improvement

The service was responsive.

Care plans provided staff with consistent and accurate

information about care needs. End of life care planning was taken into consideration.

People's preferences weren't always considered.

People weren't satisfied with the entertainment and activities provided to avoid social isolation and provide meaningful engagement.

Is the service well-led?

Requires Improvement 

The service was not always well led.

Action to prevent and lower risks in response to accidents and incidents took place.

Premises were well-maintained and monitored.

The registered provider's monthly quality checks were completed on time. Audits carried out by the registered manager were not sufficiently robust to identify poor practice.

Aden View 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 took place on 23 August 2018 and was unannounced. The inspection team comprised one adult social care inspector and one assistant inspector.

Before our inspection visit we reviewed the service's inspection history, current registration status and other notifications the registered person is required to tell us about. We contacted commissioners of the service, safeguarding and Healthwatch to find whether they held any information about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. This information was used to assist the planning of our inspection and inform our judgements about the service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well, and improvements they plan to make.

During the inspection we spoke with three people who lived at the home and two of their relatives. We spoke with the regional director, the registered manager, the deputy manager, three care assistants and the cook. We looked around the home and saw the communal lounges and dining rooms and bathrooms. With people's permission we saw two bedrooms. We spent time observing the meal time experiences and care in the communal lounges to help us understand the experience of the people using the service.

We reviewed a range of records, which included three people's care files. We also inspected four staff member's recruitment and supervision documents, staff training records and other records relating to the management and governance of the home.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the home. One person said, "Oh, I'm very well looked after." A staff member said, "Yes, people are safe here definitely." Another said, "Residents are safe, everyone is trained."

Staff were able to explain the different types of potential abuse, and the policies and processes to keep people from harm. A staff member said, "Safeguarding training, we did a lot of this and I'm very confident I would be able to spot abuse. This would be reported to the manager straight away." Another said, "I am confident I would know if something was wrong, we've been really well trained in this." A further staff member told us, "[The registered manager] would definitely react to safeguarding concerns I had, I'm very confident with that." Safeguarding notifications were completed promptly.

People's care plans included standardised risk assessments and were reviewed on a monthly basis. One of the care plans we looked at showed a falls risk assessment had been completed each month and the person's risk had increased but there was no evidence any action had been taken as a result of the increased risk. This meant this person's risk was not managed safely. We brought this to the attention of the registered manager who arranged for the person's risk assessment to be reviewed.

Staffing levels at the home were decided by the use of a dependency tool. This assessed the dependency needs of people living at the home. However people and staff told us there weren't enough staff. A staff member said, "We could do with more staff, we all agree there needs to be more. The residents do suffer because there's not enough. We do use agency, yes. recently a lot, mainly since the new provider's taken over." A relative told us, "There's often no carers in the lounge."

The registered manager felt there were enough staff to support people living at Aden View Care Home. They explained recruitment had been undertaken to cover all vacancies at the home and agency staff use was minimal to cover holidays, sickness and maternity leave only. One of the activities co-ordinators was on maternity leave and the other had been off work for some time due to sickness. We saw from rotas and from discussion with the registered manager the home had not employed anyone else to undertake these duties. A staff member said, "When I started there was an activities coordinator [who] was fantastic, every day [they] did something different. But now it's just carers, I think there could be more and we're really trying but it's not enough really." Staff were expected to support people with activities within their other duties. Throughout the day we observed people sat in one communal lounge for long periods without staff present. We observed people being supported to the dining room and waiting over 40 minutes before lunch was served. Staff were task orientated, focused on, for example, serving meals quickly and moving people back to the communal lounge as quickly as possible. This meant we were not assured staff levels at the home were sufficient to meet people's social needs. We were assured people were receiving support safely.

Staff were recruited safely. We looked at the employment files of two recently employed staff and one existing staff member. We saw they contained an application form including a full employment history, interview questions and answers, health declaration, at least two relevant references and proof of identity which included a photograph of the person. We saw that checks had been carried out with the Disclosure

and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. These checks should help to ensure people are protected from the risk of unsuitable staff.

Medicines were administered safely by trained and competent staff. Staff administering medicines had their competencies checked every year. The medicines room was kept locked and room temperatures were recorded. The count of stock tallied with that in the medicines administration record (MAR) sheets. Controlled drugs were stored, recorded and administered in line with current guidance. Topical creams administration was recorded on a body map for each person. Infection control procedures were followed, for example, the nurse administered eye drops whilst wearing gloves. A person refused their medication and, after attempting to administer a second time, was recorded appropriately for return to the pharmacy.

Staff were knowledgeable about infection control processes. A staff member said, "We have access to PPE [personal protective equipment] all the time, they're in every single bathroom with gloves and aprons and wipes." In the ground floor communal toilet, however, there was a strong smell of urine. This was brought to the attention of the registered manager who told us they did not like the toilet and for us not to use it. During the day of our visit we observed this toilet was frequently used by staff supporting people to the toilet. The home manager had not taken action to ensure this was sufficiently clean and appropriate for people to use, or had taken action to stop people using it. On the day of our visit all hand gel dispensers throughout the home were empty. This meant people were at some risk from infection.

The registered manager explained how they undertook regular analysis of accidents and incidents. For example, falls analysis showed how the date, time, and place of the fall was recorded to identify trends and put in place improvements. The registered manager documented how these were discussed with staff at meetings to support the improvement of the service. Documentation showed how the recommendations made by a recent fire service audit had been completed.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we found a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because care and treatment was not always provided with the consent of the relevant person and staff did not act in accordance with the requirements of the Mental Capacity Act 2005 (MCA). At this inspection we found people had consented to their care and treatment and this had been recorded however staff were not always aware about the Mental Capacity Act and what this means to the people they support.

At this inspection we also found people's needs and preferences were not always supported. Staff did not always recognise and support people to maintain a balanced diet.

A person told us, "My meal's nice, it's pleasant." There was a choice of different food at each meal, people's likes and dislikes were considered and vegetarian options were available. We saw one person being provided with milk so they could choose how much to put on their cereal. Condiments were available on the table. The home followed a four-week menu rotation which meant people received a variety of food and we saw alternatives being offered to people. For example, people were able to have a yogurt if they didn't want the hot pudding. Kitchen record keeping was sporadic, for example, food temperature checks were not always undertaken and were taken for different types of foods on different days. We brought this to the registered manager's attention during our visit.

Information about people's dietary needs was not always followed. For example, we saw a person being given a low-fat yogurt when their dietary needs were recorded as being a high protein, normal fortified diet. This meant this person was at risk of being malnourished. Another person repeatedly asked when lunch time was and was not offered any food or snacks instead.

People in care homes who lack capacity are particularly at risk from dehydration, this meant that these people could be at risk as we observed care staff were not proactive in supporting people to eat and drink, however we did not find evidence to support this impacted negatively on people as records demonstrated food and fluid intake, and people's weights were monitored.

The registered manager explained how they received regular updates from the registered provider about national guidance in relation to the care and safety of people living at the home. We saw from staff meeting minutes these were discussed with staff.

The registered manager used a training matrix to monitor staff training. We saw from this not all training for staff was up-to-date. The registered manager explained how a recent change in provider had meant a change in how staff training was recorded. We saw further work was being undertaken to update the training record. The majority of training undertaken in the previous 12 months was online. The new provider had commenced a programme of face to face training. Some training such as safeguarding, moving and handling, and dementia training was provided face to face by an in-house trainer. A staff member told us, "I received a full induction and shadowed shifts. I was happy with everything, everyone was helpful and

everyone was patient. It [training] was both face to face and online." The new staff files we looked at during our visit did not include a completed induction record. This meant we were unable to conclude these staff had received appropriate training before they started work at the home.

There was a supervision and appraisal matrix in place to ensure staff received regular support. We saw from this most staff received regular supervisions and had received an appraisal in the last year.

Daily handover sheets were pre-printed with details of each resident and a snapshot of their needs, such as risks and allergies. At the handover meeting senior carers updated each other and made notes on these sheets so all carers were aware of key information.

The registered manager explained how people's Lasting Power of Attorney (LPA) details was recorded in care plans and held in the main office. This meant staff were aware of who to discuss care needs with if the person lacked capacity to do so.

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). Aden View Care Home had assessed people's capacity and made appropriate referrals to the local authority for DoLS authorisation.

Care files contained consent by people to their care and there was good evidence of MCA assessments and best interest decisions being made, with appropriate people involved. Care files included consent by the person to receiving care and treatment, and also consent to having a flu vaccination. However in one person's care plan a MCA assessment had been completed saying the person had dementia but another record for the same person said their dementia had not been diagnosed. A staff member told us, "MCA? Yes, I received training but I couldn't tell you about it. DoLS, most people have them but I'm unsure on the number." A staff member we asked to speak with in private told us we could use a person's room, we asked if the person had given permission for this and were told, "They don't know anyway." This meant we were not assured staff had full knowledge and understanding of the Mental Capacity Act, nor did we feel this staff member had respected this person's privacy.

Most people were given a choice of where to sit in the lounge, however on the day of our inspection we also observed some people being taken to a chair and seated without being given a choice. For example, during breakfast in the 'dementia' dining room we saw two people being brought to breakfast and told where to sit. When asked about people's choices a relative said, "[Person's name] doesn't sit anywhere else, we've only been twice to their room." This meant people's choices were not always considered.

People had generally good access to health care. One person's care file contained a doctor's letter advising the person needed to see a dentist regularly because they were at a high risk of oral decay. An oral care plan had not been completed for this person and we did not see a record of dentist visits. We were assured people had access to doctors when they needed it however in this instance there was no evidence the doctor's advice had been followed. This meant this person was at risk of oral decay.

The above examples demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people's needs were not always met, people's preferences

were not always supported and people were not always encouraged to be independent.

Signage throughout the home was supportive for people living with dementia. Communal areas on the dementia care unit showed people's needs had been considered. We discussed with the registered manager how they would involve people living at the home with plans for refurbishment.

Requires Improvement

Is the service caring?

Our findings

At the last inspection we found caring was good. At this inspection we found staff did not always respect people's dignity and privacy and did not always promote and support people's independence. We did not see evidence of how the views of people and their relatives were encourage and action taken to support these.

People told us staff were kind. One person said, "They [staff] always ask me what I like."

We observed staff talking to people kindly. A staff member told us, "When delivering personal care, we make sure the curtains are drawn and doors are closed and tell people what they are doing, we make sure they're properly informed of what's happening. We always knock on doors too, to make sure they know we're here." Another staff member explained about their knowledge of people's communication needs, "We have two people who have hearing aids, we don't have any blind people, we try to make sure they [the hearing aids] are working and have fresh batteries."

Clothes protectors were offered to people before their meal. We observed carers asking whether people had finished their meals and if they wished to sit in the lounge, people were asked where they wanted to sit.

We saw one person was brought to breakfast asleep in a wheelchair, they were not asked where they wanted to sit, and were then given cereal without being asked. Another person was brought to breakfast, supported to walk by a carer, who promoted independence and encouragement during this support however this person was then told by the carer where to sit.

During lunch time on the unit where people lived with dementia, people were not offered second helpings of their meals when they had finished. We observed one person, visibly struggling to eat with their knife and fork, who had their meal taken from them by a staff member. They were not asked whether they had finished their meal or whether they needed assistance. Another person had to ask staff for a spoon because they had seen their neighbour at the table was struggling to eat. Staff had not noticed this and did not offer to assist, although they did provide a spoon. This meant staff did not always provide people with a choice or identify when people needed support to eat independently.

On the same unit we observed one person repeatedly asking to go outside and being refused to do so by staff who said, "It's too cold." This person also repeatedly asked for a drink, but staff did not respond. A staff member told us, "[Person's name] is very needy." This meant people's personal preferences and choices were not met.

During our visit we observed a person ask a staff member for a shave. The staff member took them to the communal bathroom, which had a strong odour, to do this, rather than talking them to their own room. This meant people's dignity was not always promoted.
The above examples demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not always treated with dignity and respect

and staff did not always support people's autonomy and independence.

Staff were knowledgeable about people living at the home. One described how a person was supported in their faith by staff who joined them in prayer each evening. People living at the home were also supported to participate. The staff member told us, "With religious and cultural needs there's no one here really, [person's name]…says prayers to carers on an evening in the communal areas. The residents join in too sometimes, it's nice."

The registered manager explained how people accessed advocacy services and information about this was displayed in the reception area of the home.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection the service was rated good. At this inspection we found evidence people were not always receiving care which was personalised to their needs.

People told us, "I go out and take a walk around." A relative said, "There's not enough to do." A staff member said, "We try to do activities with [people], but on this unit it's hard. There's only a couple of things we can do. They listen to music, we play with a balloon, they watch films."

The registered manager was knowledgeable about people living at the home and was able to explain about people with protected characteristics. We saw care files contained equality and diversity care plans for each person. The registered manager explained how they discussed and recorded people's needs in relation to equality and diversity at their pre-assessment.

Some people's life histories recorded in their care plans were very detailed however there was no evidence of how the home met their social needs or involved people in activities they liked to do. For example, we saw from a person's care file they liked fashion, shoes, handbags and socialising but did not find any evidence in their care records they had been supported in any of these activities.

In other care plans we saw people's life history was left blank, the information was very limited or it was out of date and had not been reviewed. For example, in one person's care file their life history had been completed by a relative but aspects such as the person's social history had been left blank. This meant people's social needs were not recorded and could not be met.

Activities were limited. We saw from daily flash meeting records activities undertaken in the month prior to our inspection comprised 'walking outside', 'walking in the garden', 'young people doing the garden', 'bingo', 'music', 'ice cream', 'ice lollies' and 'none, carers to do in and amongst'. We saw from these records that activities did not take place every day.

For example, in one person's daily record only three social activities had been recorded in June; two instances stated 'had hair done' and one instance stated 'relaxing in sun with a cup of tea'. We discussed this with the registered manager who explained there was no contingency for the activity co-ordinator's absence and explained "[staff member's name] will do some quizzes." This meant we could not be assured people had access to meaningful activity.

One person had asked for a female carer, this was not captured at the front of this person's care plan but half way through, which meant it was not easily identifiable. It was recorded on the person's daily notes they had been upset at being assisted to move by an agency worker. This suggested that their preference for which carers supported them had not been met.

We looked at what the service was doing to meet the Accessible Information Standard (2016). The Accessible Information Standard requires staff to identify record, flag and share information about people's

communication needs and take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it. People's and relative's communication needs were recorded and we saw evidence from care files these needs were met.

We saw from care files people had been asked about their end of life care wishes and these had been recorded. There was no one living at the home during our visit who was receiving end of life care.

The home had a complaints policy and we saw complaints were recorded and action was taken in line with this. The home had received one complaint in the previous year.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection the home was rated as requiring improvement in how it was led. At this inspection we found the home continued to require improvement in this area.

Staff told us the home was well-led. A staff member said, "The manager is very professional and I can go to [them] with problems should I need to. [They are] is very good and help me." Another staff member said, "I think the home is well led, I would say everyone seems quite happy it's just with the changes it's out of their hands. The [registered] manager does the best [they] can with what [they've] got, the pressure is on from people who are higher up. It's had a negative impact from the new provider. A lot of staff are fed up and tired because they're trying to cut costs and it isn't fair."

The registered manager said they felt "very supported by [registered provider]" but explained there had been "lots of changes in paperwork".

The registered manager was well known by people and staff. One staff member said, "The [registered] manager's supportive…I could go to [them] about anything and [they] would sort it."

'Residents' meetings took place regularly and minutes from these showed how people discussed things such as portion sizes, food temperature, not enough activities happening and items of clothing going missing. Records showed how the registered manager had dealt with these concerns. Relatives' meetings also took place regularly and an occasional coffee morning.

A staff member said, "We all get on really well as a staffing team, we're part of a little family, if we have something to say we just say it and it's over and done with." Records showed staff meetings took place regularly and staff were consulted and involved in the running of the home. The registered provider sent out annual staff questionnaires however there were no results available from these.

Regular monthly quality audits took place and actions from these were recorded and progress monitored. For example, the accident record showed where, when, why and how the accident or incident had taken place and the outcome from the analysis.

The quality audits had not identified some risks, such as there was no induction record for some new staff and reviews for staff performance had not been undertaken during their probationary period.

Audits were undertaken on a monthly basis for aspects of people's care however the registered manager had not identified gaps in people's care plans for aspects such as people's likes and dislikes in relation to activities and also people's social histories. The registered managers dining experience audits had not identified the poor practice we observed from staff. For example, people being taken to the dining room in advance of meals being served and staff not recognising people's support needs. The registered manager had not identified staff's inadequacies about understanding the Mental Capacity Act.

There was a clear vision and strategy, supported by documentation, to deliver high-quality person-centred care and support however it was not evident that staff were always encouraged to deliver this. Observations showed outcomes for people were task orientated rather than person-centred.

An inspector witnessed an instance of a member of staff using inappropriate language. This was investigated during the day by the registered manager and regional director and was not upheld.

The registered manager told us about groups of young people who volunteer in the home's garden. There was limited evidence of the services involvement or partnership with other organisations.

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 People's care and treatment did not always meet their needs or reflect their preferences. People weren't always supported to make decisions about their care or their independence encouraged. People's nutrition and hydration needs and choices relating to these were not always met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy, dignity and respect were not always considered by staff. People were not always supported and encouraged to be independent.