Ackroyd House Limited

Aaron House

Inspection report

20 Collegiate Cresent
Sheffield
South Yorkshire
S10 2BA

Tel: 01142660310

Date of inspection visit:
16 September 2016

Date of publication:
18 October 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this inspection on 16 September 2016. The inspection was unannounced, meaning that the home's staff and management did not know the inspection was going to take place. The location was previously inspected in January 2014, where no breaches of regulation were identified.

Aaron House is registered to provide residential care to 25 older people, including those living with dementia. On the day of the inspection 24 people were receiving care services from the provider. The home had a registered manager who registered with CQC in August 2015. 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.

People gave us positive feedback about their experience of living at Aaron House. They told us they felt well-supported and found the home to have an enjoyable atmosphere. We observed that staff spoke to people with warmth and respect, and worked hard to ensure that people had a positive experience at the home.

Food in the home was good. People were offered a wide range of choice, and mealtimes were a pleasant experience. There were plentiful activities in the home, which people told us they enjoyed taking part in

We looked at the arrangements for obtaining and acting in accordance with people's consent, but found that the provider did not act in accordance with the requirements of the Mental Capacity Act 2005

We found that medicines were safely managed, and that staff and the provider had a good knowledge of safeguarding. The provider had good arrangements in place for reviewing people's care, and responding to changes in people's health and social care needs.

We identified that risk assessments had not always been implemented where required, and found an incident where staff had failed to take appropriate steps when a person using the service sustained an injury.

The home had a registered manager, and additionally the nominated individual, who was one of the company's directors, was involved in the day to day running of the home.

Audits took place to monitor the quality of the service provided, and actions were devised from audits in order to ensure continuous improvement.

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.

We found that medicines were safely managed, and that staff and the provider had a good knowledge of safeguarding.

We identified that risk assessments had not always been implemented where required, and found an incident where staff had failed to take appropriate steps when a person using the service sustained an injury.

Is the service effective?

Requires Improvement

The service was not always effective.

Food in the home was good. People were offered a wide range of choice, and mealtimes were a pleasant experience.

We looked at the arrangements for obtaining and acting in accordance with people's consent, but found that the provider did not act in accordance with the requirements of the Mental Capacity Act 2005

Is the service caring?

Good

The service was caring.

People gave us positive feedback about their experience of living at Aaron House. They told us they felt well-supported and found the home to have an enjoyable atmosphere.

We observed that staff spoke to people with warmth and respect, and worked hard to ensure that people had a positive experience at the home.

Is the service responsive?

Good

The service was responsive.

The provider had good arrangements in place for reviewing people's care, and responding to changes in people's health and social care needs.

There were plentiful activities in the home, which people told us they enjoyed taking part in.

Is the service well-led?

Requires Improvement

The service was not always well led.

The home had a registered manager, and additionally the nominated individual, who was one of the company's directors, was involved in the day to day running of the home.

Audits took place to monitor the quality of the service provided, and actions were devised from audits in order to ensure continuous improvement. The areas we found where improvements were required at this inspection had not been identified through a fully effective monitoring system.

Aaron House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

We carried out this inspection on 16 September 2016 and was unannounced. This meant that the home's staff and management did not know the inspection was going to take place. The inspection was carried out by an adult social care inspector.

Before the inspection, we reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

We also reviewed the information we held about the home, including the Provider Information Return (PIR). The PIR is a document we ask the provider to complete to give us information about the service, what the service does well and improvements they plan to make.

We spoke with people who were using the service at the time of the inspection, we spoke with staff, the home's management team and company directors.

We observed care taking place in the home, and observed staff undertaking various activities, including handling medication, supporting people to eat and drink, engaging in social activities and using specific pieces of equipment to support people's mobility. In addition to this, we undertook a Short Observation Framework for Inspection (SOFI) SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

We asked people using the service whether they felt safe at Aaron House. One person told us: "It's safe here [because] they do everything necessary to keep us safe." Another agreed that they felt safe at the home, telling us: "They keep us safe." We asked three people what they would do if they had any concerns about safety in the home, and they all told us they would be comfortable raising this with the home's manager.

There was information throughout the home in relation to safeguarding, and what steps staff should take if they suspected or identified abuse. The provider's training records showed that staff had received training in safeguarding vulnerable adults, as well as in other safety – related training areas, such as fire safety and moving and handling.

We observed staff carrying out various moving and handling techniques; this is when they support people to move around the home, or from one chair to another, at times using specialist equipment. We saw that staff did this safely, ensuring that they gave people reassurances and explained each task to the person as they supported them to transfer.

We checked a sample of six people's care plans to look at how risks that they were vulnerable to or may present were managed. We saw that in most cases there were suitable risk assessments in place, although this was not consistent. For example, one person's care plan stated that they had "a tendency to wander" however there was no information about how staff should manage this to reduce the risk of harm to the person. Another person's care plan contained a falls risk assessment, which considered the risk of harm though the person falling. However, this assessment had not been properly completed meaning that the provider did not have a full picture of the person's risk of harm or injury through falls. One person's records showed that they had recently suffered a fall which resulted in them having a lump on their head and a bruised eye. Although staff then conducted half hourly checks on the person, they did not follow the provider's own procedure, which was to obtain medical attention. The registered manager told us they did not know why staff had failed to follow procedure, and that they would be taking steps to address this.

We looked at the arrangements for managing and administering medication within the home. There were appropriate procedures in place to ensure that people's medicines were safely managed, and our observations showed that these procedures were being adhered to. The staff member who was responsible for medication on the day of the inspection spoke with knowledge about their responsibilities and good practice. Medication was securely stored, with separate storage for controlled drugs, which the law says should be stored with additional security. Records of the temperatures of medication storage areas were kept, as medicines can spoil or become less effective if stored at the incorrect temperature.

We checked records of medication administration and saw that these were appropriately kept. Each medication administration record included photographs of each medication item to reduce the risk of administration errors. There were systems in place for stock checking medication, and for keeping records of medication which had been destroyed or returned to the pharmacy. These records were clear and up to date.

People's care records contained details of the medication they were prescribed, any side effects, and how they should be supported in relation to medication. Some people were prescribed medication to be taken on an "as required" basis, often referred to as PRN. Although people's records showed what each PRN medication was for, they did not show what signs and symptoms the person might show to indicate that this medication was required. We discussed this with the registered manager who identified where they could record this information, and told us that this work would be carried out straight away.

There was appropriate information around the home in relation to fire risk and fire safety, including clearly marked emergency exits. Fire drills were regularly conducted, and each person using the service had been assessed for their ability to leave the building in the case of a fire. These assessments were kept together so that in the case of an emergency the information could be easily accessed by the fire service.

We checked a sample of three recruitment files to assess whether appropriate checks were carried out before staff were appointed. We saw that recruitment procedures at the home had been designed to ensure that people were kept safe. All staff had to undergo a Disclosure and Barring (DBS) check before commencing work. The DBS check helps employers make safer recruitment decisions in preventing unsuitable people from working with children or vulnerable adults. This helped to reduce the risk of the registered provider employing a person who may be a risk to vulnerable adults. In addition to a DBS check, all staff provided referees and a checkable work history. However, we identified that not all staff had supplied a full work history or given the reason for leaving any post where they had previously worked with vulnerable adults, or an explanation for any gaps in their work history. We discussed this with the registered manager and two of the company's directors on the day of the inspection, and they gave assurances that this would be rectified for future recruitment.

Requires Improvement

Is the service effective?

Our findings

People were positive about the way they were supported and assisted with their needs. One person said to us: "They [the staff] are ever so good – I don't know how they do it because it's not an easy job." Another said: "They know how to help me with the things I need help with."

We asked people about their experience of the food at Aaron House. They were all overwhelmingly positive. People told us the food was always good, and they always had a choice. We noted that the menu offered two choices each day, however, during the inspection we saw that people were offered, and received, alternatives if they didn't want what was on the menu. Staff we spoke with told us that the vast majority of food was home cooked, including cakes baked on the premises and homemade desserts. The registered manager told us that the home had regular food themed evenings, recent ones being an Indian food evening and an Italian food evening.

We carried out an observation of lunchtime in the home. We saw that people were able to have their meal where they chose, with a choice of dining rooms, tables at easy chairs or eating in their rooms. Lunch was unhurried with staff giving discreet support where required. When people had finished their meals staff checked whether they wanted an extra course or anything else to eat, and drinks were regularly topped up through the course of the mealtime.

We checked a sample of five people's care plans to look at whether information was available about their food preferences and their needs in relation to nutrition and hydration. Some people had been assessed as being at risk of malnutrition or dehydration, and there were clear plans setting out how staff should support people in relation to this. Where required, we saw that people had been referred to external healthcare professionals for guidance and advice around nutrition and hydration.

We looked at staff training records and saw that the provider ensured staff were up to date with relevant training. Staff we spoke with confirmed that training was plentiful in the home, and described that it helped them undertake their roles effectively.

The registered manager told us that staff had received Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS), and the training records we checked confirmed this. 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS)

The provider's Provider Information Return told us that they had applied to deprive a number of people of their liberty, in accordance with the MCA, although these applications were still with the local authority and

were awaiting authorisation. The registered manager spoke with knowledge about this process.

We checked five people's care plans to check the arrangements in place for acting in accordance with the law when people did not have the capacity to make decisions about their care. We found that the provider was not undertaking this appropriately. For example, one person's file contained an assessment of their mental capacity, which concluded that they lacked capacity to consent to their care. In such a situation, the Mental Capacity Act 2005 sets out how providers should ensure decisions are made in people's best interests, and are specific to the issue being considered. This person's care plan contained a form which stated that their relative had consented to all their care and treatment. It was not specific and didn't record who else had contributed to the decision making to ensure that it was in the person's best interest.

Another person's file showed that they had bedrails on their bed. Bedrails are a form of restraint which can cause entrapment or injury if used incorrectly. It is therefore important that the person using them has given informed consent in relation to the risks, or, if they lack capacity then providers must ensure that they are used in the person's best interests. The person concerned lacked the capacity to give consent to this form of restraint being used. There were no records in their file to show that the decision to use bedrails was in the person's best interest, or that it was the least restrictive option available. A third person's file showed that they lacked the capacity to give consent to the use of a sensor mat in their room. Again, there was no evidence to show that the use of this mat had been considered against the person's best interest, nor was there any information to evidence who had contributed to the decision making process.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We discussed best interest decision making, and the requirements of the Mental Capacity Act (2005) with the registered manager during the inspection. They identified paperwork within the provider's own policies that they could use to address this, and described that they would commence work to ensure decisions made about people's care and treatment were in their best interests and decision specific.

We looked at records of staff training, and found that staff received a comprehensive training programme which included topics that the provider considered to be mandatory, such as moving and handling and adult safeguarding, as well as other topics including nationally recognised qualifications and dementia awareness.

Good

Is the service caring?

Our findings

People spoke positively about the staff at Aaron House and their experience of receiving care there. One person said to us: "They [the staff] are kind and really caring." Another said: "Once you get past the fact that it's a lot of old people living together, it's really quite pleasant." This person went on to describe how everyone living in the home got on well, and described the atmosphere as "enjoyable."

In our observations during the inspection we saw that staff and the management team worked hard to create a homely and welcoming environment. Staff spoke with people with a genuine warmth and took time to stop carrying out tasks to chat with people. Staff we spoke with knew people's needs very well, and could describe their individual preferences and the way they wished to be cared for. When staff were supporting people with care tasks, they did so in a calm and unhurried way, ensuring that tasks were carried out at the person's own pace.

We observed that many people were wearing jewellery, watches and in some cases cosmetics. Everyone was well dressed, indicating that when staff had supported people to get ready for the day they had taken time to ensure each person's preferences were upheld and reflected in the way they presented themselves. Staff we observed preserved people's dignity in their day to day work, ensuring, for example, that if they needed to discuss someone's care it was done discreetly and away from the risk of being overheard. When people requested assistance it was provided straight away in a friendly and respectful manner.

Bedrooms we looked at were personalised, with people furnishing them with photographs, ornaments and other mementoes, enabling them to reflect their personal tastes in their rooms.

We looked at five people's care plans to check whether people had been involved in their care planning, and whether care was delivered in a person centred way. Care plans set out how people should be cared for in accordance with their own personal preferences and needs. They reflected each person's individual choices. There was some limited evidence that people had been involved in planning their care, although it was not consistent. The registered manager told us that an advocacy service was available to enable people to become more involved in planning their care, but said that no one had requested to use it.

Good

Is the service responsive?

Our findings

The home had two dedicated activities coordinators, and a weekly programme of activities which incorporated two organised activities within the home every day. These included things like organised games or films, but other activities included visits from the animals at local animal rescue centres and visits from entertainers. We asked people using the service about the activities available. One said: "There's lots going on, but you do have to join in and be part of it. It's no good just keeping yourself to yourself, I tell everyone that, it's important to join in." Another person told us they enjoyed chatting with staff and said they liked watching the "comings and goings" of the home.

In addition to regular in house activities, the provider organised frequent trips out for people. There were regular trips to a local tea dance, as well as visits to the coast and other tourist attractions. A newsletter was produced within the home which held information about forthcoming events as well as photographs and stories about recent activities. One person we spoke with told us they had enjoyed a recent visit to the tea dance, and said that by supporting them to participate in such activities staff enabled them to remain active and independent.

People's needs were assessed prior to their admission to the home, and these assessments were used to develop their care plans. Care plans we checked covered all aspects of people's health and social care needs, and were regularly assessed to ensure they remained suitable to people's needs.

The care plans we looked at showed that people's assessments of needs and care plans were tailored to their individual needs, and we saw that the service responded to people's changing needs. For example, where a person was assessed as being at risk of injury through falls, then the provider promptly supplied appropriate equipment to reduce risk and improve the person's safety.

Care plans were regularly reviewed to ensure that they remained suitable to people's needs. Reviewing staff checked each person's notes for the preceding period and checked whether there had been any changes before recording whether the care plan still met their needs, or making any necessary changes.

We looked at the way people's care plans stated they should be supported and then carried out observations of staff supporting those people. We saw that staff adhered to people's care plans and provided care and support in the way set out as meeting their needs.

Complaints arrangements were available within the home, and a complaints policy available to people using the service. The guide for people using the service set out how people could make a complaint if they wished, although it did not contain correct information about the route for external remedy. We asked people if they knew how to make a complaint, and they told us they did and would be happy to do so if they ever felt the need. The provider had not received any complaints in the year prior to the inspection, however they had received a number of compliments and letters of thanks.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the service had a manager in post who had registered with the Care Quality Commission. They had been in post for approximately one year. The registered manager was supported by the deputy manager, and additionally one of the provider's directors visited the home on a very regular basis.

We asked people using the service about management within the home. They praised both the registered manager and the nominated individual. One person said to us: "They are both there when you want them, anything you need to say, they listen." Another told us the nominated individual was "always looking out for us."

The provider had a quality assurance system, which was carried out by an external consultant. The consultant visited the home monthly to carry out an audit of the service. This included checking care plans, accidents and incidents, personnel issues and the condition of the premises. This was done to a good degree of detail, however, it had failed to identify some areas that needed to be addressed. For example, the registered manager told us that the consultant had carried out an audit of care plans just before the inspection, however, they had not identified that the provider had not acted in accordance with the requirements of the Mental Capacity Act when making decisions about people who lacked capacity to consent to their care.

The registered manager told us that they monitored practice within the home, and as well as using the action plans developed by the external consultant, they had identified other actions. For example, they had noted that the entries staff made in people's daily notes were quite brief. In response to this they had booked places for some staff on a training course related to documentation and record keeping.

Staff attended regular team meetings. We looked at the records of recent team meetings and saw that they were used to communicate developments within the home, and plan events and improve practice.

Regular staff supervision also took place. We looked at a sample of four staff members' supervision records. They evidenced that supervision topics included training and development, the needs of people using the service, safeguarding and health and safety. Staff we spoke with told us they felt supported by the registered manager and the provider, and felt they could speak up if they had any concerns, and make suggestions for improvements or changes.

Each staff member had an annual appraisal. We looked at records of a sample of four staff members' appraisal records. We saw that they looked at staff performance over the review period, as well as setting goals for the forthcoming year. These were tailored around areas that would improve the experience of people using the service, such as developing staff's knowledge in specific aspects of care, or enabling staff to contribute to developments in the home.

The provider had a survey which was sent to relatives regularly. However, we observed that it was lengthy

and quite unwieldy, which may have contributed to the small number of returned surveys. The provider told us they had recognised this, and shared a new survey format with us that was more concise and which they would be using in the future.

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 11 HSCA RA Regulations 2014 Need for consent The provider did not have appropriate arrangements in place for obtaining people's consent in relation to their care. Where people lacked the capacity to give consent, the provider did not act in accordance with legal requirements. Regulation 11(1)(2)(3)