Aden House Limited

Aden Court Care Home

Inspection report

Birkhouse Lane
Moldgreen
Huddersfield
West Yorkshire
HD5 8BE

Tel: 01484540251
Website: www.newcenturycare.co.uk

Date of inspection visit:
08 September 2016
09 September 2016
12 September 2016

Date of publication:
21 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Aden Court Care Home on 08, 09 and 12 September 2016. The first day of the inspection was unannounced, which meant the home did not know we were coming. People who live and work at the home refer to it as 'Aden Court.'

The home was last inspected on 05 August 2013. We found it was compliant in all the aspects of care we inspected at that time.

Aden Court is a privately owned home providing nursing and residential care for up to 40 older people. It is situated in the Moldgreen area of Huddersfield. At the time of our inspection the home was fully occupied, with 17 people receiving nursing care and 23 people receiving residential care.

The ground floor of the home has a reception area, a large dining room, a choice of lounge areas and an activities room. All bedrooms are ensuite; some are located on the ground floor with the rest on other floors. There is a lift for access.

The home had a registered manager in post. 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.

Most medicines were managed properly and we saw their administration was person-centred. However, we found there were a lack of protocols for 'as required' medicines, the administration of topical creams was not recorded and the temperature of the clinic room where medicines were stored had frequently been above 25°C in recent months.

Risk to people was not always assessed and managed appropriately. Issues arose as care plans had not been updated when people's circumstances or health had changed. One person had become trapped in their bedrails; the home's response in terms of minimising the risk of this happening again was not documented.

People told us they could not always use the toilet when they needed to due to a shortage of care staff. Relatives and care staff also thought the home was understaffed and the rota showed this had been the case in recent weeks. The registered manager was in the process of recruiting more care workers to address this issue.

We noted people's access to baths and showers was structured and not person-centred. Care staff did not always close people's bedroom doors when providing personal care because they said they could not hear call buzzers.

We found issues with record-keeping and incident follow up at the home which had not been identified by audit and monitoring.

We found breaches of regulation during this inspection. You can see what action we told the provider to take at the back of the full version of the report.

The recruitment for new care staff at the home was robust and staff had received training in safeguarding and could demonstrate a good knowledge of the subject. However, no documentation was available to show a regular volunteer had been checked to ensure they were suitable to work with vulnerable people.

Staff received the training they needed to meet people's needs. Supervision records showed sessions focused on addressing issues and problems rather than providing the staff member with support. Annual appraisals were thorough and records were detailed.

Care workers' knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) was appropriate for their roles. Applications for DoLS authorisations had been submitted to the local authority for people who needed them; however, no assessments of people's capacity to make other decisions had been made.

People said they enjoyed the food at Aden Court. We saw they were provided with a choice each mealtime and had access to drinks and snacks in between meals. We found issues with the level of detail in records care staff kept for people at risk of weight loss.

Care files showed some people and their relatives had been involved in planning their care. Other care plans had been signed by relatives only, and the involvement of the person was not clear. The home was about to implement a 'resident of the day' system whereby each person had a set day of the month where they and their relatives would be invited to assist care staff to review and update their care plans.

Care staff could recognise when people needed advocacy services and knew how to make referrals when they needed to. At the time of the inspection the provider was investigating a serious complaint about end of life care at the home. We spoke with people, their relatives, the staff at the home and checked people's future wishes care plans. Whilst end of life care training for staff was lacking, appropriate care plans were in place and feedback from relatives whose family members had received end of life care at the home was positive.

People's care files contained risk assessments and care plans for a range of care aspects. Of the four files we inspected in detail, three contained care plans which had been reviewed and evaluated regularly. One other care plan had not been reviewed for over three months because the named nurse responsible had been absent from work and another nurse had not been allocated to cover. Daily records did not always evidence people had been supported according to their care plans.

We saw the home was clean. Regular safety checks had been completed on the building, facilities and equipment used to support people. Contingency plans were in place for fires, floods or other emergencies and people had personalised plans which emergency workers could use to help them evacuate, if required.

People had access to a range of healthcare professionals to help them maintain their holistic health. Healthcare professionals we spoke with who helped support people living at the home gave us positive feedback about the home's staff and the care they provided.

People told us they were treated with dignity and respect by the staff. Staff knew people well as individuals and could describe their likes, dislikes and preferences.

People enjoyed the range of activities on offer at Aden Court; this included those nursed in bed. Relatives were encouraged to take an active role within the home and told us they were always made to feel welcome. We found the atmosphere at the home was warm and friendly as a result.

None of the people or relatives we spoke with told us they had ever made a formal complaint. Those who had either raised concerns or given feedback said it was acted upon quickly. All those we spoke with said they would feel comfortable raising any issues with the registered manager or other staff at the home. People and their relatives were asked to feedback about the service so improvements could be made.

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.

Most medicines were managed well, however, we found the home had no protocols for medicines prescribed 'as required' and staff were not recording the administration of topical creams.

Risk was not always managed effectively in order to keep people safe.

People, relatives and staff thought there was a shortage of staff at the home and people felt their needs were not always being met in a timely way.

Care staff were knowledgeable about safeguarding. The home was clean and facilities and equipment were regularly checked for safety.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received the training they needed to support people safely and effectively. Staff supervision focused on addressing issues rather than providing support.

Mental capacity assessments and best interest decisions had been completed to determine people's ability to consent to live at Aden Court. Capacity assessments for other decisions had not been completed.

People told us they enjoyed the food at the home. We found some issues with the way food and fluids had been recorded for people at risk of weight loss.

People had access to a range of other healthcare professionals. Their relatives told us the home let them know if their family members were not well.

Is the service caring?

Requires Improvement

The service was not always caring.

People had set weekly bath or shower days which was not a person-centred approach. Care workers did not always shut people's bedroom doors when assisting people with personal care.

People and relatives thought staff were caring. We observed positive and friendly interactions between staff and people.

Relatives were made to feel welcome at Aden Court. They contributed to the happy atmosphere and activities on offer at the home.

People had access to advocates if they needed them and the home worked with people and their relatives to develop end of life care plans.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Most care files contained risk assessments and care plans that were person-centred and regularly evaluated. We found some which were not.

People's access to meaningful activities, including those nursed in bed, was excellent. They gave positive feedback about the activities they took part in.

People told us they felt able to complain if they needed to. Those who had raised concerns said they had been dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager completed regular audits; however, we found issues at the home which had not been identified by audit and resolved.

People and their relatives had regular opportunities to feedback about the service to the registered manager. They told us the registered manager and other staff were approachable if they needed to share concerns.

We saw staff at the home supported people according to the vision and values of the service. The home was in the process of

appointing 'champions' so staff could lead on improvements to the service.

Aden 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.

This inspection took place on 08, 09 and 12 September 2016. The first day was unannounced. The inspection team consisted of one adult social care inspector, an adult social care inspection manager and an expert by experience. An expert by experience is someone who has experience of, or has cared for someone with specific needs. In this occasion the expert by experience had cared for family members and was a Healthwatch volunteer.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The closing date for the submission of the PIR was during the inspection so we could not use the information to plan our inspection.

Before the inspection, we reviewed the information we held about the home and requested feedback from other stakeholders. These included Healthwatch Kirklees, the local authority safeguarding team and the Clinical Commissioning Group; they did not have any information of concern to share with us. After the inspection we also contacted five other healthcare professionals involved with people living at the home. The three that responded to us gave us positive feedback about the care provided at Aden Court.

During the inspection we spoke with people, their relatives and care staff to obtain their feedback about the home. This included 12 people living at the home, seven people's relatives, the registered manager, the clinical lead, five care staff (including nurses and care workers), the head cook, the laundry assistant, the activities coordinator and the home's administration worker. We also spoke with a quality support manager and area manager who were visiting from the home's provider.

Some of the people at Aden Court were living with dementia. We spent time in communal areas of the home observing how care staff interacted with people in order to try and understand their care experience.

As part of the inspection we looked at four people's care files in detail and specific care plans for four other people. We inspected four people's medicines administration records, three care staff recruitment records, the staff training matrix, supervision and appraisal documents, audit and monitoring records and various policies and procedures related to the running of the home.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they thought the care provided at Aden Court was safe. One person said, "The staff keep us safe", and a second commented, "The home is safe and clean." A relative asked if the home was safe told us, "Yes definitely. They are good at lifting and handling."

We found most aspects of medicines management and administration were done correctly by the home. The majority of people's tablets were provided by pharmacy in pre-filled dosettes, although some tablets and liquids were supplied in boxes or bottles. Liquid medicines stored in the fridge were dated when opened to ensure they were used before their expiry date. The temperature of the fridge was recorded daily to make sure medicines were stored at the right temperature. We observed a morning medicines round on the second day of inspection. The nurse checked each person's medicine administration record (MAR) prior to administering medicines. We saw people were then given their medicines in a supportive and person-centred way. The nurse then signed the MAR to confirm the medicines had been taken by the person. We checked four people's MARs and found they had been completed fully. Tallies of boxed medicines were kept to ensure supplies did not run out. Controlled drugs, for example morphine, were stored appropriately in the clinic room. We saw stocks of controlled drugs were checked by staff twice a day; we counted stock for three controlled drugs found they agreed with what was recorded in the controlled drugs book.

Some people at the home were prescribed medicines on an 'as directed' basis, which meant they were to take them when they needed them, rather than regularly. Medicines often prescribed 'as required' include pain killers, laxatives and topical creams. In order to administer medicines 'as directed' care staff need a medicine care plan or protocol which is individualised for the specific person and medicine. Protocols make it clear how much of the medicine can be given and how often. They are particularly important when people live with conditions like dementia and may not be able to tell staff when they need their medicines. We found some 'as required' medicines lacked protocols at Aden Court. These included Paracetamol, some topical creams and an oral spray used to relieve the symptoms of angina. This meant care staff did not have all the information they needed to administer 'as required' medicines safely.

We found some issues with medicines storage at the home. Most medicines should be stored at room temperature, which is 25°C or less, unless they need to be refrigerated. Records at Aden Court showed the medicines room had regularly exceeded 25°C over the summer months as there was no air conditioning equipment fitted in the clinic room. This meant the effectiveness of people's medicines may have been reduced. We raised this with the clinical lead and area manager. They said the issue had already been noted and plans were underway to try and remedy the problem.

Some people at the home were prescribed topical creams and lotions by their GP. Three of the MARs we looked at had topical creams. None had been signed to say they had been administered; instead 'care staff apply' had been written on the MAR. We checked people's daily records to see where topical cream application had been recorded. Daily records contained topical medicines application records, which were a combined topical medicine protocol and application record. However, none of the 10 topical medicines records we saw included instructions to tell care staff what the cream or lotion was for or how often it

should be applied. Records had been signed and dated when creams had been applied, but without specific information on how often they should be applied, it was not possible to judge whether people were receiving their topical medicines as prescribed.

The issues we identified with medicines constituted a breach of Regulation 12 (1) and (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at care records to see how the home managed risks to people. Care files included risk assessments for various aspects, including people's risk of falls, of developing pressure ulcers or of becoming malnourished. Risk assessments were accompanied by care plans which included risk control measures to be followed by care staff in order to minimise people's identified risks as much as possible. Not all risk assessments and care plans were in place and not all of those we checked were being followed by care staff. Some care plans had not been updated when the person's circumstances had changed. For example, one person with bed rails lacked a risk assessment for them which meant their safety and suitability for the person had not been assessed. Another person's mobility care plan dated 11 July 2015 and last evaluated in May 2016 described them as 'independently mobile with a zimmer'. We noted the person used a wheelchair during our inspection and so spoke with a member of care staff. The care worker confirmed the person's mobility had deteriorated such they did not mobilise independently. This meant the person's care plan was out of date, and care staff unfamiliar with the person who supported them according to their care plan may do so unsafely.

People at risk of developing pressure ulcers had risk assessments and care plans in place for this. We checked risk assessments and care plans for four people at risk of pressure damage to see if they were supported to minimise their risk. Three people's care plans stated they were at risk of pressure ulcers and risk assessments indicated each person should be assisted to reposition in bed every two hours. We checked these people's repositioning charts and saw care staff were recording 'in bed' or 'bed' for each intervention during the night, so it was not possible to evidence if they were being assisted to reposition. Care plans also stated two of the people should sit on special pressure-relieving cushions when seated in a chair. We saw one of these people was not using a pressure cushion on two occasions during the inspection and brought it to the attention of care staff. A third person's care plan stated they had a pressure ulcer on admission at the start of 2016; their care plan was dated 31 January 2016. Monthly evaluations for the care plan referred to a leg ulcer and a lesion which developed on the person's buttock area but not to the pressure ulcer they came in with. We could find no care plans for these other skin problems. This meant the person's skin integrity risk assessment and care plan were not updated, so care staff did not have the instructions they needed to support the person appropriately.

We checked accident and incident records to determine how incidents had been investigated and followed up to minimise future risk to people. We saw incidents had not always been followed up properly. Post-incident actions focused on documenting health checks on the person affected by the incident at regular intervals and did not include reviewing risk assessments and care plans or taking other measures to reduce risk. For example, on 15 May 2016 one person got their leg stuck in their bedrails and records showed it took three care staff to free the leg. Bedrails can pose a risk of entrapment to people if they are not fitted correctly and their use must therefore be carefully assessed. When we checked the person's care plan we noted it was dated 07 February 2016; it had therefore not been updated since the incident. The person's risk assessment and care plan evaluations also did not mention the person's incident of bedrail leg entrapment and there was no evidence to show the registered manager had acted to prevent the person becoming trapped in their bedrails since the incident. When we asked the registered manager about the incident she said the person's mattress had been replaced as a matter of urgency; however the only record of this was a request to the maintenance worker asking for it to be done. We noted the person's bedrails risk assessment was not

updated until 04 September 2016, and then only partially so. This meant the registered manager could not evidence how they had managed, and continued to manage, the risk of bedrail limb entrapment for a person with a history of this type of incident.

Issues with risk management at the home constituted a breach of Regulation 12 (1) and (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives raised concerns about problems with staffing at the home. The main issue people raised was waiting for support to use the toilet. People said of the home's staffing levels, "The staff number is mostly acceptable, they are the best even though I would rather prefer to have staff frequently ask me if I needed to use the toilet, rather than wait until I am desperate for it", "It differs. There are times when you want to go (to the toilet), you want to go and you can't wait until staff are free to help you in five or ten minutes", and, "Sometimes you wait a long time before someone comes to your rescue." However, people were keen to highlight how much they appreciated the care staff despite these issues; they told us, "Sometimes there is a shortage but there are always staff making efforts. I think things are improving", and, "Just short staffed sometimes, that's all, otherwise they are very helpful!" Relatives agreed with this. One relative told us, "There is a shortage of staff. It was brought up last week in the meeting and I believe it is being sorted", a second said, "Even though there is a shortage of staff, staff on duty are always brilliant!", and a third commented, "I think they need a few more carers and lately I've heard them grumbling. They always seem to be rushing about."

Staff also commented on the problems with staffing levels. They told us, "On the nursing side I feel there is more than enough. There are days when the care side is short staffed", "If we're fully staffed we have enough", and, "It depends day to day. Not always (enough staff)." One member of care staff described how they felt when the home was short staffed, saying, "We all feel really upset when we can't meet their (the people's) needs because we love every one of them."

We checked rotas to establish what the desired level of staffing was compared to the actual levels that had been on duty. The rotas showed eight staff members should be at the home to support people during the day; this would consist of two nurses and six care workers in the morning and one nurse and seven care workers in the afternoon and evening. There should then be one nurse and three care workers at night. According to the August 2016 rota, this level of staffing during the day had never been achieved. The highest level of staffing recorded was six during the day which happened once; we saw the home had been mostly covered by five to six care staff in the mornings with four care staff on duty in the afternoon and evening a total of 19 times. This is exactly half the number of staff the rota indicated should have been on duty.

We spoke with the clinical lead and the registered manager about the staffing levels at the home. The registered manager explained the home used a dependency tool to assess people's level of need on a monthly basis; however, this tool did not include a function to calculate the number of staff hours required to support the total level of need identified. The registered manager did acknowledge staffing had been a problem at the home but felt it was getting better. She told us the home had recently recruited more nurses and now had a full complement, and had since shifted the focus to employing more care workers. The clinical lead felt part of the issue with staffing was due to their deployment. They had worked with the senior care workers to reorganise where staff were focused at certain times during the day, to ensure a care worker was always available in the dining area at mealtimes and in the lounge area at other times of the day. This redeployment had been trialled for one week when we inspected and the clinical lead thought there had been a marked improvement in care staff visibility. They were keen to evaluate the trial with the care staff at a forthcoming team meeting.

Despite the efforts made to recruit more staff prior to this inspection, feedback from people and their relatives showed people had been effected by a lack of care staff, particularly care workers, who provided the majority of personal care. This constituted a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We inspected the personnel records of three members of care staff. We saw recruitment files included all the necessary documents, including a Disclosure and Barring Service (DBS) check, proof of identity and references from previous employers. The DBS helps services to make safer recruitment decisions when hiring staff to work with vulnerable people. The registered manager had investigated gaps in prospective employees' employment history. This meant appropriate checks had been made to ensure new employees were suitable to work with vulnerable people.

We noted the involvement of a volunteer at the home. They had been supporting care staff with providing activities to people for several years and we observed they were very much liked and appreciated by people who lived at the home. When we asked for the home's volunteer policy and the records relating to this volunteer, including the checks made to ensure they were suitable to assist with vulnerable people, these could not be located. The area manager said the volunteer had been asked to stop coming to the home until their records had been updated and confirmed the volunteer had never supported people on a one-to-one basis or with any personal care. This meant the vetting of a volunteer had not been undertaken properly and the people might therefore have been placed at risk as a result.

Care staff we spoke with could all describe the different forms of abuse people might be vulnerable to, for example, physical abuse, financial abuse and neglect. Care workers said they would report any concerns directly to a nurse, the clinical lead or the registered manager. Nurses could describe how to report concerns to the local authority safeguarding team and to the Care Quality Commission. This meant care staff knew how to identify the signs of abuse and how to report it properly.

Risk assessments for the building were in place and up to date. We saw the repainting of the reception area which was ongoing at the time of our inspection had been risk assessed to ensure the safety of the people at the home. Records showed safety checks had been made on all the facilities, equipment and utilities used to support the people at the home or keep them safe. This included checks of gas and electrical appliances, water temperatures, fire extinguishers and moving and handling equipment. People had individualised personal emergency evacuation plans which would provide emergency workers with the information they needed to evacuate them effectively. The home also had contingency plans in place in case of a fire, flood or other emergency that stopped the service. This meant the appropriate checks and assessments had been undertaken and measures put in place to make sure the building and equipment at the home was maintained properly and the people kept safe.

People and their relatives told us they thought the home was clean and tidy, although some commented that parts of the building were tired in appearance. One person said, "There is no smell of wee (urine) or number two (faeces), that's why I have been living here for [number] years", and a second person told us, "The home is the cleanest I have ever seen, polished every day." Relatives said of the home, "I think the fabric of the building needs attention but I'm impressed with the cleaning", and, "Since [my relative's] come the room has been redecorated and re-carpeted." As part of the inspection we looked in communal areas, in people's rooms (with their permission), in bathrooms and toilets and at the equipment used to support people. We found the home and equipment was clean which helped to keep people safe from infections.

Requires Improvement

Is the service effective?

Our findings

People told us care staff had the knowledge and experience they needed to meet their needs. One person said, "I have seen new staff being guided by staff who are more experienced", a second person told us, "Staff are as good as it gets", and a third commented, "They look after me well – they must be well trained." We asked relatives if they thought the care staff were well trained. One relative replied, "It's the only reason why [my relative] is alive today", and a second said, "In essence yes. They know what they're doing with moving and handling and infection prevention stuff."

Staff at the home told us they attended regular training courses and two newer members of staff gave positive feedback about the induction they received. One told us, "It was quite good. I had almost a week." A second described how they had been allowed more time shadowing other staff to build up their confidence when they first started. We checked care staff training files and the training matrix to determine whether care staff were up to date with mandatory training courses. The matrix showed the majority of care staff had completed courses in fire safety, infection control, safeguarding and moving and handling. Dates were being planned for staff who had missed training due to illness or annual leave. Most care staff had also completed training in dementia awareness and nutrition and hydration support; one told us they could ask for additional training or support if they did not feel confident in any particular area. Nurses we spoke with had completed additional training in medicines administration and had been checked for their competency by the clinical lead. The clinical lead was also supporting nurses to complete the new revalidation process so they could maintain their nursing registration. This meant care staff had received the training they needed to support people safely and appropriately.

We asked care staff if they received regular supervision and an annual appraisal. Feedback was mixed. One member of care staff told us their last supervision was, "Quite a long time ago", and a second said, "I've not had one for a while." Supervision records showed some staff had received as many as eight supervisions in 2016 up to the time of our inspection, whereas others had received one or two. Staff files showed supervision at Aden Court was always linked to problems, issues or incidents. Examples included the use of sharps bins for the safe disposal of needles, the correct disposal of medicines and infection control. Supervision was therefore used as a way of addressing poor practice with individuals or to share lessons learned after incidents had happened. According to the home's supervision policy, supervision should also be an opportunity to provide support to the staff member and not purely be about training and maintaining standards. This meant care staff were not receiving supervision according to the registered provider's supervision policy.

Care staff we spoke with told us they had received annual appraisals. The supervision and appraisal schedule showed appraisals had been completed with some staff. The clinical lead had been in post for six months; they told us staff appraisals had been delayed until they had settled into their role and got to know staff better. Appraisals for the remaining staff were being booked and we heard the registered manager discussing this with members of the management team who appraised other members of staff. Appraisal records we saw were detailed, thorough and completed according to the registered provider's policy.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We spoke with care staff at Aden Court about the MCA. All had received training and could describe the process of establishing capacity and understood how best to support individuals to make basic decisions, such as what to eat or wear. Senior care workers could explain the process of best interest decision-making for more complex decisions, such as the administration of covert medicines. This meant care staff knew how to support people in line with the legislation.

We checked care files to see if capacity assessments had been undertaken for people who may lack capacity due to mental health conditions such as dementia. Records contained capacity assessments for those thought to lack mental capacity to consent to living at Aden Court. Those deemed to lack capacity to make this decision had been subject to a best interest decision and DoLS application to the local authority. However, we saw no other capacity assessments had been undertaken of the people living at the home to establish if they could consent to, for example, receive care and treatment or be supported with specific moving and handling equipment. The clinical lead showed us a list they had compiled of tasks to complete and MCA assessments for other decisions was listed as outstanding. This meant that whilst capacity assessments and best interest decisions had been made in order to submit DoLS applications, there was further work needed to ensure the home was fully compliant with the MCA.

People told us they enjoyed the food at Aden Court. Comments included, "Meals are very good. I get to choose what I would like to eat from the menu", "I enjoy breakfast the most", and, "Food here is brilliant." Relatives were also complimentary about the food at the home. One relative said, "Nutrition – I think they've got it spot on here", and, "[My relative] says the meals are good." We saw signs at the home informing relatives they could book to have a free meal with their family members living at the home any time they wished. One relative said, "They've told us anytime we can come and book a meal with [my relative]", and a second said, "The food is fantastic. The whole family came on Mothers' Day and it was great." During the inspection we saw people eating with their relatives in the dining room; the head cook told us some relatives ate at the home as often as three times a week.

The head cook had received training in food hygiene and preparation and could describe the individual needs of people living at the home. This included people with diabetes, those at risk of weight loss and people with swallowing difficulties who needed foods of a specific consistency. The head cook also knew details about people's food likes, dislikes and preferences. For example, they described one person always left some food on their plate after a meal, so kitchen staff ensured they got a larger portion. The provider had a four-weekly menu which the head cook said they had modified after consulting people to ensure they liked the foods on offer. They told us, "I come out every meal time. I need to know that they like the food and they're happy." We saw people were given a choice of home cooked options for each meal the day before and could choose from a range of foods at breakfast time, including hot items cooked to order.

We observed three meal times during the inspection and ate lunch with the people. Tables were pleasantly arranged with cutlery, tablecloths and condiments. People seemed to enjoy the food and there was a

sociable atmosphere, with conversation between people and between care staff and people. One person eating breakfast told us, "I've had prunes and a fried egg sandwich. Sometimes I have a bacon and egg sandwich." Our expert by experience who ate a meal with people reported the food was hot, tasty and there was an adequate portion. The quality support manager explained how dining room tables had been rearranged recently to give the room a more informal feel. A relative told us the late afternoon meal had recently been moved back to 4.45pm from 4pm as people, including their relative, had said they were still too full from lunch. During the inspection we noted a drinks and snacks trolley circulated the home between breakfast and lunchtime, and lunchtime and teatime, serving hot and cold drinks, biscuits and cakes. People had also asked at a residents' meeting for the drinks and snacks trolley to go round in the evening before bed, and this had been implemented by the registered manager. This meant people were provided with a choice of good quality food in sufficient quantities which they told us they enjoyed.

Nutrition and hydration risk assessments and care plans showed some people were at risk of weight loss. Care records showed they were weighed regularly according to their care plans and we saw referrals had been made to GPs and dieticians when concerns were identified. However, when we checked daily records for two people at risk of weight loss, whose care plans stated their food and fluid intake should be recorded, we found the information recorded was not of sufficient detail to be meaningful. This was because quantities of foods provided were not written down. For example, on 05 September 2016 one person ate 'all' of 'fish pie, veg, yoghurt', and on 06 September 2016 a second person ate 'all' of 'cottage pie, veg, banana custard.' Without recording how much food the person was served, recording 'all', 'half' or 'three quarters' lacks meaning. We fed back our findings to the clinical lead during the inspection. By the end of the inspection they had spoken with care staff about the level of food and fluids detail they needed to record for people.

We observed two 'handover' meetings between the night staff going off duty and the day staff coming on duty. At this meeting the amount of fluids recorded for each person on a food and fluid balance chart the day before was considered and people with low consumption were identified. The care staff were then asked to encourage those people to drink more during the coming day. The clinical lead explained there were plans to install nutrition and hydration stations at various places in the home, so people could help themselves to drinks and snacks at any time. This meant the home tried to identify people with low fluid intake in order to improve their consumption and prevent dehydration.

Handover meetings were also a forum to discuss people's day-to-day health and wellbeing. We observed care staff discussing people's health status, medical and other appointments and sharing any concerns. The clinical lead took an active role in these discussions and provided advice to care staff, when required. The administrative worker also routinely attended handover and notified care staff of any updates affecting people's care, for example at one handover they reported a person had been appointed an advocate.

People told us they could see a GP or other healthcare professionals if they needed. Relatives agreed and said staff were good at letting them know if their family member was poorly. One person told us, "The nurse will do all necessary checks before a doctor is called", and a relative said, "Staff always call me if [my relative] needs a doctor, or even if it was for a physio or district nurse." Another relative told us, "The nurses definitely know what they're doing here." We saw from people's care files they had access to a range of healthcare professionals. These included GPs, tissue viability nurses, the dietician, opticians and a specialist diabetes nurse. After our inspection we spoke with two healthcare professionals who regularly visited the home. Both gave positive us feedback. One commented, "They're really good at reporting things we need to look at", and then added, "They seem to follow all the advice we give them." A second told us the care staff followed the advice they provided. They were also complimentary about the impact of the current clinical lead who had been in post for six months. This meant that the home supported people to maintain their

holistic health.

Some of the people at Aden Court were living with dementia, so we looked at whether the building was 'dementia friendly.' There are ways to modify buildings to better accommodate people living with dementia in residential and nursing care settings, for example, by using picture signage, wall and floor colours that aid navigation and memory boxes to stimulate memory and promote discussion. We found Aden Court had no signage (picture or otherwise) to aid navigation, in places carpets were patterned and people's bedroom doors were numbered and did not all have people's names on. Wall colours and hand rails were of contrasting colours which would help people to see them more clearly, however, a lot of the corridors looked very similar and we had problems navigating ourselves. We discussed the home's layout with the area manager. They agreed more could be done to improve the home's environment for people living with dementia and told us old photographs of the local area had already been purchased for the dining room to promote discussion at mealtimes. In addition we saw the reception area was in the process of being decorated to make it brighter and more inviting for people; the clinical lead explained lighting there had been improved to make it safer for people. During the inspection the area manager also sourced picture signage for communal areas which was to be put up the following week and some memory boxes for the care staff to use during activities. This meant whilst the home was not dementia friendly when we arrived to inspect, the area manager and home staff were keen to make improvements.

Requires Improvement

Is the service caring?

Our findings

People told us they thought the staff at Aden Court were caring. Feedback included, "The staff are very good", "Staff are very kind and approachable. They treat us with respect, everyone, even those who can't talk", "Staff are mannerly", and, "It couldn't have been any better!" Relatives were also complimentary about the staff and the home's atmosphere. One relative told us, "When I came to this home the first time it was non-clinical, warm, welcoming and full of activities." A second relative described how staff had made a, "Huge deal" of their relative's milestone birthday shortly before the inspection. Other relatives said of the staff, "I love them to bits", and, "They genuinely care. They are hard-working and never stop."

People told us care staff respected their privacy; we saw staff knocking on people's bedroom doors as they went to answer call buzzers or see if they needed support. One person told us, "I press a buzzer and they come knocking at my door." We also noted people's care files and other personal information was stored securely so their confidentiality was maintained. One aspect we observed during the inspection was the use of people's open ensuite bathroom doors to provide privacy while care staff supported people with personal care, rather than closing their main bedroom door. We noted in supervision notes that this issue had already been raised with care staff. They had been asked to cease the practice, as conversations between people and care staff could be heard clearly from the corridor outside and therefore did not respect people's privacy. We asked one care worker why they did this and they told us it was because they could not hear people's call buzzers, including emergency buzzers, when they were supporting people with the bedroom door shut. We fed this back to the registered manager and area manager during the inspection and they said they would consider options to address the issue. This meant people's privacy was not always respected when they received personal care in their rooms.

This constituted a breach of Regulation 10 (1) and (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One aspect of care that was not always individualised at Aden Court was people's access to baths and showers. People we spoke with did not complain about this part of their care; they stated they were grateful for the assistance they received. However, we noted there was a list whereby people were allocated a bath or shower weekly and on set days. One member of care staff told us, "There's a list in the nurses' office for shower days", and a second said, "It suits us more than them. It helps the home to function. It's how it's always been done." This meant people's access to baths and showers was regimented rather than person-centred.

We saw people looked well cared for; their clothes were clean and well-fitting. Staff at the home spoke with people respectfully and we did not overhear any discussion of people's personal information where others could listen. Care staff gave us examples of how they helped people to remain independent and make their own decisions and people told us they made decisions about the support they received. One person said, "Staff know I like to go to bed early and get up early." People's rooms were clean and tidy, and they and their families had been encouraged to personalise their rooms with furniture, pictures and ornaments. Staff at the home knew people as individuals; they could describe people's personalities as well as their likes, dislikes

and personal preferences. Some care records, particularly those relating to people's involvement in activities, contained warm and positive descriptions of people. For example, "[The person] has a strong character, knows [their] own mind and can share opinions", and, "A lovely [person] who is intelligent, perceptive, witty and has a great sense of humour." This meant staff respected people's dignity and treated them as individuals.

We asked people and their relatives whether they had been involved in developing their care plans or if they had seen and signed them. None of the people we spoke with were sure they had been; most said they could not remember. Relatives told us they had spoken to staff about care plans and we saw in some care files that the person had either signed their care plans or it was documented they had delegated the signing to a relative. Some care plans were signed by relatives but there was no detail added as to the involvement of the person. We spoke with the quality support manager who was visiting from the provider during the inspection. They told us the home was shortly to move to a 'resident of the day' system, whereby each person would have a designated day each month when their care plans would be reviewed, evaluated and updated, if required. The quality support manager said the person and their relatives (with the person's permission) would be invited to take part and their input would be documented. This meant the home had planned to improve people's involvement in planning their own care.

We found the home had a warm and welcoming atmosphere. A lot of relatives visited every day and many took part in activities with people and provided additional input and interaction. We observed there was friendly banter between relatives, staff and other people living at the home and a lot of laughter and smiles. Many people and care staff we spoke with commented that the happy, family feel to the home stemmed from the involvement of people's relatives. They said the home very much encouraged and supported this. One relative said, "Lots of relatives come and help out." Another relative told us they were involved in a project to make the home's reception area more inviting for the people to use. All relatives we spoke with told us staff at the home made them feel welcome and they could visit whenever they liked. As discussed earlier in this report, relatives were free to come and eat with their family member at the home whenever they chose. Another relative told us, "They're incredibly welcoming. I can visit anytime I want." This meant relatives were made to feel welcome at Aden Court and in return they enriched the lives of other people living at the home.

Care staff we spoke with could give examples of when people may need access to advocates and knew how to refer people to advocacy services if they needed them. We saw information about advocacy services was clearly displayed in the staff room of the home. The clinical lead said the home had referred a person who came to the home for respite care to an advocate as there was uncertainty around the person's mental capacity to understand the implications of returning home to live alone. This meant people had access to advocates if they needed them.

Shortly before this inspection we received a copy of a serious complaint regarding end of life care at Aden Court. At this inspection, we looked in people's care files, checked other records and spoke to people and their relatives about end of life care at the home. Care files we saw contained individualised end of life care plans which showed care staff had asked people and/or their relatives about their end of life wishes. All four of the people whose care files we examined in detail had elected to die at Aden Court, if possible. Relatives told us they had been asked about their family member's end of life wishes. One relative described sitting down with their family member and care staff to discuss the issue shortly after the person's admission; they told us, "[My relative] calls this [their] own home. [They] want to die here." A second relative said, "This home is fantastic for our [relative], they know about our [relative's] wishes. As a family we are happy for our [relative] to die here", and a third told us, "It came up in last week's meeting. I'm glad it was discussed and planned."

At the time of the inspection no one was receiving end of life care, although some people approaching the end of their lives had end of life care medicines ready at the home in case they should deteriorate. The clinical lead said one person was about to be placed on end of life care and showed us the detailed care plan they were about to implement. This care plan would replace the person's existing care plans and aimed to ensure support focused on comfort and symptom control. Care staff told us they had not received end of life care training and the registered manager confirmed this. She accepted this was an issue, given the significant proportion of people who accessed Aden Court for this type of care. The registered manager and clinical lead assured us they would source end of life care training for all staff as a priority. We saw feedback that had been received from relatives of people who had received end of life care at the home. It was highly complimentary. Comments included, "You cared for [name] as if [they] were a member of your own family", "Once again, thank you all so much for your care and support during a difficult time", and, "For the times you were there for [them] when we could not be."

At the time of our inspection a quality support manager from the provider was investigating the serious complaint that had been made about the home's end of life care for one person. They confirmed the home had stopped taking new admissions for people needing end of life care until their investigation was complete and any lessons had been learned.

Requires Improvement

Is the service responsive?

Our findings

People at Aden Court had access to a comprehensive range of activities, and feedback about activities was very good. People told us, "I enjoy trips and outings to the museum, church and others", and, "They do all sorts of activities here. Dominoes, bingo, music. I've got nought to complain about." Relatives were also happy with the activities on offer at the home. One relative told us, "My [relative] joins in all the activities. Bingo on Monday, DVD and gentle exercise on Tuesday. On Wednesday it's entertainment, singing and sometimes a church visit for communion, Thursday they do dominoes whilst Friday is singing and DVD. Other activities include going out for brass band events and museums." Other relatives said, "My [relative] does more now than [they] did when [they] came in", and, "My [relative's] never complained about not having enough to do."

We checked four people's care files to determine whether their care plans were individualised and person-centred. Each care file contained a standard set of risk assessments and care plans which covered various aspects, for example, safe environment, mobility, mental health, skin integrity, pain and medicines. Each care plan had an evaluation sheet which was to be completed monthly (or sooner, if required) as per the registered provider's policy. Care plans we saw were detailed and individualised, although they focused on meeting people's clinical needs and did not always encompass people's emotional needs and personalities. We discussed this with the quality support manager and they agreed with our assessment. They explained a new 'resident of the day' system about to be implemented was designed to address the issue and would ensure care plans would become more holistic and person-centred. In addition, the quality service manager said the new system would involve an initial assessment whereby the person's individual needs would be identified and relevant care plans put in place. This would replace the current system where people had a standard set of care plans, not all of which may be necessary. This meant the home had already identified issues with care plan content and were in the process of introducing improvement measures.

Six of the eight care files we examined in detail contained care plans and risk assessments which were reviewed and evaluated on a monthly basis. In one care file we saw care plans and risk assessments had not been updated for nearly four months. We were concerned because this person had an unstable medical condition which care staff and a specialist nurse were working together to try and manage better for the person. As a result, the person's medicines had changed numerous times over the past few months, as had their mobility. These changes had not been reflected in the person's care plan for this condition (it was dated 11 July 2015), and it was not clear in the person's care plan that their medicines could change almost on a weekly basis. We spoke to care staff about this person during the inspection; they could describe the person's care and mobility needs in detail and were aware of the issues relating to their medicines. In addition, staff had attended specialist training about the person's medical condition and during the inspection we observed the person being supported appropriately. Feedback from a healthcare professional about the care this person received at the home was also positive; they told us the staff, "Are very diligent."

Another person's care plans had not been reviewed and evaluated in August 2016; their dietary care plan dated 30 March 2016 stated they were nursed in bed following an accident, however, we saw them up and mobilising independently. This meant two people were not being supported according to their care plans

because they had not been reviewed and evaluated since their needs had changed.

We spoke with the clinical lead about the process of care plan evaluation. They told us each person had a named member of care staff who was responsible for reviewing and updating care plans every month. We saw the list was displayed in the nurses' office. The clinical lead said the person whose care file had not been updated for over three months had been allocated to a staff member who was on long term sick leave; there had been an oversight which meant another member of staff had not done the reviews instead. Once again, the quality support manager stated this issue would be resolved by the resident of the day system which was to be implemented at the home.

We asked care staff how they knew what people's needs were and gave an example of a new person admitted to the home while the staff member was on holiday. Each staff member told us they would listen to instructions at the daily handover meeting, speak to the person and other staff, and read the person's care plans. Care staff also evaluated care plans in the daily records they kept about people. These were kept in a folder in people's rooms if they were nursed in bed or came downstairs with the person when they did. As discussed earlier in this report, the quality of these records was not always good; however, during the inspection the clinical lead met with care staff to give guidance on the required standards. In addition, we heard the registered manager remind senior care workers to check and sign the daily records each shift; when we checked eight daily records we saw this was not done in half of them. This meant whilst daily records did not always evidence people were supported according to their care plans, the registered manager and clinical lead were responsive to feedback and tried to make improvements.

Issues with care plan reviews and evaluation constituted a breach of Regulation 17 (1) and (2) (a) (b) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted one person at Aden Court could not speak to staff in order to make their needs known. It was clear workers at the home knew this person very well and could usually understand what the person was communicating and gave choices and options if they could not. We checked the person's communication care plan and it was very basic. The quality support manager agreed with our assessment and said other methods of communication should have been tried to assist the person to communicate more easily, for example, with picture cards. The quality support manager said they would ensure the person's care plan was reviewed and updated to include all appropriate methods of support available to the person.

During the inspection we observed people playing dominoes, attending a book club, singing as a group and there was an entertainer who came and sang to a large group of people and relatives. People and relatives told us how joining in activities had allowed people to make friends with other people in the home and we noted people chatting amongst themselves and greeting one another by name. At all times during the inspection there was a pleasant atmosphere and lots of friendly chatter and laughter.

We asked how people nursed in bed were included in activities. The activities coordinator said they developed a range of activities for each person depending on their likes and preferences. They told us, "I do whatever it takes to involve them. I do quizzes, song games, I go through family albums and memory boxes with them." The activities coordinator also organised for a singer to come to the home once a month to sing for the people nursed in bed; they told us, "We sit and sing all their favourite songs with them." People nursed in bed told us they enjoyed the activities they did with the activities coordinator. One person said, "I like joining in when there is a singer", and a second told us, "I enjoy playing cards, dominoes and crosswords with [name], you know, the activities girl."

Feedback about the activities coordinator was very positive and it was clear they were highly thought of by

people, their relatives and other staff at the home. They kept detailed evaluations about the activities at the home, so they could identify which activities individuals enjoyed most. A home meeting was held every November whereby all the activities people had tried during the year were discussed, along with ideas for new activities and plans for trips and outings for the following year. The schedule of activities was provided on weekdays only, with only occasional trips, outings and socials at weekends. Some care staff and relatives thought more activities should be provided at weekends and the registered manager said she was looking into various options for this. However, none of the people we spoke with said they were bored or did not have enough to do at weekends. One person told us, "It's good to have a rest at weekends. I think we do enough." This meant people were happy with their level of access to meaningful activities at the home.

People and their relatives told us they knew how to complain if they needed to and would feel comfortable to do so. Only one person we spoke with had made a complaint about the service. They said it was taken seriously and resolved to their satisfaction. Other people and relatives we spoke with said they had never made a formal complaint about the service. One person said they had provided feedback; they told us, "When I did raise a concern things were made up (put right)." As discussed earlier in this report, the registered provider had received one serious complaint shortly before our inspection and was in the process of a detailed investigation. We checked the records of other complaints made in the last year and found they had all been documented, investigated and resolved according to the registered provider's complaints policy. This meant people felt able to complain if they needed to and any complaints had been addressed properly.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager. They were on annual leave for the first two days of inspection and returned for the third day. In their absence, we spoke with the home's clinical lead, and the quality support manager and area manager who visited from the provider.

The registered manager conducted monthly audits on a range of aspects at the home, including wound care, bed rails and pressure area care, which then contributed to an overarching action plan. The registered manager showed us an audit of falls which compared the time of day falls had occurred and their location. The tool had been used to identify a higher incidence of falls in people's rooms at night; the registered manager had then used this evidence to increase the number of night staff on duty. This was a good example of using audit to improve safety at the home.

However, we identified issues at the home which had not been identified and resolved by audit. For example, some care plans had not been reviewed and evaluated for over three months and we found instances where people's health had changed and their care plans were out of date. We saw daily records did not always evidence people were supported according to their care plans. One person with bed rails fitted lacked a risk assessment for them and this had not been highlighted by the bed rails audit as it did not contain a prompt to check if a risk assessment was in place. An audit of accidents and incidents had not identified there was no documented risk management follow up of a person who had been trapped in their bedrails. The audit of medicines did not identify the lack of recording of topical cream application or of 'as required' protocols for all relevant medicines, as this was not part of the audit. This meant the audits undertaken at the home were not always effective at identifying issues and areas for service improvement.

Issues with record-keeping at the home and the failure of audit to identify and remedy them constituted a breach of Regulation 17 (1) and (2) (a) (b) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We accompanied the registered manager on one of her twice daily walkarounds. These were inspection checks of the home performed on weekdays which were recorded on a checklist. After the morning walkaround the registered manager held a 'flash meeting' with senior members of the domestic, kitchen, maintenance and care staff. At the flash meeting we attended the registered manager fed back to the maintenance worker about a potential trip hazard in the garden and reminded the senior care worker about the checks they needed to make on daily records to ensure they were completed fully. There was also discussion between the attendees about the best way to serve liquid supplements to people; the cook felt people would drink more if they were served in glasses rather than in their original containers with a straw. The registered manager agreed this should be trialled to see if people's intake improved. The registered manager checked the actions from the meeting at the second daily walkaround later in the day and outstanding actions were raised at the following day's flash meeting. This meant the registered manager and management team at the home had a proactive and responsive approach to resolving day-to-day issues at the home.

The home had been through a period of change in 2016. There had been changes in senior management at provider level and a new clinical lead had commenced at the home six months earlier. The quality support manager and area manager were also relatively newly in post. Feedback about the registered manager and clinical lead from people, relatives and other care staff was positive. We saw they both had a visible presence at the home and clearly knew people and their relatives well as individuals. One staff member said of the registered manager, "She's absolutely amazing", and another said, "She's a good manager." With reference to the clinical lead's input into one person's care, one healthcare professional told us, "Things have significantly improved since [they] came and pulled things together." At times during the inspection we had difficulty differentiating the roles and responsibilities of the registered manager and clinical lead, as they seemed to overlap. For example, the registered manager did monthly clinical audits and line managed the nursing staff. The clinical lead said they were still in the process of settling into the home and their roles and responsibilities were being discussed and reviewed.

People and their relatives thought the home was well managed and staff were approachable. The home also sought feedback from people and their relatives about the service provided. The registered manager told us they used to hold regular residents' and relatives' meetings but stopped because they were poorly attended. Instead the registered manager held a surgery one day every month where people and their relatives could come and speak with her or raise any concerns. One relative told us, "It's always easy talking to management, they are the ones who are answering the doorbell", and a second said, "If there's anything I want I just go to the office door." We observed people and relatives approaching the registered manager and administration worker with questions and queries during the inspection. We saw they responded in a friendly and approachable manner and tried to resolve any issues. This meant people and their relatives were encouraged to provide feedback about the service and felt comfortable to do so.

The registered manager was also receptive to feedback from staff and told us, "I will back them as much as I can. We work as a team and I have an open door policy." A staff member said of the registered manager, "The staff feel comfortable speaking to her. The residents and relatives love her." The home had regular staff meetings and staff were encouraged to draw up the agenda for them. Minutes we saw were detailed and covered various aspects relating to the quality of the service, for example, concerns about the shortage of care staff. The area manager had recently attended one of these meetings and we saw another was to be held shortly to discuss the changes made to staff deployment at the home. This meant the registered manager involved the staff in service improvement.

We asked the clinical lead how they kept their clinical skills and knowledge up to date. They told us they accessed online journals and other learning resources and were sharing them with the other nurses to help with their continuing professional development and nursing revalidation. The clinical lead had also arranged for specialist training for staff on diabetes and was in the process of arranging courses on nutrition and end of life care. The quality support manager said the home was in the process of seeking volunteer 'champions' from amongst the staff at the home. The aim was for them to be in place by October 2016. The champions would be upskilled and then responsible for improving practice in their chosen area, for example skin integrity, equality and diversity, Mental Capacity Act (2005) and dignity. This meant the home encouraged staff to develop their skills and experience in order to improve the service for the people who used it.

As part of the inspection we asked the care staff about the vision and values of Aden House. The registered manager told us the home aimed, "To ensure that each client maintains a sense of self, participates in decisions regarding their lives and are reassured that their lives still have value." A member of care staff explained, "For me it's making residents' lives easier and better in some way. I come in with open arms to help and support people." A second told us, "I like to care for people. I like to think they're safe and happy

and content where they live", and a third care worker said, "I come to work because I care. I want to make a difference to their lives." Feedback from people, their relatives and our own observations of care at the home showed us the staff understood the vision and values of the service and it underpinned the support they provided.

In accordance with the regulations, registered managers are responsible for notifying the Care Quality Commission (CQC) about certain incidents, accidents or events. We checked the records of notifications made by the registered manager to CQC against the records of incidents and accidents held at the home and found all notifications had been made correctly.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Care staff did not always respect people's privacy and dignity when assisting people with personal care. Regulation 10 (1) and (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines prescribed 'as required' lacked protocols and the application of topical creams was not being recorded by care staff. Regulation 12 (1) and (2) (g) We found issues with the way risks to people were assessed and managed. Regulation 12 (1) and (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Care plans had not been reviewed and updated when people's care and support needs had changed. Regulation 17 (1) and (2) (a) (b) (f) Issues with out of date care plans, poor quality daily records and the follow up of accidents and

	incidents had not been identified by audit. Regulation 17 (1) and (2) (a) (b) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The people had been effected by a lack of care staff at the home. Regulation 18 (1)