Four Seasons (Bamford) Limited

Aarondale Care Home

Inspection report

Sunny Brow
Off Chapel Lane, Coppull
Chorley
Lancashire
PR7 4PF

Date of inspection visit:
18 October 2016
25 October 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Aarondale Care Home provides accommodation and assistance with personal care for up to 48 adults, some of whom live with dementia. The home does not provide nursing care. People who live at the home have varying needs and specialist support is provided where necessary. The home is arranged over three floors, each having lounge, bathing and dining facilities. A car park is available and on road parking is permitted in the surrounding area. A range of amenities are close by and public transport links are within easy reach.

The last inspection of this location was conducted on 4 September 2013, when all outcome areas assessed at that time were being met. This inspection was conducted on 18 October 2016 and 25 October 2016. The first day was unannounced, which meant that people did not know we were going to visit the home. The registered manager was given short notice of the second day of our inspection.

A registered manager was in post at the time of our inspection. However, she was not on duty on the first day of our inspection, but she was present on the second. 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 of the Health and Social Care Act and associated regulations about how the service is run. The deputy manager was in charge of the home on the first day of our inspection.

The care planning system was, in general person centred providing clear guidance for staff about people's needs and how these needs were to be best met. The plans of care had been reviewed regularly.

Risks to the health, safety and wellbeing of people who used the service had, in general been assessed. However, where risks were identified these were not consistently incorporated into the care planning system.

Fire procedures were easily available, so that people were aware of action they needed to take in the event of a fire and records we saw provided good information about how people needed to be assisted from the building, should the need arise.

A range of internal checks were regularly conducted and environmental risk assessments were in place, showing that actions taken to protect people from harm had been recorded. However, we found that several fire doors did not fully close into the door frames. This created a potential fire hazard. We observed that in one person's bedroom there was a very large stuffed toy and an abundance of smaller soft toys. None of those we looked at were labelled as being fire retardant. We have made a recommendation about this.

Records showed that equipment and systems within the home had been serviced in accordance with the manufacturer's recommendations. This helped to protect people from harm. Infection control practices could have been better in some areas.

Records showed that Mental Capacity Assessments had been conducted in some cases, in order to determine capacity levels. However, there was a 'Do Not Attempt Cardio-Pulmonary Resuscitation' record on one care file, which was not fully completed or signed by a medical practitioner.

The rights of people were not always protected as applications to deprive someone of their liberty for their own safety had not always been obtained for restrictive practices. People's privacy and dignity was consistently respected.

The service had reported any safeguarding concerns to the relevant authorities and suitable arrangements were in place to ensure that staff were deployed, who had the necessary skills and knowledge to meet people's needs safely. A range of training for staff was provided. However, staff on duty appeared to be rushed during busier periods of the day, such as meal times. We have made a recommendation about this.

Recruitment practices adopted by the home were robust. Appropriate background checks had been conducted, which meant that the safety and well-being of those who used the service was adequately protected. We observed that staff were rushed during the busier periods of the day, such as meal times. We have made a recommendation about this.

There were systems in place for monitoring the safety and quality of the service. Audits viewed had identified areas which were in need of improvement and action was taken to address these shortfalls.

People we spoke with were aware of how to raise concerns, should they need to do so. A complaints procedure was in place at the home and a system had been implemented for the recording of complaints received. However, we did not see any evidence to demonstrate that complainants were formally informed of the outcome of an internal investigation. We have made a recommendation about this.

During the course of our inspection we assessed the management of medications. These were not always dispensed safely. The service worked well with a range of community professionals. This helped to ensure that people's health care needs were being appropriately met.

We found the management of meals to be somewhat disorganised and the provision of leisure activities was limited. We have made recommendations in these areas.

People we spoke with were, in general complementary about the staff team. They felt that they were treated in a kind, caring and respectful manner. People expressed their satisfaction about the home and the services provided. However, the records for the provision of personal care did not accurately reflect the care people said they were receiving. We have made a recommendation about this.

Regular meetings were held for those who used the service and the staff team. This enabled people to discuss topics of interest in an open forum and people's views were also gained through processes, such as satisfaction surveys.

Although we found the management team co-operative and helpful at the time of the inspection we found that quality monitoring systems had not identified shortfalls recognised by the inspection team.

We found breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to safe care and treatment, Safeguarding service users from abuse and improper treatment, person centred-care and good governance.

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

This service was not always safe.

Recruitment practices adopted by the home helped to ensure that only suitable staff were appointed to work with this vulnerable client group.

Some fire doors did not close properly. This created a potential fire hazard. Infection control practices could have been better in some areas.

Risks to people's health and well-being were, in general addressed to ensure that those who stayed at the home were protected from harm. However, medicines were not always dispensed in a safe manner.

Safeguarding referrals had been made to the relevant authorities and emergency plans had been generated, so that people were kept safe. Staff members were aware of the procedures to follow should they have concerns about the welfare of those who lived at the home.

Is the service effective?

Requires Improvement

This service was not consistently effective.

Records showed that staff received a good induction programme when they started to work at the home. This was followed by a range of training programmes, regular supervision and annual appraisals.

Consent had not always been obtained for care interventions and evidence was not always available to demonstrate that those who had given consent on behalf of people had the legal authority to do so.

Relevant assessments had not always been conducted for restrictive practices.

The premises were, in general well maintained and suitably adapted for those who lived at the home.

Meal times could have been better managed.

Is the service caring?

Good

This service was caring.

Staff were seen to be kind, caring and respectful of people's needs.

Those who lived at Aarondale were supported to be involved in the day to day activities of the home and were enabled to access advocacy services, should they require this.

Records were retained in a confidential manner and people's privacy and dignity was consistently respected.

Those who stayed at the home were supported to maintain their independence, as far as possible and staff members, in general communicated well with those in their care.

Is the service responsive?

Requires Improvement

This service was not consistently responsive.

The plans of care were based on assessments of people's needs and we found them to be up to date, in general person centred and well written documents, providing the staff team with clear guidance about people's needs and how these needs were to be best met.

The provision of activities was limited. Staff could support people to maintain their individuality and to participate in activities specific to them.

Daily records could have been better in relation to the provision of personal care and assisting people to wear prosthesis.

Complaints could have been better managed, as complainants were not formally informed of the outcome of any investigation.

Is the service well-led?

Requires Improvement

The home had developed some good systems for assessing and monitoring the quality of service provided. These included audits and surveys for service users and their relatives. However, systems in place had not consistently identified areas in need of improvement, as recognised by the inspection team.

A wide range of policies and procedures were in place, which

provided the staff team with relevant guidance and current legislation in a variety of areas.

Meetings were held for those who lived at the home and the staff team, so that important information could be appropriately disseminated and so that those who worked at the home could discuss any relevant topics in an open forum.

Aarondale 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The first day of our inspection was unannounced. The registered manager was given short notice of the second day of our inspection. The inspection was conducted by two Adult Social Care inspectors from the Care Quality Commission (CQC) and an expert by experience. An expert by experience is a person who has experience of the type of service being inspected. At the time of our inspection there were 42 people who lived at Aarondale Care Home. We were able to speak with eleven of them. We received positive comments from most of those we spoke with.

We also spoke with three members of staff, the deputy manager of the home, the administrator, the registered manager and two company representatives, who attended the inspection on separate days. We also communicated with five relatives. We toured the premises, viewing private accommodation and communal areas. We observed the day-to-day activity within the home and we also looked at a wide range of records, including the care files of six people who used the service. This enabled us to determine if people received the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed. We also looked at the personnel records of four staff members, which helped us to establish the robustness of the recruitment practices and the level of training provided for the staff team. Other records we saw included a variety of policies and procedures, training records, medication records and quality monitoring systems.

We conducted a Short Observational focussed Inspection (SOFI) during our visit to Aarondale. This part of our methodology enables us to specifically observe a small number of people over short time frames.

The provider completed and submitted a Provider Information Return (PIR) within the time frames requested. A PIR 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.

Prior to our inspection we reviewed all the information we held about the service, including notifications the provider had sent us about important things that had happened, such as accidents, deaths and safeguarding incidents. We also looked at the information we had received from other sources, such as the local authority and community professionals involved in the care and support of those who lived at the home.

Requires Improvement

Is the service safe?

Our findings

We asked those we spoke with if they felt safe whilst living at the home. Comments we received included: "Everybody's nice"; "I'm quite happy here"; "I've got a bed and if I'm not well I can lie down"; "You can't get out, as soon as you get up, they want to know where you're going"; "The staff are wonderful and very helpful"; "I feel no different than I did outside" and "Nobody can come in as they like. They [the staff] have to let people in first."

A relative we spoke with said, "Mum's changed dramatically [for the better] since she's been here" and another told us, "She [relative] can't be better anywhere. I think it's really good here."

We asked if there were enough staff on duty. Most people we spoke with felt there were. However, one person said, "They are short staffed. You have to wait a little time for help." This person was unable to elaborate on their statement by telling us how long they had to wait or if there were specific times when they thought the home was short staffed. Another person told us, "Sometimes they're a little bit short of staff," but again this person could not tell us of any specific incidents. One visitor we spoke with said, "Probably at weekend it seems less well staffed", whilst another told us, "There seems to be plenty of staff. They're all really good."

Lancashire Fire and Rescue service had conducted an inspection several months earlier, when a minor breach of fire regulations was noted. However, on the day of our inspection work was in progress by an external contractor to rectify some areas of fire safety, which had been identified as needing improvement. We saw a report to show how shortfalls were being addressed.

A fire risk assessment had been developed, which had been reviewed and updated annually and the procedure to follow in the event of a fire was easily accessible. During our tour of the premises we noted several fire doors, which were not closing fully into the door frames and one which was not closing due to the carpet pile. This created a potential fire hazard and needed to be addressed. Some of these fire doors had been identified as not closing properly on the last fire risk assessment, conducted in March 2016, but had subsequently been recorded as being resolved.

We asked people about the cleanliness of the home. One person said, "It's spotless." Most people told us that their bedrooms were cleaned every day. There was a cleaner visible throughout most of the time we were at the home.

We noted during our tour of the premises that some door handles were dirty and in need of cleaning. The underneath side of one bath seat was very dirty and in need of a thorough clean. The sluice rooms were in need of refurbishment, so that they could be easily cleaned, in order to promote infection control. There was no soap available for hand washing in one of the sluice rooms.

We assessed the management of medicines. A wide range of written policies and procedures were in place in relation to the management of medicines. The policy for Controlled Drugs [CD's] indicated that CD's were

not to be ordered through the usual dispensing system, but they must be delivered in a tamper proof box. However, we found that this was not happening in day to day practice. We saw that the supplying pharmacist conducted medication audits four times a year and that a monthly internal audit was completed, which helped to identify any areas in need of improvement.

Medication Administration Records (MARs) showed that medications received into the home were recorded and that MAR charts were completed appropriately. People were supported with their medication in a dignified manner. They were asked if they wanted their prescribed 'as and when required' medicines during each medicine round.

One person who lived at the home expressed their concerns about the management of their medications. This was discussed with the registered manager of the home. It was established that a GP had discontinued one medication, which had concerned the individual. A recent medication error, involving this person had been appropriately reported under safeguarding procedures and their plan of care had been reviewed and updated. There were systems in place at the home, which would support people to manage their own medications, should they wish to do so.

Records showed that those staff responsible for dispensing and administering medication had received training in the management of medicines and that practical assessments had been conducted. We looked at these records for one member of staff and found that all areas were ticked as being met, without any areas in need of improvement. However, on observation of one medicine round this member of staff left the medicine trolley open and unattended on four separate occasions.

The above shortfalls amounted to a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. For example, in relation to fire safety, cleanliness and the management of medications.

The fire risk assessment indicated that all furnishings were fire retardant. However, we observed that in one person's bedroom there was a very large stuffed toy and an abundance of smaller soft toys. None of those we looked at were labelled as being fire retardant. We recommend that the provider seeks advice from Lancashire Fire and Rescue Service about this observation.

One person, who lived at the home, told us that staff did not have time to assist them to use the telephone and we did on occasions witness some people having to wait for assistance. Some staff we spoke with and a relative told us they felt that there were enough staff on duty each day. However, one member of staff told us that there were not enough staff to meet people's needs, although this member of staff confirmed that call bells were answered within a reasonable amount of time. The duty rotas we saw corresponded with the number of staff on duty on the day of our inspection. However, we noted that staff were rushed at the busier times of day, such as meal times. We recommend that staffing levels be reviewed, particularly during the busier times of day to ensure these are sufficient to fully meet the needs of those who live at the home.

Records showed that all staff members had completed training in relation to fire safety awareness. Each person who used the service had a PEEP in place. A PEEP is a Personal Emergency Evacuation Plan. It is a bespoke plan for individuals who may not be able to reach an ultimate place of safety unaided or within a satisfactory period of time, in the event of any emergency, such as fire or flood. This assists emergency services to help people to vacate the premises in the safest and most effective way.

We saw that a wide range of environmental risk assessments had been conducted in order to keep people safe and records showed that some internal checks were completed regularly in order to protect people

from harm. Information was available for staff in relation to fire safety. A fire alarm test was conducted regularly to ensure the system remained operational and in good working order.

A business continuity plan, designed by a Health and Safety advisor outlined what action staff needed to take in the event of an emergency situation arising, such as gas leak, power failure, flood, fire, adverse weather conditions, bomb threat, terrorist attack, pandemic or utility disruption. This helped to ensure that people were protected from harm.

Records showed that systems and equipment within the home had been serviced in accordance with the manufacturers' recommendations. This helped to make sure they were fit for use and therefore promoted people's safety.

During the course of our inspection we toured the premises and found the environment to be warm and comfortable throughout. It was generally well maintained, although some areas were in need of updating. There were no unpleasant smells and it was clear that a friendly environment was created for those staying at the home.

Cleaning schedules were completed and there was a detailed infection control policy in place with good information for staff about the correct use of Personal Protective Equipment [PPE]. We noted that Personal Protective Equipment and clinical waste receptacles were not always provided at the point of need. However, staff members we spoke with told us that there was ample PPE available and that this was easily accessible. Clinical waste was being disposed of in the correct manner.

During the course of our inspection we looked at the personnel files of four staff members. We found that robust recruitment practices had been adopted by the home. References had been obtained and Disclosure and Barring Services [DBS] checks had been conducted before people started to work at the home. DBS checks allow managers to establish if any prospective employees have a criminal record or if they have received any cautions, to enable employers to make a decision about appointing them.

Staff we spoke with talked us through their recruitment and induction processes. They felt that their recruitment and induction were thorough and they gave some good examples of subsequent training, which they had completed. These modules included health and safety, moving and handling, first aid, dementia awareness, safeguarding vulnerable people, mental health and first aid.

Staff members were aware of the procedures to follow should they have concerns about the welfare of those who lived at the home. Accident and incident records were maintained appropriately in line with data protection guidelines and these events were escalated in accordance with the company's written reporting policy and procedure guidelines.

Requires Improvement

Is the service effective?

Our findings

We asked if people thought the staff were well trained and competent to deliver the care they needed. Comments we received included: "Yes, they [the staff] are all nice"; "I don't bother the staff much"; "Yes, they're wonderful"; "They're OK" and "They're very good."

We asked people what they thought about the food served. Comments we received included: "You get a choice, but I don't know what's for lunch today"; "You get a choice. I've never asked for anything different"; "Some days it's cold [the food]. I like egg and chips, but I'm not allowed chips, cheese or pastry. They've [the staff] put me on a diet. They give me mashed potato instead of chips." However, one member of the inspection team ate lunch with the people who lived at the home and the meal was hot. We also observed the person who made these comments being offered a biscuit at morning coffee. No-one else we spoke with complained about the food being cold. Other comments we received about the food included: "I do like the food. We get quite a lot. We can have snacks if we want them"; "It's very good. I'm enjoying it. I get a choice"; "It's always very, very good, I've no complaints whatsoever"; "It's alright. It's fine. I'm not that fussy" and "I just go with it. I would like something spicier, but if I don't want it I leave it. Sometimes they give me something else." One relative told us, "She [the resident] eats the food now. I was asked about her likes and dislikes."

During the course of our inspection we assessed the management of meals. The home had been awarded level five for food hygiene by the Environment Health Officer from the local authority, which is equivalent to a 'very good' outcome and which is the highest grade available. However, one member of the inspection team ate lunch with some people who lived at the home. The dining room felt cold and people were complaining of feeling the cold. We told a carer about this, who switched a heater on. The menu was not displayed anywhere, so people could not refer to the menu of the day. There were small blackboards on each table, but these were blank. People were verbally offered a choice of menu at the time of dining; although a choice of cold beverages was not offered. One person was shown both options of meals, but said they didn't want either. However, they were still given one of the choices available. This person was then struggling to cut the pie, but no-one offered any assistance, so they did not eat much of the main course. They told a staff member that they did not like it. The staff member responded by saying that they might like the pudding.

We observed lunch being served on the ground floor, which we found to be somewhat disorganised. Although people we spoke with confirmed they were offered menu choices no-one we spoke with knew what was for lunch at the time of our inspection. There was no direction for staff about allocated lunch time duties. One member of staff was assisting two people with their lunch, which was not entirely person centred. We saw that one person did not want their meal. Therefore, it was removed, but no alternatives were offered and there was no further exploration as to why the individual did not eat their meal. The dessert served was bananas and custard. Several people said they did not like bananas, so were served a bowl of custard. One person told a staff member they wanted something else for their desert. The staff member told the individual that they could have yoghurt instead only to discover that there were no yoghurts available. Tea or coffee was offered with the main course and residents were offered another drink

if they finished their first one.

We spoke with the chef, who was not aware of people's special diets, except for one person who was receiving a gluten free diet. However, we were told he had only been in post for four weeks however peoples special diets should be a priority. One person told us that they did not enjoy the food served, as it was 'bland'. We discussed this with the registered manager and suggested that something more suited to the individual's cultural tastes could be more acceptable.

These shortfalls around peoples choices and preferences is was a breach of regulation 9 (1)(3)(l) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Nutritional care plans were found to be comprehensive and were reviewed as was required. Specialist advice was sought when necessary from dieticians and Speech and Language Therapists (SALT). Dietary and fluid intake was monitored and recorded in accordance with risk. This helped to ensure that people were receiving adequate nutrition.

We looked at the weight records of a high percentage of people who lived at the home. We found that people were weighed each month and that in general their weights remained fairly stable during the current year. Several people had gained weight. However, a few had lost weight over time. We saw that a monthly weight loss monitoring form had been implemented. However, this included only those who had lost some weight from the previous month and therefore an overall picture of weight loss was not portrayed, although the individual weight charts did show where individual weights fluctuated and a member of staff we spoke with was aware of one person losing weight over two months and was able to describe the action which was being taken to monitor this. Other staff we spoke with were fully aware of those whose weight needed to be monitored more closely, because they were at risk of malnutrition.

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. We checked whether the service was working within the principles of the Mental Capacity Act.

We noted that one person had sustained an unwitnessed fall earlier in the year and had agreed to use a specialised chair for their safety. The plan of care showed that the individual liked the chair as it was comfortable. However, this person had later decided that they would prefer to sit in a standard armchair instead of the specialised chair, but due to the individual being at high risk of falling, the service continued to use the specialised chair. This person was living with dementia and whilst capacity must be the first presumption, and to not go along with her wishes was not to obtain valid consent. However, the sudden change of mind should have triggered a capacity assessment to determine if indeed she had the mental capacity to understand the risk of not using the specialised chair. There was no evidence of a mental capacity assessment or risk assessment conducted in relation to this, despite the chair restricting the individual's ability to get up alone. Had she been deemed to lack capacity then given it was a restrictive practice should also have triggered a Deprivation of Liberty (DoLS) application. Whilst we were informed that this had been done there was no evidence available to demonstrate that this persons capacity had been assessed and that the decision to use the chair had been made in the best interest of the individual.

This unlawful and unauthorised restraint amounted to a breach of regulation 13 (1)(5)(7)(b)of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found a further example of failing to obtain valid consent. A 'Do not attempt cardio-pulmonary resuscitation' [DNACPR] form was on one care file we looked at. However, this was not signed by a medical practitioner, the reason for implementing DNACPR had not been recorded and the decision had not been discussed with the individual concerned. There was no evidence in the care file that this person was at risk of cardiac arrest or that the decision had been made as part of a best interest process.

This was a breach of regulation 11 (1)(2)(3) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A policy was in place at the home in relation to the MCA and Deprivation of Liberty Safeguards [DoLS], We saw that the majority of care files included consent to receive various aspects of care and support, such as the sharing of information, medication administration and the taking of photographs. However, it was not always clear if those who had signed consent on behalf of the people who lived at the home had been granted legal authority to do so. People are assumed to have capacity unless it can be shown otherwise. People either consent to their own care or if they are deemed to lack capacity, then the principles of the MCA must be followed unless relatives or carers are authorised by law to act on a person's behalf. It is recommended that copies of relevant legal documents are retained on people's care files, as appropriate, to demonstrate who has legal authority to give consent on behalf of those who live at Aarondale.

In general, the care planning process for mental capacity and consent was of a good standard and we saw some detailed examples of decision specific mental capacity assessments and best interest decision making, which was pleasing to see. However, the plan of care for one person, in relation to consent and capacity could have been a little clearer, as the care plan indicated that the individual had fluctuating capacity and was unable to retain information to make a decision. However, a mental capacity assessment had not been completed in relation to consent for care interventions. This was discussed with the management team, who assured us that this isolated occasion would be addressed without delay.

During the course of our inspection we toured the home. We found the premises to be, in general maintained to a satisfactory standard. However, we noted that some areas were beginning to look 'tired' and in need of upgrading. It is recommended that an assessment of the environment is conducted, so that general painting and decorating can be incorporated into the business plan for the forthcoming year.

New employees were issued with a good amount of information, which helped them to understand what was expected during their employment at Aarondale. An employee handbook, job descriptions relevant to specific roles, terms and conditions of employment and general social care codes of conduct were given to all new staff. Together these contained relevant information about important policies, such as disciplinary and grievance procedures, equal opportunities, effective communication and appraisals. This helped to ensure that new staff were supported to do the job for which they were employed.

Staff personnel records showed that new employees received a three months probationary period. This helped to ensure they were suitable for the position for which they had been appointed and that they wished to continue as a permanent employee.

Induction programmes for new staff members showed that they were assigned to a mentor, who guided them through their initial learning modules. The programme covered a wide range of topics, including fire safety, confidentiality, safeguarding and whistle-blowing, moving and handling, dignity and respect,

people's rights and safe working practices. This helped to ensure that all new staff were provided with sufficient information to assist them in doing the job for which they were employed. However, all topics were signed on the same date, which seemed a little unrealistic, in relation to the significant amount of information provided during the induction period.

Records showed that employees received regular, structured supervision sessions, which covered a wide range of topics, such as caring skills and competence, communication skills, reliability, conduct and attitude, professionalism, initiative and record keeping. Each topic received a rating from unacceptable through to excellent. These supervision sessions enabled staff to discuss their work performance and training needs with their managers and allowed them to highlight any areas of concern or difficulties experienced, so that any issues could be addressed promptly. Regular group supervision sessions were also conducted, which covered pre-determined topics, such as privacy and dignity, personal belongings, infection control and the Mental Capacity Act. This was considered to be good practice.

Annual appraisals were also conducted for each member of staff, which covered a self-assessment and comments from the registered manager of the home. The ones we saw were detailed and well written, providing staff with some constructive feedback about their work performance.

Staff we spoke with felt that sufficient training was provided and they gave some good examples of learning modules, which they had completed. Records we saw supported this information. The training matrix showed a good percentage of staff had completed modules, such as first aid at work, food hygiene, infection control, medicines management, information governance, safeguarding, fire safety, moving and handling, health and safety, basic life support, Mental Capacity Act and Deprivation of Liberty Safeguards, dementia awareness and equality and diversity. Evidence was available to show that mandatory training programmes were renewed at set intervals.

We found that the unit for those who were living with dementia was a well-designed and productive environment for that specific group of people.

Good

Is the service caring?

Our findings

Everyone we spoke with told us that staff promoted their privacy and dignity. They told us that staff always knocked before entering bedrooms and always kept the bathroom door closed if they were having a bath or a shower. One person said, "They [the staff] knock on the bathroom door and ask if I'm decent."

We asked people to tell us what they thought about the staff. Comments we received included: "I've liked them all. They're kind and caring"; "I like [name removed] and [name removed]"; "Some of them are quite funny and others are more serious"; "They're wonderful and kind. They're all very good"; "I like them, they're kind" and "They're alright." One relative commented, "They're smashing, very good. They're all good. If you ask for something, it's there."

We asked if people were able to make decisions about the care and support they needed. Comments received included: "I don't think I'll ever move. I'm settled and happy"; "I get undressed for bed after tea. I've always done that"; "They [the staff] encourage hobbies. We play games and we have a quiz twice a week and bingo" and "I've no complaints about anything."

One relative we spoke with felt the attention given by staff to their family member was, 'just great.' We were told of their recent diamond wedding. This relative explained how the staff found out what hymns the resident liked and these were played for them on the day of their golden wedding party. The relative said, "They [the staff] really did us proud." The staff were described by this person as, 'lovely' and they explained how relieved they were to know their loved one was being well looked after. Another relative we spoke with said they were 'as pleased as punch' with the service provided.

During the time we spent around the home we overheard staff members speaking with people in a respectful manner. One care worker entered a communal area and with a cheerful tone of voice, pleasantly asked, "How are you all today ladies?" There were no gentlemen occupying this area of the home at this time. Another member of staff announced in a friendly manner, "It is dinner time. What would you like to drink?" We observed staff members knocking on people's bedroom doors before entering and treating them with respect and dignity.

There were 42 people who lived at the home at the time of our inspection. We spoke with eleven of them, who, in general provided us with positive feedback about the level of service they received and the caring attitude of the staff team.

We observed that people appeared comfortable and relaxed in their surroundings with their dignity being respected. Everyone looked well presented. We observed staff members knocking on people's bedroom doors and asking politely if they could enter. This helped to ensure privacy was promoted for those who lived at Aarondale.

Staff were seen to approach people in a kind and respectful manner. They helped people to be as independent as possible and supported them to join in activities at the home. It was evident from our

observations that staff knew people well. Good guidance was provided for the staff team, in relation to people's care and support and how to promote people's independence.

There was evidence available to show that people would be assisted to access the support of an advocate, should they wish to do so. An advocate is an independent person, who will help people to make specific decisions, which will be in their best interests. This demonstrated that people's best interests were considered and that they were supported to access services relevant to their needs.

We spoke with one relative who expressed some concerns to the inspectors. These were discussed with the registered manager at the time of our inspection. It was established that the registered manager of the home had involved the local authority in dealing with the issues raised. However, the relative did tell us that they felt their loved one was safe and that staff were pleasant, but that there were some missed opportunities.

We spoke with another relative who was very complimentary about the attitude and approach of staff members who were supporting those living with dementia. They described them as, 'caring' and 'patient'.

During our inspection we spoke with two visiting health care professionals, who attended the home regularly. They were both very satisfied with the care and support people received at Aarondale. One of them told us, "The staff are very accommodating and they are aware of people's needs." The other said, "The staff communicate well and contact health professionals when needed, but not unnecessarily." Neither of these people had any concerns about the care of those who lived at Aarondale.

Requires Improvement

Is the service responsive?

Our findings

We asked people if they were involved in the planning of their care. Comments we received included: "I see it [their care plan] once a year"; "It's [care plan] in my room." One relative responded by saying, "Absolutely."

We asked people if they were able to maintain their hobbies and interests whilst living at the home. The majority said they could not carry on with previous hobbies, such as knitting due to their physical condition. We asked them how they spent their time during the day. Comments received included: "I just sit here watching the telly. The carers choose the channel sometimes"; "I see friends and family from outside"; "I used to knit, but I can't now. I just sit in here. I get a bath on Wednesday and Sunday afternoons"; "I do crosswords in the daily paper"; "I taught tap dancing and I used to put on pantomimes and concerts. I don't do an awful lot now. I'm happy to just sit around, I'm quite content here. I've no wish to go out"; "I used to do a lot of sewing and crocheting, but I don't now. I mostly read. I can't say there's a lot of activities I'm interested in" and "I used to like going out. I watch telly. I don't like the activities." A family member told us, "She [the resident] did at the beginning [join in activities]. Sometimes they take her in the lounge if there's singers on. They don't leave her out of anything."

We asked if people were able to make choices about their days. One person said, "I like sitting in the lounge with the other ladies. I've never met anyone I dislike here." Another person commented, "I just sit about. There's nothing else to do" and a third told us, "I get up and go to bed when I want. There are no restrictions. It's just like being in your own home. You're free to do whatever you want."

An activities co-ordinator was employed at the home. One member of staff told us that activities were organised for events and special occasions, but nothing else. We did not observe much leisure activity on the days of our inspection. However, we noted that people were supported to maintain contact with family and friends and we did observe a pleasant sing song during both days of our inspection. It is recommended that the provider gathers feedback and suggestions about the provision of activities, so that people can enjoy pastimes, in accordance with their preferences, as many people said there was not much going on at the home.

People talked with us about making the decision to go to live at Aarondale. Some had visited the home before making a decision. Close relatives of others had been to have a look around and others were visited in their previous environment by someone from Aarondale. Comments we received included: "I was so lucky. The carers couldn't be nicer. They're all friendly." And, "I was brought here, but I've been so comfortable since I came."

People we spoke with were confident in making a complaint, if they needed to do so, or they would ask a relative to support them in doing so. A complaints policy was in place at the home. This included specific time frames to expect during an investigation and included external agencies that may be contacted, if it was necessary. A system was in place for recording any complaints received. One complaint had been documented during the course of the current year. The system adopted by the home helped the management team to audit complaints and to identify any recurrent themes, so that these could be

properly investigated. However, although an investigation had been conducted by the management team, which recorded the outcomes of each issue raised, there was no evidence to demonstrate that the complainant had been notified in writing of the findings of the investigation or the final outcome. It is recommended that this be included within the home's complaints policy.

Records showed that some people who lived at Aarondale had not received a bath or shower for more than a month. We looked at the daily notes for one person who lived at the home and there was no reference to their bathing routine for several weeks. However, those we spoke with told us that there were specific bath days allocated. One person told us, "They have certain days for a bath." We asked this person if they could have a bath on other days of the week, to which they replied, "They wouldn't have enough staff." Another person confirmed that they had a bath twice a week, but again these were on set days. The system of allocating bathing days does not promote person centred care and is institutionalised. Some people we visited at the home had not been assisted to wear their prosthesis, such as hearing aids and spectacles. This could have had an impact on their daily lives. It is recommended that the provider reviews the recording system and the management for the provision of personal care, in order to promote flexibility, choice and person centred care.

We looked at the care files of six people who lived at the home. We found these to be well written; person centred documents, containing detailed assessments of people's needs. It was evident that information had been gathered from a variety of sources about what people required. These records showed that those who lived at the home had, in general been involved in planning their own care and support. The plans of care were generated from the information gathered during the pre-admission assessment process and, in general good guidance was provided for staff about how people's needs were to be best met. However, on one isolated occasion we found that the assessment for one person did not accurately reflect their current needs in relation to continence and visual impairment.

A wide range of risk assessments had been incorporated into the plans of care in relation to health and personal care and this information had mainly been followed through onto the plans of care. Each care plan had been reviewed on a monthly basis, or more regularly where circumstances had changed and any changes in needs had been recorded well. Records showed that a wide range of community professionals had been involved in the care and support of those who lived at the home. This helped to ensure people's health and social care needs were being appropriately met.

Records showed that assessments had been conducted within a risk management framework and any identified risks were, in general integrated into the care planning system, with strategies implemented in order to minimise the possibility of harm. However, one person who lived at the home told us of a recent incident, in which one member of staff did not fulfil a request for food and drink, in order to reverse the physical effects of a low blood sugar.

Evidence was available to show that the service worked effectively with external professionals, such as community health care workers and social workers. This helped to ensure that the health and social care needs of people were being appropriately met. However, one person told us they had asked staff to request a visit from the podiatrist, but that this had not yet happened. Staff members who we spoke with were able to easily discuss the needs of those in their care and how these needs were to be best met.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with felt the home was well-managed. They told us that the manager of the home did go around seeing everyone occasionally. One person said, "I like her very much, she listens to what you say." Another person told us, "She's very nice, very good." And a third commented, "She's always around." However, someone else said, "As a matter of fact I don't know who the manager is. I just deal with the staff."

We asked people what they liked best about the home, One person said, "It's very friendly", another commented, "Everything" and a third told us, "The freedom, you're not a prisoner." Other responses included, "I like the staff. They like a laugh"; "Everything is so good and comfortable that's all you want. Good food, good sleeping accommodation"; "I can do as I want really" and "It's clean and in a perfect place."

Records showed that a range of audits had been conducted. For example the hoists and hoist slings had been checked every month to ensure they were clean and in good working order. Other audits we saw included, safeguarding, nutrition, medications, health and safety, falls and staff training. Audits of eight care plans were conducted each month. These were detailed and included a discussion with each person whose care file was being audited, which was considered to be good practice. An audit of the dining experience had been conducted the previous month. This recorded the outcome as, 'The shift was effective, caring, responsive and well – led.' We appreciate that meal times in care homes may vary from day to day. However, on the day of our inspection we found lunch time on the ground floor to be somewhat disorganised and staff were not always responsive to people's needs.

Although we found the management team co-operative and helpful at the time of the inspection we found that quality monitoring systems had not identified shortfalls recognised by the inspection team.

This was a breach of regulation 17(1)(2)(a)(b)(c)(f) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection to Aarondale Care Home there was a registered manager in post. However, the deputy manager was in charge of the home on the first day of our inspection. The Registered Manager was on duty at the time of our second visit to the home.

A Statement of Purpose [SoP] was in place at the home. However, the information provided in this document was very limited, providing a brief description of the home only. It is recommended that the SoP be extended in order to be more explanatory, telling people of the aims and objectives of Aarondale and the services and facilities offered by the home.

A wide range of policies and procedures were available at the home. These included areas, such as infection control, fire safety, confidentiality, safeguarding vulnerable adults, health and safety and the Mental Capacity Act and Deprivation of Liberty Safeguards. Good information was also readily available for the staff team in relation to care practices and clinical guidance, such as person centred care, diabetes, mouth care, neurological observations, pressure care and oxygen therapy.

A system was in place for obtaining feedback about the quality of service provided. This was open to anyone who wished to comment at any time. However, we noted that this was done by the use of an electronic system and the surveys we saw had been completed by staff on behalf of those who lived at the home. This method of providing feedback did not support those who were unable to use an i-pad and wished to submit their feedback anonymously. It is recommended that the provider considers a paper based survey to run alongside the electronic feedback.

The managers of the home were aware of the need to notify the Care Quality Commission of certain events, such as allegations of abuse, unexpected deaths and incidents resulting in serious injury.

Records showed that meetings for those who lived at the home and the staff team had been held regularly. This enabled relevant information to be passed on and allowed people to discuss any topics of interest. The results of questionnaires were produced in percentages and pie charts for easy reference by any interested parties.

The company had been accredited with an external quality scheme, which involved an independent professional organisation periodically auditing the business, to ensure that acceptable standards were being maintained.

Senior staff members conducted 'Daily Walkabouts'. These were recorded and covered a wide range of areas, such as infection control, presentation of residents, engagement of staff, the environment, record keeping, personalisation and discussions with people.

A monthly workplace inspection was conducted by the management team, which covered areas, such as general housekeeping, machinery, equipment, first aid, Personal Protective Equipment (PPE) and the Control of Substances Hazardous to Health (COSHH). A monthly tracker was utilised by the regional manager in order to process and analyse the information received from each area of the quality monitoring systems.

We found that there was a structured management structure in place and staff members we spoke with told us that they felt well supported by the management team. One member of staff said, "I love it" and another commented, "I love my job. All I know is that I give people the care they deserve. You can't fake care."

One community professional wrote on their feedback, 'From my experience with the care home I have always been happy with the level of care provided and how they have supported my service users.' Another wrote, 'I have visited and liaised with staff from Aarondale Care Centre on numerous occasions. I have generally found staff to be helpful and well informed. They are timely in their contact with our service if a review/advice or support is required. They appear to manage their clients very well. I believe they provide an invaluable service to Dementia patients within Central Lancashire.'

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's nutritional needs were not always being appropriately met and menu choices were not consistent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent A 'Do not attempt cardio-pulmonary resuscitation' record was not signed by a medical practitioner, the reason for implementing DNACPR had not been recorded and the decision had not been discussed with the individual concerned. There was no evidence in the care file that this person was at risk of cardiac arrest or that the decision had been made as part of a best interest process.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Several fire doors were not closing fully into the door frames and one was not closing due to the carpet pile. This created a potential fire hazard. Some door handles were dirty and in need of cleaning. The underneath side of one bath seat was very dirty and in need of a thorough clean. The sluice rooms were in need of refurbishment, so that they could be easily cleaned, in order to promote infection control. There was no soap available for hand washing

in one of the sluice rooms.

One member of senior staff, who we saw dispensing medicines left the medicine trolley open and unattended on four separate occasions during one medicine round.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There was no mental capacity assessment or risk assessment conducted in relation to a decision made for one person to be supported in a chair, which restricted the individual's ability to get up alone. There was no evidence available to demonstrate that the decision to use the chair had been made in the best interest of the individual, as this person had expressed a wish to sit in a standard armchair. We were told that a Deprivation of Liberty Safeguard [DoLS] application had been submitted to the local authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We found that quality monitoring systems had not identified shortfalls recognised by the inspection team.