Aaron House Care Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Aaron House Care Limited is a care home registered to accommodate up to six adults with a learning disability or autistic spectrum disorder in one adapted building. At the time of our inspection six people were using the service.

People's experience of using this service and what we found

The service did not have manager in place at the time of the inspection. In the absence of a registered manager, the service was managed by the team leader with some support from the provider. However, we found ineffective governance systems and monitoring roles and responsibilities were not clearly allocated and defined.

A comprehensive, effective quality monitoring or audit system was not in place to ensure the quality of care and risks were monitored and improved where needed. The provider had therefore not identified the concerns we found at this inspection.

People and their relatives told us they felt safe living at the service. However, we found shortfalls that placed people at risk of receiving unsafe care.

People's individual risks were not always identified, assessed and mitigated and staff were not given clear guidance or information on how to protect people from associated risks. Not all staff knew what to do in an emergency. People's medicines were not managed safely. A robust system was not in place to ensure the provider had oversight of all incidents or accidents.

Systems to ensure safe staff recruitment practices were not in place.

Infection prevention and control was unsatisfactory. This placed people, visitors and staff at risk of infections. People were not always protected from the risks of their environment. The provider had not always undertaken effective measures to ensure that people would be protected from risks associated with fire safety and legionella.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or

autistic people. We considered this guidance as there were people using the service who have a learning disability and/or who are autistic.

Based on our review of safe and well led, the service was not able to demonstrate how they were meeting some of the underpinning principles of Right care, Right support, Right culture.

Right support: The provider was not always able to demonstrate how they planned the needs of people with a learning disability in line with best practice guidance. People's care records did not reflect the support that had been planned and delivered.

Right care: Care was not always person-centered and did not always promote people's dignity, privacy and human rights. .

Right culture: The lack of quality audits and absence of feedback systems did not support the development of an open and transparent service.

We sign posted the provider to the Right support, Right care, Right culture information on the guidance for providers page on our website.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was good (published 14 June 2018).

Why we inspected
We received concerns in relation to several aspects of the management of the service and the quality of people's care and support. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service.

This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Aaron House Care Limited on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to risk management, safe staff recruitment, good governance and safeguarding.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Aaron House Care Limited

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 1 inspector, and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Aaron House Care Limited is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Aaron House Care Limited is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. The provider had advertised for the position and was in the process of reviewing applications from candidates. In the interim some of the aspects of the day to day running were overseen by the team leader.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in their last provider information return (PIR) dated 7 July 2022. This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with 4 staff including 1 team leader and 3 support workers. We spoke with 3 people who use the service and 5 relatives of people who use the service.

We reviewed a range of care documentation and medicine records. A variety of records relating to the management of the service, including policies, procedures, staff training and quality assurance records. We looked at 4 staff recruitment files and documents around staff support.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
- People's risks were not effectively assessed and managed.
- Guidance was not in place and staff were not always clear what action they should take to keep people safe if they were to experience a seizure or become distressed. This put people at risk of not receiving safe care.
- People were not always protected from the risks of their environment. The provider told us they had considered the risks of legionella bacteria, but no risk assessment was in place. Fire safety checks were completed randomly, and these were not sufficient to ensure that fire risks would be identified promptly. The provider had not identified, assessed and mitigated the risk of not having window restrictors fitted to windows.
- The provider had a system in place for staff to record incidents when people displayed anxiety related behaviour. However, this information had not been analysed or used to minimise the potential risk to people from future incidents.

The provider did not always assess and do all that was reasonably practicable to mitigate the risks to people who received care. This placed people at risk of harm. This was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- Three people were unable to leave the service without staff supervision, because they would not be able to independently remain safe. They were unable to consent to these restrictions and DoLS had been authorised to protect people's rights.
- For one person a DoLS renewal application had been submitted to the local authority for re-authorisation.

For the other two people whose DoLS authorisation expired in 2019 no further action had been taken to renew these authorisations to ensure the restrictions that remained in place for people were lawful.
● Five out of the 6 people living at the service where not able to manage their finances independently. The decision had been made for the provider to manage this on their behalf as their appointee. Mental capacity assessments, best interest decisions and support guidance had not been completed to determine if this arrangement was appropriate and how people's money was going to be managed safely to protect them from abuse. The provider had a system in place to monitor people's finances however this was not always completed to ensure people had been supported safely with their moneys and protect them from abuse.

The provider had failed to ensure people were protected from the risk of abuse and seek legal authorisation when people continued to be deprived of their liberties. This was a breach of Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People we spoke with told us they felt safe living at Aaron House Care Limited. This was confirmed by the relatives we spoke with.
● Staff felt confident to report concerns about abuse to the provided and were aware of the escalation procedures outside of the organisation they would follow to keep people safe.

Staffing and recruitment
● Safe recruitment procedures were not followed to ensure staff were safe to provide care to people. The required pre-employment checks had not always been undertaken. Reference checks from staff's previous social care employers and health status were not always sought to gather assurances about staff conduct and their fitness to undertake their role and whether any adjustments might be needed.
● Interview records were not always in place to support the provider's decisions to employ staff.
● Records did not show how the provider had assessed the risk to people when they were unable to obtain references or complete checks on an applicant's employment history. This meant additional safeguards were not in place to ensure staff were of good character.

Safe recruitment practices had not always been followed. This placed people at risk of harm. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider told us that there was enough staff on each shift to support people, however they did not have a clear breakdown of the local authority commissioned hours for all people. The provider was aware that 2 of the people who were living at the service had an allocated number of local authority funded 1:1 hours per week. There was no evidence to show how these were planned and delivered. This meant that people might not have always received the support they required as per their local authority assessed needs.
● People were supported by a consistent staffing team who knew them well. One person told us, "All staff can read me like a book."
● One person told us that staff are "really nice" and another explained that the one thing they enjoy about living at Aaron House Care Limited was the staff. They explained that staff know what they were thinking and liked to banter with staff.

Using medicines safely
● The service did not always record when medicines such as creams and liquid medicines were opened. Staff did not monitor and record medicine storage temperatures to ensure people received medicines which were safe to administer. Medicines were not always stored safely which risked their efficiency.

● Where people were prescribed medicines on an 'as required' basis individual protocols were not in place to guide staff on appropriate administration. This put people at risk of not receiving their "as required" medicines as prescribed.
● Good practice was not always followed when staff transcribed people's medicines onto their Medicine Administration Records (MAR). This increased the risk of medicine errors occurring.
● Staff had not always clearly documented when people had received 'as required' medication or homely remedies such as pain relief. This increased the risk for potential medication errors.
● Medicines were stored in the medicines cabinet which had not been recorded on a MAR chart or part of the homely remedy list. This meant people were at risk at receiving medicines which had not been prescribed for them or checked for possible interaction with prescribed medicines.

People's medicines were not always managed safely. This placed people at risk of harm. This was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● The provider had not ensured safe infection prevention control practices were being implemented and used as per national COVID-19 current government guidance. This included, but were not limited to, policies and procedure, use of PPE and audits.

COVID- 19 government guidance in relation to infection prevention control was not always implemented in the service and followed. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We have signposted the provider to resources to develop their approach.

● People were supported to see their families, friends and representatives in accordance with their preferences and in line with government guidance

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centered care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care;

- At the time of the inspection, there was no manager registered with the Care Quality Commission. In the absence of a registered manager the service was managed by the team leader with some support from the provider. However, we found ineffective governance systems and monitoring roles and responsibilities were not clearly allocated and defined.
- The provider's policies and procedures had not been reviewed and updated for a number of years which meant that staff and managers did not have access to current information in relation to legislation, guidance and best practice. Examples included policies and procedures related to medicines, safeguarding and recruitment.
- There was a lack of governance processes and systems to help ensure the safe running of the service. Without these systems, the provider could not proactively identify issues and concerns in a timely way and act on these.
- The lack of a provider quality and risk monitoring systems meant they did not identify the concerns we found at this inspection. These concerns included, but were not limited to, risk assessments, infection control, medicine systems and practice, recruitment, accidents and incidents monitoring, DOLS monitoring and environmental safety.
- The provider had not sustained their own environmental monitoring systems. For example, records relating to in-house fire checks were not always completed and available. The provider had not identified these recording shortfalls through their own monitoring.
- The service did not have a robust and effective auditing system in place to monitor medicines management. A system was in place to monitor the stock of medicines however, this was no longer used by staff. This meant the service did not have a clear stock count of the medicines, for example to aid them in investigating any medicines errors.
- There was no formal system in place for people and their relatives to contribute to the review of people's care plans and all aspects of their care.

The registered provider failed to implement and operate effective systems to maintain and monitor the safety and the quality of the service. This placed people at risk of harm. This was a breach of regulation 17 (1) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Some residents' meetings took place. We have seen evidence of meetings from September, October and November 2022 where discussions included activities, complaints procedure and cleaning of people's bedrooms

● Staff meetings were taking place and staff told us they felt supported, listened to and able to provide feedback. The provider explained that it was difficult to bring the majority of the team together at once so meetings were taking place in smaller forums, however we did not see evidence of staff meetings since October 2022. We were told that daily handovers were also taking place; however these were not documented.

Promoting a positive culture that is person-centered, open, inclusive and empowering, which achieves good outcomes for people

● Relatives provided mixed feedback about their relative's care and support. This was discussed with the provider who took the feedback on board and was, for example, planning to work with professionals to address one of the concerns.

● Although staff strived to provide an individualised service, the provider had not evidenced how statutory guidance such as "Right Support, Right Care and Right Culture" had been considered in their care practices. There was limited evidence of people and their representative's involvement in planning their care and how they would like to reach their potential and have their independence encouraged.

● People provided examples of activities they were doing. The provider employed a staff member who was supporting people within house activities a couple of evenings per week. People's records did not show how they had been involved in deciding and reviewing activities that met their preferences.

● One person gave us examples of life skills activities they were involved in such as cleaning their room, preparing vegetables for meals and going food shopping for the house.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider understood their responsibilities in relation to the duty of candour and knew about the importance of being transparent and the need to share information with people's relatives and key professionals.

● The provider was reviewing their system for identifying when DoLS notification to CQC was required to ensure that all information was shared as required.

Working in partnership with others

● The service was working in partnership with the GP and the chiropodist who was visiting the service on a regular basis.

● We have received positive feedback from the GP in relation to communication with the service and the staff.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure people were protected from the risk of abuse and seek legal authorisation when people continued to be deprived of their liberties.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment practices had not always been followed.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people relating to their care, medicines, infection prevention control and the environment were not always assessed and mitigated. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued a Warning Notice to ensure the provider made this improvement within a specified timescale.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to monitor quality and risk in the service were not in place or effective. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued a Warning Notice to ensure the provider made this improvement within a specified timescale.