Aden House Limited

Aden House Care Home

Inspection report

Long Lane
Clayton West
Huddersfield
West Yorkshire
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Tel: 01484866486

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Aden House is a care home providing personal care for up to 60 people. At the time of our inspection there were 29 people living at the service. There are communal areas and accommodation on both the ground and first floor. The Butterfly unit on the ground floor supports people living with dementia.

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

There had been insufficient improvement in management and oversight of the service since the previous inspection and we continued to identify repeated shortfalls that compromised the safety of people and the quality of care at the service.

Risks to people were again not safely assessed, monitored and mitigated. People continued to not always be protected from the risk of harm when they had been involved in incidents of a safeguarding nature. Accidents and incidents continued to not be appropriately addressed to ensure lessons learned were identified and the risk of harm reduced.

Concerns were again identified in relation to infection prevention and control (IPC) particularly regarding the management of a recent outbreak at the service. There were not enough staff to adequately respond to people's needs, and medicines were not always managed safely.

Quality assurance systems were still not effectively implemented and consistently overseen by the manager. They were not always effective in identifying and monitoring shortfalls and driving improvement at the service. Whilst some improvements had been made to the environment, which appeared more homely, there were still significant shortfalls in other aspects of the service.

There was an activities staff member in place. However, the available activities were not always suited to the needs of people with dementia. People who were unable to participate in group activities received little to no activity.

The service was working within the principles of the Mental Capacity Act (MCA) and appropriate legal authorisations were in place when needed, to deprive a person of their liberty. Policies in the service supported this and staff supported people in their best interests, in the least restrictive way possible. However, people were not supported to have maximum choice and control of their lives and care was not delivered in line with their needs and preferences. Care records were not always complete and contained inaccurate and conflicting information. People's care was not always collaboratively planned, or person centred. People's varying communication needs were not always considered or met.

Staff were kind caring and respectful towards people. Systems were in place to support staff and they received appropriate training.

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 inadequate (published 10 August 2023) and there were breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

At our last inspection we recommended the provider reviewed systems and processes for safe recruitment. We also recommend the provider sought advice and guidance from a reputable source to ensure people's privacy, dignity and independence was respected and promoted. At this inspection both recommendations had been actioned and resolved.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. During this inspection, we checked whether the provider had followed their action plan to confirm whether they now met legal requirements.

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.

The overall rating for the service remains inadequate based on the findings of this inspection.

Enforcement and Recommendations
We have identified breaches in relation to assessing and managing risks to people, IPC, medicines management, staff numbers, person centred care, record keeping and oversight of the service.

We have made recommendations in relation to joint care planning, people's communication needs and obtaining feedback from people fully considering their equality characteristics.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service remains 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 5 key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Aden House Care Home

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.

Inspection team
The inspection was carried out by 2 inspectors, 1 medicines inspector and a regulatory coordinator.

Service and service type
Aden House 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. Aden House is a care home registered to provide nursing care. However, at the time of inspection, there was no nursing care being provided. 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 a manager in post who had submitted their application to register with the CQC.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection. We sought

feedback from the local authority, commissioners and Healthwatch Kirklees. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return (PIR). 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 of this information to plan our inspection.

During the inspection
We spoke with 7 people who used the service and 2 relatives about their experience of the care provided. We spoke with 13 staff members including the manager, care workers and domestic staff. We spoke with 3 healthcare professionals who worked with the service. We reviewed a range of records including 10 people's care records and a range of medication records. We looked at a number of staff records in relation to supervision and 3 staff files in relation to recruitment. We reviewed records relating to the management of the service, including policies and procedures and quality assurance records.

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 inadequate. The rating for this key question has remained 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

At our last inspection the provider failed to ensure safe assessment, monitoring and management of risks to people's health. This placed people at risk of harm. This was a breach of regulation 12 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● At our last inspection, risks to people's health were not safely assessed, monitored and managed. This continued to be the case at this inspection. We were not assured sufficient action had been taken in response to risks associated with choking, pressure damage and weight.
● Two people's positional change records contained gaps, where their repositioning needs had not been met, placing them at risk of pressure damage. For example, 1 person's care records stated they should be repositioned every 3 to 4 hours. Records showed numerous occasions when this had not been adhered to, and on 1 occasion, indicated they had not been repositioned for over 6 hours.
● People's choking risks were not managed safely. For example, 1 person had information in their care records stating they must be supervised and seated upright when eating. We observed the person not seated upright and left unsupported with their meal, placing them at increased risk of choking.
● Accidents and incidents were not always recorded and appropriately reported. Systems in place were not effective in identifying and sharing lessons learned to improve practice and manage future risks. This issue had also been identified and raised with the provider at our previous inspection.
● Risks within the living environment were not always managed. The staff room had a sign stating, no unauthorised access, for staff only. The laundry room had a sign stating it needed to be locked. We found these doors were unlocked on the first day of inspection. In addition, a bedroom containing decorating equipment was accessible to people.

The provider failed to ensure safe assessment, monitoring and management of risks to people's health. This placed people at risk of harm. This was a continued breach of regulation 12 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to do all that was reasonably practicable to mitigate risks to people as a result of safeguarding incidents. This placed people at risk of harm. This was a breach of

regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Systems and processes to safeguard people were not always effective. This was also the case at the previous inspection.
● Accidents and incidents of a safeguarding nature were not always investigated and reported to the appropriate agencies, for example, the local authority and CQC. Action was not always taken, and lessons learned were often not identified, shared, or used to mitigate future risks.
● People's care records were not always updated when they had been involved in incidents of a safeguarding nature. For example, 1 person had been assaulted by another person on 3 occasions and there were no interventions in place to protect them from further harm. This was also the case for a further 2 people who had been victims of assaults.
● The manager was not always aware when safeguarding incidents had taken place. For example, there were 2 documented instances whereby staff practice had highlighted concerns. The manager did not know about these, and no investigation or further action was taken.

The provider had failed to do all that was reasonably practicable to mitigate risks to people as a result of safeguarding incidents. This placed people at risk of harm. This was a continued breach of regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were trained in safeguarding and information was displayed in the home regarding how to raise an alert.

Preventing and controlling infection

At our last inspection the provider had failed to ensure risks in relation to IPC were effectively managed. This was a breach of regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Infection prevention and control (IPC) risks were not robustly managed. This was also the case at the previous inspection.
● IPC practices following a recent outbreak of diarrhoea and sickness were not robust. There was a lack of manager oversight regarding the outbreak and who had been affected. Deep cleaning had only taken place in 2 out of 8 affected people's rooms. Housekeeping records were not always accurate, and staff lacked information about the areas to deep clean. They were not alerted to the increased risk of cross infection.
● Thorough cleaning in some areas of the service had not taken place. One person's room had a strong odour of urine, yet they had not been in the room for 4 days prior to the inspection.
● Bathroom areas were not always clean and there was a clinical waste bag left in 1 person's ensuite. People's crash mats and sensor mats had dirt, debris and stains evident, and 1 person's mattress and pillow were stained.
● Housekeeping records showed the cleaning team frequently reported concerns about not being able to clean areas of the home, due to being asked to break from their duties to support people at mealtimes. This placed people at risk of harm due to possible cross contamination.

The provider had failed to ensure IPC risks were effectively managed. This was a continued breach of regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes
● Visitors were welcome to visit people at any time.

Using medicines safely

At our last inspection the provider had failed to ensure safe management of medications, placing people at risk of harm. This was a breach of regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Medicines were not always managed safely. This placed people at risk of harm.
● People did not always receive their medicines at the correct or preferred time. For example, 1 person's Electronic Medication Administration Record (EMAR) showed nighttime medicines timed for 20:00, were given between 21:45 and 22:30, and on 1 occasion at 23.20. In addition, some people received their pain relief and antibiotic medicine mid-morning. This meant the lunchtime dose had to be delayed and medicines due at 20:00 were given at 22:00 or later. One person told us they had asked for their nighttime medicines to be given earlier, but this did not happen.
● Guidance for staff, for the administration of as required (PRN) medicines did not always contain adequate information, placing people at risk of harm. For example, 1 person's PRN protocol did not outline clear directions regarding how to use an essential medicine in an emergency situation, or what action staff should take.
● Records showed 1 person's PRN medicine, used to help manage distress and agitation, was out of stock for 15 days. In addition, the PRN protocol for the medicine lacked guidance regarding de-escalation strategies staff should try prior to administering the medicine.
● People's prescribed creams were not effectively managed. Some topical medicine records (TMARs) were incomplete, and 1 person's TMAR showed that a cream was not applied as often as necessary to be effective.
● Storage of controlled drugs was not always well organised as the cupboard contained a significant quantity of controlled medicines awaiting disposal.

The provider had failed to ensure safe management of medications, placing people at risk of harm. This was a continued breach of regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff administered medicines to people safely in a respectful way.
● Medicines were stored securely, and kept at the correct temperature.

Staffing and recruitment

At our last inspection the provider had failed to ensure sufficient numbers of staff were deployed at the service. This place people at risk of harm. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of

regulation 18 (1).

● The number of staff, and their deployment was insufficient to meet the needs of people safely. This had also been the case at our previous inspection.
● A high number of people on each unit needed 2 staff to support them with their care needs. This meant when 2 staff were attending to 1 person, there were not enough staff to adequately support other people.
● Housekeeping staff were regularly asked to break from their cleaning duties to assist people with their meals. We observed this happening on both days of inspection. In addition, the activity coordinator told us they assisted with meals or took people to the toilet if care staff were busy.
● Feedback from staff regarding staffing numbers was mixed. However, most said there weren't enough staff. Feedback included, "Mostly [there are enough staff], sometimes an extra pair of hands would be helpful. Mealtimes are sometimes a struggle" and, "Staffing is the worst part about the job as there's just not enough staff" and, "There's not enough staff, I can't get round all the work." In addition, 1 person told us, "Everyone seems to whizz off, they never stop."

The provider had failed to ensure sufficient numbers of staff were deployed at the service. This place people at risk of harm. This was a continued breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we recommended the provider reviews systems and processes for safe recruitment. The provider had made necessary improvements.

● Processes and procedures were in place to ensure safe recruitment at the service.
● The service completed appropriate staff recruitment checks, including Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

At our last inspection the provider had continued to fail to ensure accurate, complete and contemporaneous records were consistently maintained. This was a breach of regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17. This has been reported on in the well-led section of this report.

At our last inspection the provider had failed to ensure reasonable steps had been taken to mitigate risks to people. This placed people at increased risk of harm. This was a breach of regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● People had enough to eat and fluids were readily available. However, monitoring of people's fluid intake was not always sufficient.
● The same generic daily fluid target was in place for people, which did not reflect their differing needs. Where fluid intake amounts totalled did not meet the target, there was no evidence of any follow up action being taken.
● People's weight was being monitored. However, this was not always documented in the person's care file and used to inform accurate assessment of their needs, placing people at risk of harm. For example, 2 people's malnutrition screening tools (MUST)s had been completed without their weight being included to inform the assessment. One person's MUST showed their weight had been obtained by staff "looking at" them.

The provider had failed to ensure reasonable steps had been taken to accurately assess, monitor and mitigate risks to people. This placed people at increased risk of harm. This was a breach of regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the last inspection, people had to wait a long time for drinks in the morning. At this inspection, we saw people had plenty of opportunity for drinks and snacks. Food at mealtimes looked appetising and we

observed people to be enjoying their meals. The lunch time experience was pleasant and relaxed. One person told us the food was "lovely".
● When staff were assisting people to eat and drink support was provided in a kind and respectful way.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff received appropriate support, training, supervision and appraisal to enable them to carry out the duties they are employed to perform. This was a continued breach of regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18 (2).

● Systems and processes were in place to provide staff support. However, action was not always taken following issues raised during staff supervision.
● Staff were appropriately trained. Staff received e-learning and face to face training. The manager told us they were developing staff skills in dementia care through sourcing enhanced training.
● Staff told us they received appropriate training and support to fulfil their role. Feedback included, "We get lots of training" and "Yes, we are supported. I had a formal supervision recently."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's support needs were not always accurately assessed, and care plan reviews were inconsistent. Where reviews had taken place, they did not always identify where people's needs had changed.
● Care records contained inaccurate and conflicting information regarding people's risks and support needs and there was a lack of clear and accurate guidance within care records to enable staff to support people safely. For example, 1 person's care records contained conflicting information regarding what level of diet they needed and how much thickener should be used in their drinks to manage their choking risk. This placed them at risk of harm.
● Some people's care records were person centred and their preferences and choices were recorded. However, this was not always the case for people who were less able to communicate.

Adapting service, design, decoration to meet people's needs
● Improvements had been made to the living environment since the last inspection.
● The provider told us they had worked in partnership with the local authority regarding service decoration and opening up more space for people living with dementia. Some redecoration work was ongoing at the time of inspection.
● We discussed with the manager where further improvements could be made to make the environment more personalised and enhance experiences of people living with dementia. For example, creating personalised memory boxes for outside people's rooms to help them recognise their environment. The manager told us they had considered this and were looking to incorporate a similar feature in the future.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● The service worked in partnership with other healthcare agencies, for example, occupational therapists, district nurses and GPs.
● There was evidence of referrals being made to appropriate agencies, for example, speech and language therapy (SALT), resulting in assessments taking place. However, the outcomes from the assessments were

not always accurately added to care records to inform and guide staff.
● Two professionals told us staff worked well alongside them and they felt advice they gave was listened to and acted on.

Ensuring consent to care and treatment in line with law and guidance 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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
● The service was acting within the legal framework of the MCA. Best interest processes were followed where people lacked capacity to make decisions.
● DoLS applications were completed, and these were reviewed and re-applied for within required time frames.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

At our last inspection the provider had failed to provide appropriate care to meet people's needs. This was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection the provider had made enough improvement in some areas and was no longer in breach of part of regulation 9. However, the provider remained in breach for other aspects of regulation 9. Please see the responsive section of this report.

- People were not always well supported to express their views and be actively involved in their care.
- Care records contained some evidence of people and relative involvement in decision making. However, this was not consistent for all people. For example, people who were less able to communicate and a person who did not speak English.

We recommend the provider reviews systems and processes regarding collaborative care planning for people less able to communicate their needs and preferences.

- People's personal care needs were mostly being met and most people were well presented. However, 1 person had debris under their fingernails despite care records stating that nail care had been completed the same morning.
- People mostly had access to sufficient toiletries, clothing, and footwear. However, 1 person did not have toothpaste. In addition, 1 person did not have a toothbrush or toothpaste to maintain good oral care. Following the inspection the provider informed us that this was the person's choice.
- We observed staff speak to people in a kind, caring and respectful way. People and relatives told us staff were caring. Feedback included, "Staff are lovely. They look after you when you are down" and "Staff are helpful and kind and treat residents with respect."

Respecting and promoting people's privacy, dignity and independence

At our last inspection we recommended the provider seeks advice and guidance from a reputable source to ensure people's privacy, dignity and independence is respected and promoted. The provider had made some improvements.

● People's privacy and dignity was mostly maintained. However, 1 person was in bed and the exposed mattress was significantly stained, as was the person's pillow. In addition, 1 person was sitting in a corridor and their clothing was not adequately covering them to maintain their dignity.
● The environment had significantly improved in décor and arrangement of furnishings. It appeared homely with pictures on the walls, appropriate window coverings, and furniture was arranged in a homely fashion. Feedback from people and relatives included, "It looks smart and clean, but I'm not convinced yet," "I like the building" and "The facilities and lounges are spot on."
● People told us staff checked for agreement before providing support. One person told us, "They ask my permission before providing me with care."

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection the provider had failed to provide appropriate care in line with people's needs and preferences. This was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● Care was not consistently personalised, and staff failed to assess people's needs in line with their wishes.
● On the first day of inspection, 1 person told us they did not feel safe and wanted to have bed rails or grab rails, as they were fearful of falling out of bed. Their care plan briefly stated their wishes, but staff had decided there were risks with bed or grab rails, so they were not in place. The person told us, "I'm scared, not senile. Nobody is listening to what I want." We asked the manager to discuss this person's concern with them. By the end of day 2, the manager had put the requested equipment in place for the person."
● Care records did not support staff to provide person centred care for people living with dementia. For example, 3 people's records lacked personal information or life history within care plans for staff to understand each person as an individual. The activity coordinator said they were creating life history records and were working with families to gather information."
● A person centred approach to care was lacking. Staff did not always demonstrate the skills necessary to support people living with dementia, and people's behaviour associated with their illness at times caused distress to themselves and others. For example, 1 person was very active in the service, frequently displaying agitation. This person had 96 documented incidents of behaviours associated with their dementia over a period of 2 months. There was limited evidence of person centred, relevant interventions having been considered and tried, as a basis for more effective care and support. One staff member told us "[Name] impacts the whole home."
● People's needs beyond living at the service were not always considered. For example, 1 professional told us staff only saw the immediate care tasks required, without considering opportunities for re-enablement to support people to go home.

The provider had failed to provide appropriate care in line with people's needs and preferences. This was a continued breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

At our last inspection the provider had failed to ensure people were provided with meaningful activity which met their needs and preferences. This was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● People's social needs were not always met and not everyone was supported to follow their interests and participate in relevant activities.
● There were missed opportunities for people living with dementia to be purposefully occupied in meaningful activities. Whilst there was an activity coordinator in post there was limited evidence of dementia friendly activities being delivered. One person told us, "There's not much activity. There are people here with Alzheimer's and they're left sat around. They don't do anything and that annoys me."
● Not all staff fully understood dementia. The manager was aware of this but had not taken action. Many people remained in their rooms during the day. There was no evidence of any 1 to 1 activity taking place for these people or for people who were unable to participate in group activities. When asked, activities staff told us, "I try and put aside an afternoon or morning each week, pop round to bedrooms, make sure people are okay."

The provider had failed to ensure people were provided with meaningful activity which met their needs and preferences. This was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was evidence of links being made with the community and the service seeking activities from external sources. For example, entertainers and singers.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's communication needs were not consistently met.
● Information in care records was not available in adapted formats for people with advanced dementia. For 1 person at the service, English was not their first language. The manager told us when the doctor came a member of laundry staff was available to translate. It was not clear how staff communicated with this person when the staff member was not available. The person did not have any adapted or translated written information available to them regarding their care and support.

We recommend the provider reviews systems and processes regarding accessible information and people's communication needs.

Improving care quality in response to complaints or concerns
● Complaints were not consistently logged, responded to, and used to make improvements. Lessons

learned were not always being identified and shared.
● There was a complaints log in place. However, not all complaints were recorded. For example, governance records documented 3 complaints which had not been recorded on the log. In addition, 1 person told us their complaints were not taken seriously when they told staff about a person who entered their room repeatedly. They said, "I tell staff all the time, they don't do anything." This complaint was not recorded within the complaints file.

End of life care and support
● At the time of inspection there was nobody receiving end of life care.
● Some people had records in place reflecting their end of life wishes.

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-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question inadequate. The rating for this key question has remained 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 our last inspection the provider failed to ensure systems in place effectively monitored and improved the quality and safety of the service. The provider failed to keep accurate, complete and contemporaneous records. This was a continued breach of regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the service was still in breach of regulation 17.

● The provider had failed to take enough action to fully address all shortfalls identified at the previous inspection. At this inspection, we again continued to identify breaches in relation to person centred care, safe care and treatment, good governance, and staffing.
● The provider had a significant history of failure to comply with regulation. The provider had been in breach of regulation in relation to safe care and treatment, good governance and staffing for the last 3 consecutive inspections. They have been in breach of regulation relating to person centred care for the last 2 consecutive inspections. In addition, the service has only been rated good on one occasion out of 8 inspections, over the last 8 years.
● Systems in place were not always effective in identifying and monitoring shortfalls and making improvements. Where issues were identified, these were not always adequately addressed. The provider had implemented a whole home action plan following our previous inspection, yet we continued to identify shortfalls in relation to several areas raised at our previous inspection. For example, risk management, accidents and incident management and reporting, safeguarding, infection control, safe management of medicines, record keeping and person-centred care.
● Quality assurance systems and processes were not always effectively implemented. Where audits had been delegated to staff, there was insufficient evidence of oversight from the manager. For example, there was a limited number of care plan audits being completed each month. Some of these were delegated to the deputy manager and senior carers. However,
the audits had not successfully identified issues we found during inspection relating to inaccurate and inconsistent information contained in care plans, or inaccurate and missing care plan reviews.
● The provider did not always follow its own policy in relation to safeguarding and infection control. For example, the provider safeguarding policy stated, "Report suspected abuse or neglect as soon as is

practical." However, we found examples where this was not always followed.
● Care records were not always complete and governance systems in place had failed to improve this. For example, fluid monitoring records. One person's fluids had not been totalled on 10 occasions over 1 month and 11 occasions the following month.
● Care records contained incomplete, inaccurate, and conflicting information. This meant there was a lack of guidance for staff to monitor people's needs and support them safely.

The provider failed to ensure systems in place effectively monitored and improved the quality and safety of the service. The provider failed to keep accurate, complete and contemporaneous records. This was a continued breach of regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the time of inspection there was a manager in post who was in the process of registering with the Care Quality Commission (CQC). They were supported by a regional manager. The deputy was absent at the time of the inspection, which meant the on-call system was continuously staffed by the manager out of hours. The provider told us the manager had support from the senior management team if they needed it during this time.

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

At our last inspection the provider failed to seek and act on feedback for the purposes of evaluating and improving the service. This was a breach of regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection enough improvement had been made and the provider was no longer in breach of this part of regulation 17 (2).

● Systems were in place for engaging and obtaining feedback from some people and relatives.
● People and relatives were involved through the provision of surveys and newsletters, showing upcoming events. However, it was not evident that equality characteristics had been considered within this process to obtain feedback from people who had more advanced dementia or for a person who didn't speak English.

We recommend the provider reviews processes for obtaining feedback from people fully considering their equality characteristics.

● Staff had opportunities to give feedback via staff meetings and supervision sessions. One staff member told us, "We get asked for our opinions. They asked what colour walls and pictures we wanted up for décor."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others
● The culture at the service was not always person centred and did not consistently achieve good outcomes for people.
● During the inspection we identified numerous shortfalls that meant care was not always person-centred and people were not adequately protected from the risk of harm. In addition, not all people were engaged in meaningful activity that met their needs.
● Staff felt supported, and morale had improved since the last inspection. They felt the manager was approachable and they felt comfortable in raising concerns. One staff member told us staff were happier in

their work. We observed good communication between staff during the morning handover.
● The environment had improved since the last inspection and the atmosphere was more homely.
● The provider worked in partnership with other agencies and health professionals. For example, the local authority and district nurses.

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 had a suitable policy in place regarding the duty of candour. However, due to concerns identified during our inspection regarding the reporting of safeguarding, accidents and incidents we were not assured the policy was being consistently implemented.