Aden House Limited

Aden House Care Home

Inspection report

Long Lane
Clayton West
Huddersfield
West Yorkshire
HD8 9PR

Tel: 01484866486

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection of Aden House Care Home took place on 16 and 23 May 2018. We previously inspected the service on 16 December 2016; we rated the service Requires Improvement. The service was not in breach of the Health and Social Care Act 2008 regulations at that time.

Aden House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Aden House accommodates a maximum of 60 people; there is accommodation and communal areas located on both the ground and first floor. The home provides care and support to people who are assessed as having nursing and personal care needs; there is also a unit (Butterfly Unit) with 19 beds which provides personal care for people living with dementia. There were 48 people living at the home at the time of the inspection.

The registered manager had left the service the week prior to our inspection; a peripatetic manager was present on both days of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe and staff understood their responsibilities in identifying, recording and reporting concerns safeguarding concerns.

Where people were nursed on pressure relieving mattresses we found two of the three mattresses we checked were not set correctly and people's position change records did not always evidence staff were repositioning people in line with their care plan.

Not all the in-house maintenance checks had been completed due to changes in personnel and we were unable to locate any thermometers in communal bathrooms to enable staff to check the water temperature prior to showering or bathing people.

We found the recruitment of staff was safe. Feedback from staff and people who lived at the home was mixed regarding their being sufficient numbers of staff to meet people's needs. People told us staff did not always meet their needs in a timely manner and staff did not have time to talk to them.

The management of people's medicines was safe although improvements were needed to the management of people's creams.

West Yorkshire Fire Service had highlighted shortfalls in fire training for staff. The registered providers training matrix indicated other areas of staffs' training was also not up to date.

Very few people ate in the main dining room. People who ate their meal in their bedroom, staff served both the main course and pudding at the same time, meaning the dessert was probably cold by the time the person ate it.

People had access to external health care professionals.

Staff supported people to make daily decisions and supported them in the least restrictive way possible. Although further improvements were needed to ensure the requirements of the Mental Capacity Act 2005 were fully met.

People told us the staff were caring and kind. Staff knew people well and were pro-active in ensuring they respected people's privacy and dignity. People's care records were not stored securely and we were unable to evidence people or their families were involved in the care planning process.

People told us they did not have enough to do during the day. Two activities organisers had recently left, leaving one in post. During the period of our inspection, we saw minimal activity to engage or stimulate people.

New care planning paperwork was being implemented throughout the home. Each of the care files we reviewed contained care plans which had been updated, reviewed and were reflective of people's needs.

Complaints had been logged but from the information available, we were unable to evidence, the investigation had been robust and we could not ascertain the outcome had been acceptable to the complainant.

In March 2018 the company responsible for the management of Aden House Care home, Aden House Limited had changed. Feedback from staff about this change was positive.

From discussions with the peripatetic manager present at the time of the inspection, it was clear they were aware of the key areas where improvements were required to ensure people received a high standard of care.

We reviewed a number of audits completed over the previous eight months, we found they had not been completed as frequently as the registered provider specified and they were not robust. The company responsible for the management of the home at the time of the inspection had begun to implement its own audits and systems of governance but we were not able to evidence the effectiveness as they had only recently been commenced.

This is the third time the service has been rated Requires Improvement. We found breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The fire service had identified shortfalls in staff's fire training.

The management of people's creams was not robust.

People told us they felt safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had updated their refresher training.

Appropriate snacks were not always provided for people who required a soft diet.

Assessments of people's capacity to manage their own medicines had not been completed.

Is the service caring?

Requires Improvement

The service was not always caring.

Care records were not stored safely.

People told us staff were caring and kind.

Staff took steps to maintain people's dignity and privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not provided with sufficient activities to keep them engaged.

We could not establish if the management of complaints had been robust.

Care plans were person centred and were reflective of needs and

preferences.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager had recently left and a new manager had been recruited.

Systems of governance had not been consistently applied and were not robust.

There was a lack of regular engagement with people and their relatives, to seek feedback.

Aden House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection commenced on 16 May 2018 and was unannounced. The inspection team consisted of one adult social care inspector, an assistant 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. The expert by experience on this occasion had experience of working in health and social care. The inspector and assistant inspector also visited the home again on 23 May 2018, this visit was also unannounced.

Prior to the inspection we reviewed all the information we had about the service including statutory notifications and other intelligence. We also contacted the local authority commissioning and contracts department, safeguarding, infection control, the fire and police service, environmental health, the Clinical Commissioning Group, and Healthwatch to assist us in planning the inspection. We reviewed all the information we had been provided with from third parties to fully inform our approach to inspecting this service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was used to help inform our inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time in the lounge and dining room areas observing the care and support people received. We spoke with six people who were living in the home and four visiting relatives. We also spoke with the regional director, two regional managers, peripatetic manager (referred to as manager throughout the report), two nurses, a senior carer, two care staff, three staff from catering and housekeeping team and the activities co-ordinator. We reviewed three staff recruitment files, we looked at five people's care plans in detail and a further three care plans for specific information. We looked also looked at ten people's medication administration records and a variety of documents which related to the management and

governance of the home.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. One person said, "The staff are nice and that makes me feel safe, they have a chat and give me my tablets." Another person told us, "Oh yes, I feel safe, we have our own room and staff are here all the time." A relative said, "Safe? Very much so, [name of person] is getting great care. [Nurse] would do anything for [name of person], they are getting great attention."

However, during the inspection we identified areas where improvement was needed to ensure peoples safety.

Where people were at high risk of falls, equipment was in place to alert staff to the person's movement, for example, sensor mats. Equipment was also used to reduce the risk of injury in the event of a fall, such as low height beds.

A variety of moving and handling equipment was available to support people, for example, ceiling tracking hoists, manual hoists and stand aids. We reviewed the care plan for one person who required a hoist for all transfers. The care plan directed staff to use large sling, but we saw a medium sling was in their bedroom. We also found a lack of relevant detail regarding how the sling should be applied and fitted. We spoke with the nurse on duty regarding these concerns, which they promptly addressed. This is important as it reduces the risk of harm to both the individual and the staff supporting them.

The skin integrity risk assessment for one person identified them as being 'high risk' of developing pressure ulcers. Their care plan recorded 'should be sat on a pressure cushion where possible'. We did not see them sat on a pressure cushion during our observations on the first day of the inspection, although on the second day, they were sat on a pressure cushion.

Some people were nursed on pressure relieving mattresses. It is important this setting is correct to ensure the mattress is effective. We checked three pressure mattresses and found two were not set correctly. For example, the mattress for one person was set for a person who weighed 150kg, but their most recent recorded weight, April 2018, was 84.9kg. Their skin integrity risk assessment identified them as being 'high risk' of developing pressure ulcers. We shared our findings with the nurse on duty and the management team during the first day of the inspection. We checked the setting for a second person who required a pressure reducing mattress; we found this was set correctly to their most recent weight.

We reviewed a random sample of position change records for the three people whose pressure mattresses we had checked. Their care plans directed staff to change the position every two to three hours, every three hours and every two hours respectively. Records evidenced staff were not repositioning people in line with their care plan. For example, one person's record dated 3 May 2018 staff had recorded the person was on their left side at 4.05am and at 10am, they were not moved to another position until 11am.

This evidences a failure to do all that is reasonably practicable to mitigate risk and demonstrates a breach of Regulation 12 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each of the care plans we reviewed contained a Personal Emergency Evacuation Plan (PEEP). This is a document which details the safety plan, e.g. route, equipment, staff support, for a named individual in the event the premises must be evacuated.

A recent visit to the home by West Yorkshire Fire Service had highlighted shortfalls in fire training for staff. On the second day of the inspection an unannounced fire drill took place, this was to test staffs' response to the fire alarm and enable them to practice a horizontal evacuation in a designated area of the home. Not all the staff were clear as to the procedure they should follow, a de-brief was held after the exercise was completed, this enabled staff to review their actions and discuss areas for improvement. The manager told us a number of fire drills were being held to enable staff to be confident of the actions they would need to take in the event of the fire alarm being activated.

At the time of our inspection, the manager told us the previous maintenance person had ceased to work for the registered provider. They told us they were recruiting to fill this post but in the interim a maintenance person from another of the registered provider's home was supporting Aden House. When we reviewed the in-house checks completed on the premises and equipment we saw they were not up to date. For example, weekly fire alarm tests and monthly checks of the fire escape routes had not been completed during April 2018. These were being completed by the supporting maintenance person on the second day of our inspection.

The most recent service of the fire detection system by an external contractor, was dated 27 October 2017. An approved contractor usually checks fire detection systems every six months. Following the inspection, the regional manager evidenced a service had been completed on 23 May 2018 on both the fire system and fire extinguishers. It is a requirement of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) that all lifting equipment is regularly checked to ensure it is safe. We saw LOLER checks were in place for the passenger lift and both manual and bath hoists.

We were unable to locate any thermometers in the communal bathrooms. We asked two members of staff, neither of whom knew where to locate a thermometer. One of the staff told us, "I didn't know we had any." It is important staff can check the water temperature prior to a person using baths or showers. This is particularly important where people may have communication difficulties or reduced sensation where they may not be able to feel if the water temperature is too high. The peripatetic manager assured us this concern would be addressed. Following our inspection, we received an email from the operations manager to confirm thermometers had been purchased and staff were checking water temperatures prior to bathing and showering people.

This evidences a failure to ensure the premises are safe, not doing all that is reasonably practicable to mitigate risk and not ensuring staff have the skills and competence to complete their role. These examples demonstrate a breach of Regulation 12 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told there were not always sufficient staff employed to meet their needs in a timely manner. One person said, "They do get short of staff and the staff say they are short of staff. They are a bit short on nights but weekends are ok. Staff are busy and they come if I press the buzzer but they haven't got the time to talk to me." Another person said, "They (staff) are always complaining they haven't got enough [staff]. You have to wait; they say 'two minutes' but it stretches to about an hour. I have to wait to go to the toilet, I have just got used to it. I have to wait to go to bed and to get up." A relative told us "It's very inconsistent, very understaffed; they do not answer the telephone when you call." Another relative told us the turn of staff at the home had recently been high.

Feedback from staff was mixed. Staff also told us a number of staff had recently left and the home was using a high number of agency staff. Staff told us, "No there aren't enough staff. There are a huge number of agency workers. "We can't do everything. Staffing is a huge issue", "Staff turnover is high at the moment but we are using agency (to cover shortfalls)" and "We could do with another member of staff to make a difference."

We spoke with the senior managers and peripatetic manager present at the inspection regarding staffing. They acknowledged there had recently been a high turnover of staff and agency staff were being used to cover any shortfalls in staff cover. They also told they were actively recruiting staff and had candidates at various stages of pre-employment checks. This demonstrated the registered provider was taking action to address identified shortfalls in the number of employed staff to ensure sufficient staff were on duty on a daily basis.

We checked staff had been recruited in a safe way. We reviewed the recruitment files of three staff and saw application forms had been completed, references obtained and a Disclosure and Barring Service (DBS) check had been completed. DBS checks return information from the Police National Database about any convictions, cautions, warnings or reprimands a candidate may have received. Checks had also been completed to ensure nurses employed at the home had updated their registration. This is essential to ensure nurses are continuing to meet the professional standards that are a condition of their ability to practise.

As part of the inspection, we observed a nurse and senior care worker administer people's medicines. This was done in a kind and caring manner.

Medicines were stored safely and securely and the management of people's medicines was safe. We checked a random selection of seven tablets and found the stock balanced with the number of recorded administrations for all but one of the medicines we checked. We also checked how the home was administering controlled drugs (CD's), we saw this medicine was stored safely, records of administration were completed by two staff and the medicines were administered within the prescribed time frame. A weekly stock check was completed on all CD's to ensure there were no discrepancies.

Creams which were prescribed for long term use, where applied by care staff. We checked the records for one person who was prescribed two different creams. We found the creams in their room did not tally with the prescribed creams on their medicine administration record. The senior care worker told us staff applied one of the creams on a daily basis but there was no record completed by staff to confirm this. We asked a member of care staff about this, they said, "We used to have cream charts in people's rooms." This demonstrated the management of creams was not robust.

We spoke with two nurses and a senior care worker who all told us they had completed medicines training and had their competency assessed. The training matrix recorded staff with responsibility for administering medicines received regular training and an assessment of their competency had been completed.

Monthly medicines audits had been completed, the most recent dated April 2018. A file entitled 'daily management' also contained a number of daily audit checks completed between September 2017 and April 2018, although these had not been completed every day. Regular audits enable concerns and weaknesses in systems to be identified, enabling timely action to be taken to reduce future risk.

Staff told us people were safe and well cared for. The staff we spoke with were aware of their responsibilities in identifying, recording and reporting concerns safeguarding concerns. Information for staff was clearly

displayed, providing them with contact information both internal and external, for example, the local authority safe guarding team. This ensured staff were able to raise safeguarding concerns appropriately.

We found the home to be clean and odour free. The local authority infection prevention and control team had completed an unannounced audit in January 2018, the home had scored 84%. This demonstrated further work was needed to be done to ensure the people who lived at Aden House were protected from the risk of infection.

We looked at the arrangements for reviewing and investigating safety incidents and, when things went wrong how lessons learned were shared with staff.

Staff told us they would report any accidents, incidents or near misses to a more senior member of staff. The peripatetic manager told us they reviewed all accident and incident forms. They entered specific information onto a matrix to enable analysis for trends or patterns. Due to recent changes in the management at the home they were only able to show us the matrix they had commenced for the current month. The peripatetic manager told us this analysis would be completed monthly and the findings shared with senior managers to ensure lessons learned were actioned and shared with staff. This demonstrated a transparent approach to incident management.

Requires Improvement

Is the service effective?

Our findings

Our previous inspection in December 2016 we rated this key question as 'Requires Improvement' as we identified concerns regarding mental capacity assessments and the premises were in need of refurbishment. At this inspection, we found concerns with staff induction, training and records relating to people's diet and nutrition.

The peripatetic manager recognised the importance of ensuring people's care and support was delivered in line with current good practice guidelines. This was evidenced through the involvement of relevant external health care professionals and from reviewing a random sample of the registered provider's policies.

People felt staff had the skills to meet their needs. One person said, "All the staff know what they are doing even the new ones." We asked another person if they thought staff were suitably trained, they said, "I would think so yes."

We asked how new staff were supported when they commenced employment at Aden House. A nurse told us new staff were teamed to work with a more experienced staff member to support them. Following the inspection, we asked the operations manager to provide evidence of induction for two specific members of staff. This was not produced therefore we were unable to evidence they had received a robust, role specific induction.

Staff told us they received regular training in a range of topics. One of the staff we spoke with said training had been a mixture of online and face to face, they said, "The face to face dementia training, it was really good. "The registered provider had recently changed the format of their training matrix, at the time of the inspection all the data had not been inputted into the new matrix. Following the inspection, we reviewed the 'old' matrix, we noted this only listed 27 staff however; the most recent duty rota listed 53 staff. The matrix also recorded the majority of staff's refresher training was overdue. The peripatetic manager was aware staff training was not all up to date and assured us this matter would be addressed.

We saw evidence of recent supervision in each of the staff personnel files we reviewed. A matrix recorded nursing staff's most recent supervision had taken place in January 2018 and care staff in March 2018. Although one of the staff we spoke with said they had not had supervision since November or December 2017. Following the inspection we asked the operations manager if they could confirm the supervision this staff member had received during 2017 and 2018. They were only able to confirm the staff member had received one supervision in December 2017. Regular supervision enables managers to develop and motivate staff, review their practice or behaviours, and focus on professional development.

The majority of feedback about the meals served at Aden House was positive. Comments included; "I enjoyed my dinner", "Most of it is all right" and "The food is wonderful we have drinks every two hours, I have put on weight since I came here." However, one person said, "The food is reasonable, but the beef is so tough you can't cut it, no one discusses the menu." A relative said, "According to [name of person] the food is very nice."

We observed both the lunch and evening meal service on both units. At lunchtime on Butterfly unit we saw the dining tables were nicely presented with tablecloths, cutlery and a small vase of flowers, staff encouraged people to choose where they would like to sit for their meal. Staff offered people a verbal and visual choice of two meals, people chose which they would prefer. Where people required staff support to eat this was done in a timely and caring manner, however, we observed one staff member serve dessert to a person and not tell them what it was. When another person asked which fruit was in the crumble, the member of staff said they did not know. We also observed the evening meal to be a pleasant experience for people living on Butterfly Unit.

On the main dining room on the ground floor the atmosphere at both the lunch and tea time meal was calm and relaxed. At lunchtime people were asked if they wanted any more before staff removed their plates, we heard staff offer an alternative choice of dessert when someone declined the crumble they were offered. Not many people ate in the ground floor dining room with a number of peoples receiving their meals on trays in their bedrooms. Staff served their main course and pudding at the same time, the meal was covered but the dessert was not. This meant the dessert was probably cold by the time the person ate it. Meals were also plated up by staff which meant people were not able to decide the components of their meal.

Drinks and snacks were offered to people between meals. However, we observed staff did not offer or provide any snacks to one person. When we raised this with a member of staff, they told us there was nothing on the tea trolley the person could eat due to their need for a soft diet. However, when we spoke with the cook they told us appropriate snacks were always available for people who required a soft diet, including pureed fruit, smoothies, yoghurt and ice cream. We spoke with the management team at the time of the inspection to enable them to take prompt action.

We reviewed the food records for two people and found the quality of the information recorded inconsistent. For example, the records for one person did not evidence a mid-morning or mid-afternoon snack had been offered, consumed or declined on eight out of 15 days and on one day the only food intake recorded, was breakfast. The food records for another person recorded how much of the meal the person had consumed but they did not always record the quantity offered to the person. To enable a review of the effectiveness of strategies to manage people's nutrition and weight loss, food records need to be accurate.

When we reviewed the care plan for one person which recommended the person eat a soft diet, we saw their food records did not evidence staff were following this guidance. We spoke with the nurse on duty; they told us the person had the capacity to make their own decision regarding the consistency of their diet and to understand any associated risk. They also said they did not feel the person still required a soft diet. Following our discussions, the nurse implemented a risk assessment and a referral was made for a speech and language therapist to compete a further swallowing assessment.

People were weighed at regular intervals, although we noted one person, had not been weighed since March 2018 although no rationale for this had been recorded, their care plan recorded they were to be weighed monthly. The weight record for a second person instructed staff to weigh them weekly but the only weights recorded were dated 1 April 2018 and 11 May 2018. This demonstrated staff were not always following the guidelines specified in people's care plans.

Information was shared between staff at handover, which were held at the start and end of each shift. A record of the information shared was retained. One of the nurses also showed us the nurse's diary which was used to pass on specific tasks, for example, requesting GP visits and hospital appointments. Effective communication helped staff to deliver effective person centred care and support to people.

A relative we spoke with told us their family member needed to go to hospital on a regular basis, "They [staff] are good at ringing me and keeping me informed." We saw evidence in each of the care records we reviewed that people received the input of other healthcare professionals, including GP's, district nurses, speech and language therapists, opticians and podiatrists. This showed people received additional support when required for meeting their care and treatment needs.

We found the home to be clean and odour free. The main area of the home had two lounges and a dining room on the ground floor, there was also a second dining room on the first floor. We saw the dining room on the first floor was not used other than by staff, we also found one of the lounges on the ground floor was sparsely furnished with little evidence to suggest it was used regularly. People who lived on Butterfly unit had access to a secure garden, although the grass was overgrown and the bird feeders were all empty.

On Butterfly unit communal toilets and bathroom doors had appropriate signage so that people who lived there could identify what was behind the door. We also saw sensory objects were situated on some corridor walls, for example a selection of locks and chains, and pictures of movie stars from the 1950's and 1960's'. These demonstrated steps had been taken to make the environment conducive to the needs of people living with dementia.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We identified one person who had a condition attached to their DoLS but we unable to evidence this had been complied with.

Our previous inspection, in December 2016 found mental capacity assessments were not always clear and there was little information about whether people's relatives had legal authorisation to support them with decision making where they lacked capacity to do so for themselves. At this inspection we saw evidence of some decision specific capacity assessments and best interest's decision making in each of the care records we reviewed. Although we noted where people lacked capacity to consent to their medicines there was no evidence of a capacity assessment or best interest's decision making. Following this process is essential to ensure the rights of people who lack mental capacity to make decisions are respected.

Three care records we reviewed noted the person had a power of attorney in place, this is the legal authority to act for another person in a specified matter, however, neither record contained evidence of this. If a person lacks capacity to consent, then nobody should sign a consent form unless they have specific legal powers to do so, for example, health and welfare lasting powers of attorney.

These examples demonstrate a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the full requirements of the Mental Capacity Act 2005 were not being met.

When we spoke with the peripatetic manager, nurses and care staff it was evident from their answers they

understood the principles of the capacity act and how they had to be apply it in practice. Information was recorded on staffs' handover record and in the peripatetic managers office so staff were aware which people had a DoLS in place and where application for DoLS were pending review by the local authority.

Requires Improvement

Is the service caring?

Our findings

People told us staff were caring and kind. People told us, "All the staff are kind and very nice to me. I like everything about living here, I like the staff. I don't dislike anything because they let me stay in my room and eat my meals here", "They are now, some used to be a bit clever but not now" and "Everyone's lovely, I wouldn't want to live anywhere else, they are good." A relative said, "The staff are very kind." Another relative told us, "Mum's well looked after, clean and appropriately dressed."

People were appropriately dressed and looked well care for, indicating a high standard of care. We observed positive interactions from staff who interacted easily and pleasantly with people. There was appropriate physical hugs and affection prompted by the people who lived in the home and their families. People were called by their names and staff knew people well. Staff complimented people, for example we heard a member of staff say, "Your hair looks beautiful [name of person]." One of the staff told us "We look after people as though they were your own mum, like you would want to be looked after yourself." Both nurses we spoke with expressed strong opinions regarding the importance of people receiving high quality care. One nurse said, "We go home, this is their home. We need to ensure they have good care."

However, we identified areas where improvements were needed. Peoples care records were stored in the nurse's office which was situated in the reception area. On the first day of the inspection we found the door to the office was unlocked all day, the cupboard where peoples care files were stored was also unlocked. We asked a member of staff and they told us the office and cupboard door were always unlocked. We spoke with the management team about this at the end of the first day of the inspection. When we returned on 23 May 2018 we found the situation had not changed although a senior manager told us a lock had been ordered and was awaiting delivery. Ensuring confidential information is stored securely reduces the risk of unauthorised access.

Two people told us, "I don't know anything about care planning or reviews" and "They haven't discussed care." A relative said, "Neither mum nor I have been involved in her care plan." When we reviewed peoples, care plans we saw very little evidence people, or where appropriate their representatives had been involved in the development or review of their care plans. Involving people and their families in this process ensures care plans are person centred, reflective of peoples likes and dislikes and improves helps to ensure people receive the care and support they need and want.

Staff involved people in making decisions about their daily care and support. Staff could tell us how they supported people to make choices, for example, by asking people's opinion or showing them a choice of clothes to wear. We saw this was reflected in people's care plans, one care plan recorded 'Show a selection of clothes for [person] to choose'.

Staff told us how they protected people's privacy and dignity; closing doors and curtains and knocking on doors prior to entering. We observed staff speaking respectfully to people, knocking on doors prior to entering and ensuring people's modesty was respected while being hoisted. We checked a random sample of communal toilets and bathrooms and found the door was easy to lock, enabling people to use the

facilities in private. These examples demonstrate a people's privacy and dignity were respected.

People's religious beliefs were respected. A relative said, "[Name] is catholic and the priest comes every month which I arrange." A care file we reviewed noted "[Name] attends church services." Another care file recorded how the person enjoyed attending the church services.

Requires Improvement

Is the service responsive?

Our findings

Our previous inspection in December 2016 we rated this key question as 'Requires Improvement' a we were concerned about the number of people who remained in bed with no clear rationale for this, we also noted gaps in records. At this inspection we were concerned about a lack of meaningful engagement and social activities for people.

We asked people how they passed the time during the day. People told us, "I just sit here; I don't go down to activities or go downstairs. They are not doing activities at the moment because the staff have left. I don't go out but I'm not bothered", "There's nothing to do, we did a jigsaw and we were going to do another but the problem is we don't have a table big enough. I've not gone out, there are no entertainers. The thing I don't like is the loneliness of being in a room on my own" and "There's never anything going on at all just the TV. I'm fed up of it now." An undated review form in one person's care file recorded 'one of the concerns for family was lack of social activities'.

One of the staff we spoke with told us they were worried about the lack of stimulation for people. Another staff member told us the activities organiser normally worked on Butterfly unit, we asked them what activities there were to engage people who were lived in the main area of the home, they replied, "People have nothing to do." One of the staff told us two activities organisers had recently left the home and there was currently only staff member in this role.

We saw minimal occupation for people other than the television. On the first day of the inspection, on Butterfly unit we saw one member of staff painting someone's nails, another staff member chatted for a period of time with a person about the recent royal wedding. In the main area of the home we saw the activity organiser supporting two people with a craft activity. In the afternoon a visitor began to sing with a person, a member of staff put on some appropriate music and people, the staff member and visitor sang along. People were engaged and enjoyed the singing and happy atmosphere.

On both days of the inspection, we noted a number of people remained either in bed or in their own bedroom. Staff told us this was peoples own choice. This meant some people may be at risk of social isolation as we saw minimal interaction with staff other than as part of a task related activity.

When we spoke with the peripatetic manager they told us they had noticed the high number of people living at the home who remained in their rooms. They said they had spoken to some of the people and although they were satisfied this was personal choice, they added, "I don't know if people are in bed because there is nothing else to do." They told us they had met with the activities organiser to discuss the current programme and at how improvements could be made.

Although the peripatetic manager was aware of the shortfall in the provision of activities and engagement for people, the evidence from inspection demonstrates a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care files contained a life history however, the content and detail varied, and two we looked at had no information recorded at all. We saw one, which had been completed by a family member; this contained a lot of information about the person youth, family life, employment and hobbies. This information enables staff to find out people's interests to have meaningful conversations and encourage social interaction and communication.

The registered provider was in the process of implementing new care planning paperwork and we saw a mix of old and new documentation in use. Care files were person centred and contained a range of care plans to evidence the care and support people required, for example, mobility, eating and drinking, sleep and continence care. Entries and updates were made at regular intervals. Care plans also reflected guidance from other healthcare professionals. For example, one person's eating and drinking care plan directed staff as to the consistency of the food they needed to eat as well as their preferences.

The Accessible Information Standard requires staff to ask, record, flag and share information about people's communication needs and take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it. Each of the care files we reviewed contained a communication care plan, one person's plan recorded '[Person] has glasses but doesn't like to wear them'. Staff were aware of people's individual communication methods and could explain these to us in detail.

When we asked people, if they were unhappy, who would they complain to, one person told us, "I would tell the nurse when she comes up every day, its [name] today, I have no complaints." Although another person said, "I don't know who I would complain to", a relative said, "I would complain to [nurse]."

We saw three complaints were recorded during 2017; each one included a summary of the concerns raised however, it was not always clear, what actions had been taken to investigate and resolve the issue or what the outcome was. This meant we were unable to establish if the management of these complaints had been robust or if the complaint had been resolved to the satisfaction of the complainant.

People had an end of life care plan in place although the quality of the content varied. For example, one recorded the person had a do not resuscitate instruction (DNACPR) in place and the family of the person would be involved but no details were recorded as to the person wishes or preferences. A second end of life plan clearly recorded the person wish to remain at Aden House as they did not wish to be admitted to hospital as they entered their final days. Advance Care planning is key means of improving care for people nearing the end of life and of enabling better planning and provision of care, to help them live well and die well in the place and the manner of their choosing.

Requires Improvement

Is the service well-led?

Our findings

Our previous inspection in December 2016 we rated this key question as 'good'. This inspection identified concerns regarding the consistency and quality of the auditing systems. At this inspection we highlighted a number of areas where improvement was needed. We have reviewed the evidence against our ratings characteristics and rated this key question as Requires Improvement.

In March 2018 the company responsible for the management of Aden House Care home; Aden House Limited changed from New Century Care to Hill Care Limited. The registered provider is required to have a registered manager as a condition of their registration. The registered manager had ended their employment at the home the week before our inspection; a peripatetic manager was present on both days of the inspection.

Staff told us there had been improvements following the change in ownership. Staffs' comments included; "I have noticed a lot more people are involved, management are turning up. It's a lot more positive to see", "They (Hill Care) seem to want to ensure we are properly staffed" and "It is a good place to work." A nurse told us, "I am happy with Hill Care, they have a good structure, better paperwork."

The peripatetic manager told us they had worked for Hill Care for five years. They had met the previous registered manager prior to their departure which enabled them to get a handover from them regarding the management of the home. We spoke at length with them on the second day of our inspection. We asked them what their priorities were for the home, they responded, "Fire training for staff, looking at people's weight loss and health and safety issues. From the point of view of the people who live here, my priorities are; why are so many people nursed in bed, falls, weight loss and finding something for people to do (activities). Staffing priorities are training and supervision." We felt reassured by the response from the peripatetic manager as the topics they highlighted we had identified on day one of the inspection, but we had not shared with the management team at that time.

We reviewed the systems and processes in place to monitor the quality of the service provided to people. A number of audits completed between September and April 2018 but they had not been consistently completed consistently. A file containing 'resident of the day' records evidenced regular audits of individuals care and support needs and care records. We saw the majority of the forms had blank sections which had not been completed. We also noted the auditor recorded information had been located in peoples care plan but made no reference as to the quality of that information of if any required action had taken place. For example, the auditor recorded the individuals weight but no reference was made to an increase or decrease or if appropriate action had been taken, such as robust food records.

A member of the housekeeping team told us they were responsible for auditing mattresses to ensure they were clean and fit for purpose. We asked the housekeeper how they were able to do a robust check on mattresses where people remained in bed. They told us they completed a visual check but they were not able to complete all aspects of the audits. This meant a number of mattresses within the home had not been robustly checked.

The peripatetic manager showed us a matrix which detailed Hill Care's auditing timetable. The audits included; infection control, health and safety, medicines and catering. We saw some Hill Care audits had begun to be implemented in April 2018 and included a medicines and health and safety audit.

We also looked at how the performance of the home was monitored by the senior management team. We saw a record was retained of senior management's visits to the home between September and December 2017, there was no evidence of senior management's visits for 2018. However, we saw an electronic report had been submitted by the registered manager in February 2018 to New Century Care. This provided key performance information across a range of topic, including; safeguarding concerns, people's dependency levels, falls and complaints. Due to the change in the company responsible for the management of Aden House Care home, this was no longer in use and at the time of the inspection Hill Care's management reporting system were not yet in place.

We looked at how the feedback was gained from people and relatives. One person said, "There are no resident's meetings or not often." Another person commented, "There have been no resident meetings that I am aware of." Two relatives we spoke with said, "They had a wine and cheese get together but I didn't come" and "They did have meetings but not lately." The only resident and relative meeting minutes we were provided with were dated 13 April 2018.

We asked staff if regular meetings were held with them. One staff member said there had been one in February 2018 but they had not felt listened to. We saw minutes from meetings dated 2 August and 6 October 2017 and 8 February 2018, a document recorded a meeting had been held on13 April 2018 but we were unable to locate any minutes to evidence the content of the meeting. Although a staff member told us a recent meeting had been held to talk about the management changes at the home. Staff meetings enable information to be shared and allow staff to provide feedback to the management team as to the quality of peoples care and support.

A matrix for Hill Care recorded resident and relative meetings and separate staff meetings, were to be held quarterly throughout the year. The matrix also recorded feedback surveys for residents and relatives were scheduled for September and for staff, in May.

As evidenced within this report there were still a number of areas where improvements were needed, for example, management of skin integrity, fire safety, staff training, access to social engagement, auditing and provider oversight. These findings demonstrate a breach of Regulation 17 (a) (b) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to the relatively short time frame since the change in the company responsible for the management of Aden House Care home, we were unable to evidence the new systems of governance were effective. Future inspection will seek to evidence a sustained and consistent high level of quality has been achieved and that systems of governance are reflective, transparent and robust.

We saw evidence of partnership working, for example, staff worked with other health care professionals to achieve positive outcomes for people. The manager told us they were keen to ensure links with relevant professionals were developed further.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen at the service. The registered manager of the service had informed the CQC of the required events. This meant we could monitor that appropriate action had been taken.

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 There was a lack of activities or social engagement for people living at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The requirements of the Mental Capacity Act 2005 had not been met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a failure to ensure the premises were safe, and a failure to do all that is reasonably practicable to mitigate risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems of governance were ineffective.