Aberdeen House Care Limited

Aberdeen House

Inspection report

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22 March 2019

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17 June 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Aberdeen House is a residential care home that was providing care and support to fourteen people aged 65 and over at the time of the inspection.

People's experience of using this service:
●The provider had not deployed enough staff at night to keep people and their employees safe. Although managers recognised this, the provider told us there were no plans to change the current staffing levels.
●The management of working patterns for staff was arranged in cultural way. Some staff worked particular shifts with no management oversight over 24hr period.
●There had been an increased number of falls. Audits were shown to be ineffective as no action had been taken to identify patterns. This placed people at continued risk of falls and serious injury.
●The registered manager did not always inform organisations of accidents and incidents as required to.
●People's incidents were not consistently communicated to relatives.
●People's safety needs had been assessed. However, people with higher personal needs had recently been admitted but staffing levels had not been reviewed or increased.
●People received support from staff who had appropriate employment checks in place. Staff received comprehensive training to meet people's needs.
●People received their prescribed medicines to protect their health.
●The home was clean and tidy protecting people from the risk of infection. However, the environment and deployment of staff at night placed people at risk if evacuation needed to take place.
●People's confidential information was not protected as it was not securely stored.
●Staff received regular supervision though team meetings were not regularly held. Some staff reported tensions in the team. This issue had not been addressed by the registered manager.

Rating at last inspection: Good (Report published 9 January 2018)

Why we inspected: The inspection was brought forward due to information we received of concerns at the home.

We did not inspect the key questions, effective, caring and responsive as information we received did not raise any risks or concerns in these areas.

We found two breaches of regulations. You can see what action we told the provider to take at the back of the full version of the report.

Follow up: Going forward we will continue to monitor this service and plan to inspect in line with our re-inspection schedule for those services rates requires improvement.

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

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.

Details are in our Safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

Aberdeen House

Detailed findings

Background to this 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted by concerns we received about staffing levels during the night.

Inspection team:
The inspection team consisted of an inspector, an inspection manager and assistant inspector.

Service and service type:
Aberdeen House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The Inspection visit took place on 22 March 2019 and was unannounced.

What we did:
Before our inspection we looked at information we held about the service and the concerns we had received. We contacted the local authority and asked for their views on the service provided. We used all the information gathered to help plan our inspection.

During the inspection we spoke with six people who used the service and one relative. We also spoke with the provider, registered manager, deputy manager and six members of staff.

We reviewed four people's care records, records relating to the management of the service, accidents and

incidents, audits and quality assurance reports and medicines. We also examined other records relating to the recruitment of two staff members.

Requires Improvement

Is the service safe?

Our findings

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

Requires Improvement: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations have not been met.

Staffing and recruitment

- The provider did not deploy sufficient numbers of waking night staff to keep people safe. At the time of our inspection one waking staff member was supporting 14 people living at the service, with the assistance of another member of staff sleeping in.
- The systems for alerting the sleep-in staff were not robust. Should anything happen to the waking member of staff during the night there was a risk the sleep-in staff member would not be aware of this. This could compromise both the safety of people using the service and the night staff member.
- The home had two floors, corridors were narrow, and areas of the home were isolated. With current staffing arrangements at night this may delay the safe evacuation of people.
- One staff member told us, "I am expected to manage the home alone unless there is an emergency and at that point I can summon the sleep-in staff for assistance. People are left waiting for assistance as I cannot support people quickly enough on my own."
- Other staff confirmed that two people were often awake most of the night and stayed downstairs. One person wakes on and off and one person who requires regular support with their personal care.
- The deputy manager told us, "I have worked some night shifts recently due to staff absence and recognise there is more demand on staff at night. I have discussed this with the registered manager." The registered manager told us, "We have discussed overnight staffing with the provider due to the concerns raised." The provider told us, "I have not discussed staffing levels with the managers and I feel the home is sufficiently staffed overnight."
- Care files we reviewed showed that people had fallen causing head injuries. One person's record showed there had been 11 falls in the last six months. Most of these incidents were in the afternoon and in their bedroom at night. One record we reviewed stated the night staff had been busy supporting another person before finding them on the floor.

The provider failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed across the night time to meet peoples needs and keep them safe. This is a breach of Regulation 18 Staffing (1).

- The staffing levels across the day time shifts appeared to be sufficient to meet peoples needs.
- The provider had robust recruitment systems in place. This ensured staff were suitable to work with vulnerable people prior to them starting their employment with the service.
- References from previous employers and a check with the Disclosure and Barring Service (DBS) were completed. The DBS checks helps providers reduce the risk of employing staff who are potentially unsafe to work with vulnerable people.

Assessing risk, safety monitoring and management

●People with more complex needs had recently been admitted to the home. There was no system in place to assess whether people' needs could be met with the current staffing arrangements.

●Records of incidents showed that there had been an increase in people falling. A review of the care files for one person showed they had fallen 11 times. Whilst none had caused a serious injury it was unclear what measures had been taken to reduce them occurring again or prevent potential serious injury. We also found that their relative had not been informed of all the falls their mother had.

●We saw one person being supported in a wheelchair with no foot plates attached. When transporting people in wheelchairs foot plates need to be attached to prevent injury.

●Access to the ground floor was not secure. The stairs were easily accessible to people who were at risk from falls. We informed the provider during the inspection and we were told this would be resolved.

Learning lessons when things go wrong

●The registered manager did not notify all the relevant people and agencies when accidents and incidents occurred. For example, one person had four falls in a short period of time sustaining injuries. The records showed that on one occasion the person banged their head. Advice wasn't sought from person's GP or out of hours service. There was the potential the person may have sustained a serious head injury or could do so in the future.

●A previous incident had occurred where a person had been admitted to hospital with a head injury. The management team had not learnt from this to ensure they followed correct procedures to keep people safe from harm. Lessons had not been learnt from previous incidents to prevent them happening again.

Systems and processes to safeguard people from the risk of abuse.

●People were not always safeguarded from the risk of harm. Risks to some people's health and wellbeing had not been assessed and effective action taken to reduce them.

●People told us they felt safe and one person said, "I feel safe because I have never had a reason to feel there was a problem."

●Staff had completed safeguarding training and understood safeguarding issues and how they should be reported.

●Staff we spoke with recognised different types of abuse and said they would report their concerns to managers.. One staff member told us, "If you see anything that you have not seen before like bruising when providing personal care, I would report it. There is a number on the door that I can ring up and share my concerns, and if I saw anything that wasn't right I would ring".

Using medicines safely

●People received their medicines safely and when they required them. Staff who administered medication were knowledgeable and had been trained and assessed as competent to give medicines.

●Medicines were kept securely. The storage of medicines was appropriate and met NICE guidance. The assistant manager had oversight of the medicines coming into the home and those sent back to the pharmacy for destruction. Accurate records were kept of this within the medicine's cupboard.

●Medication administration Records (MARs) showed each medicine had been given as prescribed, by a member of staff who had been trained and assessed to do so. Training certificates were viewed along with the list of assessed staff who could give medicines. However, one member of staff told us that they gave medicines but had not received any training or had been assessed as competent.

●The assistant manager showed us records of competency assessments undertaken as part of staff supervision. However, whilst the records were part of overall competency for many other areas such as moving and handling, the document lacked any details and it was not clear how often these competencies were performed.

We recommend the provider and registered manager consider a more formal medicine competency assessment be undertaken.

●Staff checked medicines before it was given to people to ensure it was correct. Medication checks were carried out daily to identify possible errors or problems. Any issues were dealt with immediately.
●People prescribed medicines to be given 'when required' did not have a protocol in place to instruct staff about when and in what circumstances this medicine should be given. Only one person had 'when required' medicine. The assistant manager told us what they did in this circumstance. The person was always asked if they required their medicine. This demonstrated they knew people well and the circumstances in which they needed the medicine for pain.
●Medicines administrated by a patch was well documented. Guidance was in place where the patch should be placed and alternating the patch to different sides. Used patches were disposed of correctly and bins removed via clinical waste every three months.
●Staff had been trained and competency assessed by District Nurses to administer insulin. They also undertook blood glucose monitoring and worked closely with the person's GP and District Nurses to ensure blood glucose levels remained as stable as possible. Frequent communication between the staff and specialist nurses, took place when blood glucose levels went beyond normal levels to obtain advice.

Preventing and controlling infection
●The service was working within current guidelines for the safe control of infection.
●The home was clean, tidy and fresh. All areas of the home we looked at showed that staff took pride in keeping the home clean and tidy for people.
●Appropriate cleaning products were used for equipment and in plentiful supply, being stored in a locked COSHH (Control of Substances Hazardous to Health) cupboard.
●Staff had the right equipment for cleaning. Posters in storage areas reminded staff of correct cleaning and colour coded equipment to use.
●Staff were mainly following correct procedures for removing dirty linen to the laundry. However, one member of staff moved dirty linen from upstairs without wearing appropriate apron or gloves. This was an infection control risk.

Requires Improvement

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.

Requires Improvement:
Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high quality, person-centred care. Some regulations have not been met.

At our previous inspection the registered manager received informal support from the provider, but formal processes to oversee the service were not evident. The quality assurance system in place was not overseen by the provider, who also did not complete their own formal audits. During this inspection we found these arrangements had not changed.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- There was a culture of managers and staff working the same shifts. This meant staff did not have the regular support of managers throughout the day or night. One person told us, "The manager and deputy manager normally leave at two o'clock most days."
- Managers were reluctant to change this working pattern when we highlighted this to them, explaining that it would be difficult to make changes due to previously agreed shift patterns between certain members of staff.
- There was mixed feedback from staff regarding the support they received from managers. Some staff told us the managers were kind and approachable whilst other staff told us their views and concerns were not listened to.
- The registered manager understood the duty of candour responsibilities. However, whilst accidents or incidents had occurred, and people had not sustained serious injury these had not been reported to the local authority and in some instances the Care Quality Commission (CQC). Records showed that relatives were not always being fully informed of all such incidents. We discussed this with the management team during the inspection.
- Complaints were recorded. The registered manager contacted complainants promptly and demonstrated these were resolved appropriately.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Systems were in place to monitor and review the quality of the service. However, these did not pick up the issues we found during our inspection and did not identify the shortfalls around the monitoring of falls. The reviews did not identify the increase in the number of falls being sustained for some people whose records we reviewed.
- The provider had completed a monthly audit which reviewed areas such as staffing, health and safety and maintenance.
- Where care plans had been identified as requiring a review these were not always carried out. For example,

we saw one person's care file where a review had been scheduled but was not completed.
●We observed people's personal information stored in a cupboard was not secured. The door to the room was open and the cupboard unlocked.
●The local authority told us, they were not being contacted when people had fallen. People's relatives were not consistently informed and records we reviewed confirmed this.
●The overall rating from our last inspection was displayed within the home as required by law. However, we found the previous inspection rating displayed from 01 September 2016 in a communal lounge which could be confusing for people and relatives visiting the service.

Continuous learning and improving care
●We looked at how the registered manager monitored the service for themes and trends following accidents and incidents. The overall falls audits were not effectively reviewed and opportunities were missed to potentially protect people from further falls. This meant people could be at risk of further harm or serious injury. The provider told us following the inspection that all incidents and accidents were recorded on their provider level system at their head office. However, themes and trends were not all identified to enable effective learning and improve care.

The provider failed to ensure that the systems to assess, monitor and improve the quality and safety of the services provided to people were effective in mitigating the risks to their health and welfare. This is a breach of Regulation 17(1) (2a, b), Good Governance.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●Records we reviewed showed staff did not have the opportunity to meet regularly with colleagues. The records showed that the last meeting was in September 2017. This meant that opportunities could be missed to meet and discuss potential issues and concerns about staffing and make suggestions about how to make improvements within the service.

●There was mixed feedback on how well the team worked together. Some staff told us they worked well together, and staff said some relationships were difficult. One staff member told us, "There is one or two of the staff that create an atmosphere and they bring people down".
●Staff told us they had supervisions on a regular basis.
●Feedback had been obtained from people living in the service, their relatives, staff and professionals. However, surveys had not contained analysis of the results or whether action needed to be taken that would enable people and other interested parties see how their input affected how the service is run and whether improvements have been implemented.

Working in partnership with others
●The registered manager and assistant manager told us they worked well with local healthcare providers and the GP Practice who also provided their medicines.
●The District Nursing service and diabetes Nurse specialist had also been involved in teaching some of the staff how to administer insulin and assess their competence.
●People benefitted from the manager inviting members of the local community into the home.

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 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure that the systems to assess, monitor and improve the quality and safety of the services provided to people were effective in mitigating the risks to their health and welfare. This is a breach of Regulation 17(1) (2a, b), Good Governance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed across the night time to meet peoples needs and keep them safe. This is a breach of Regulation 18 Staffing (1).