Aden House Limited

Aden Mount Care Home

Inspection report

Perseverance Street
Primrose Hill
Huddersfield
West Yorkshire
HD4 6AP

Tel: 01484515019
Website: www.newcenturycare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Aden Mount took place on 8 and 11 May 2017. The location had been previously inspected in January 2016 and was found to require improvement at that time, with breaches of regulations relating to safe care and treatment and record-keeping. We received an action plan from the registered provider to show how they would address those breaches. During this inspection, we checked to see whether improvements had been made. Whilst we found improvements in some areas, we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing, meeting people's nutritional and hydration needs, consent and good governance.

Aden Mount is a purpose-built home which offers personal and nursing care and accommodation for up to 45 adults. There were 44 people living at the home at the time of our inspection. All bedrooms, which are over three floors, are en-suite and all floors are accessible via a passenger lift or stairs.

The home did not have a registered manager in place at the time of our inspection. We had been made aware by the registered provider the person who was the registered manager during the last inspection had since left the service and a new manager had been appointed and had been in post for three months. They were in the process of applying to register as manager. 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 living at Aden Mount. The manager and staff were aware of relevant procedures to help keep people safe and staff could describe signs that may indicate someone was at risk of abuse or harm. Staff had received safeguarding training.

Risks to people had been assessed and measures put into place to reduce risk. The building was well maintained and regular safety checks took place.

Medicines were managed, stored and administered safely by staff who had been trained to do so, although appropriate records were not always kept in relation to topical creams.

Appropriate safe recruitment procedures were followed. However, sufficient numbers of staff were not always deployed effectively in order to meet people's needs. Staff told us they felt supported and we saw evidence staff had received appropriate induction and training, although staff lacked formal one to one supervision.

Appropriate referrals were made for additional support in order for people's health care needs to be met. However, professional advice was not always followed which meant people's nutritional and hydration needs were not always met.

Staff asked people for consent prior to providing care and support. Formal consent was not consistent and the principles of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were not always followed. People were not always supported to have maximum choice and control of their lives.

People and their relatives told us staff were caring and we observed staff to be kind and supportive. We observed people's privacy and dignity was respected. People told us staff encouraged them to maintain their independence.

Care records were person centred and reviewed regularly. However, not all care and support staff were aware of the content of care plans. The manager was aware of this and this was currently being addressed. The service was responsive to people's needs.

Staff told us they felt supported by the manager and people and their relatives spoke positively about the new manager. Meetings such as staff meetings and residents' and relatives' meetings were held. Regular audits and quality assurance checks took place, although these were not sufficiently robust and did not identify some areas found during our inspection which required action.

The manager was visible throughout the service during our inspection and they knew people's needs well.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Sufficient numbers of staff were not always deployed to provide safe and effective care and support.

People told us they felt safe.

Risks to people were assessed and measures were in place to reduce risks.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had received appropriate induction and training to enable them to provide effective care and support to people. However, staff lacked regular one to one supervision.

People's nutritional and hydration needs were not always met.

The principles of the Mental Capacity Act 2005 were not always followed.

Is the service caring?

Good

The service was caring.

We observed positive interactions between staff and people who lived at the home.

People's privacy and dignity was respected.

End of life wishes were considered.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans reflected people's needs, preferences, choices and personal histories but staff did not always read people's care plans.

We observed people making their own choices relating to how they wanted their care to be provided.

People knew how to complain if the need arose and complaints were well managed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People told us they felt the home was well-led and the manager engaged well with people.

Accurate and complete records were not always kept in relation to the care and support provided.

The registered provider had up to date policies and procedures in place.

Regular audits and quality checks took place. However, these required improvement to be fully effective in improving service provision.

Aden Mount 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.

The inspection took place on 8 and 11 May 2017 and was unannounced. The inspection was carried out by two adult social care inspectors and an expert by experience on the first day of the inspection and an adult social care inspector on the second day of the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home and gathered information from the local authority, including the commissioning and safeguarding teams, and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The registered provider had been asked to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help plan and inform our inspection.

We used a number of different methods to help us to understand the experiences of people who lived in the home, including observations and speaking with people. We spoke with five people who lived at the home, four relatives, four care and support staff, the cook, activities coordinator, manager, lead clinical nurse, quality support manager and the quality and governance director.

We looked at six people's care records, four staff files and training data, as well as records relating to the management of the service. We looked around the building and checked people's bedrooms, bathrooms and other communal areas.

Requires Improvement

Is the service safe?

Our findings

All of the people we asked told us they felt safe living at Aden Mount. Family members also said they felt their relatives were safe. One person told us they felt safe because, "The carers are there if you need them." Another person said, "Everyone gets on well together and I am quite near people."

Comments from family members included, "My relative is very safe. The sides are up on the bed and their buzzer works," and, "I've done care work myself and I always feel okay leaving my relative."

The manager told us there were nine carers, a shift leader and a nurse providing care and support to 44 people living at the home at the time of our inspection. The manager told us the number of carers had recently increased from eight to nine. Nevertheless we observed staff struggling to meet people's needs and the people and relatives we spoke with, as well as staff, confirmed this.

We were shown a dependency tool which was used to help calculate the numbers of staff required in order to meet people's needs. The tool considered needs in relation to mobility, personal hygiene, continence and the required level of assistance for dressing and for eating for example. The tool also included provision to make adjustments based on medical or social need. However, despite this tool, we found staff deployment to be a concern.

On the first morning of our inspection, we heard the nurse call bells switched from the standard call sound to the emergency call sound twice. This happens after the person has been waiting for six minutes. This also happened on the second day of our inspection. We spoke with a person who had pressed their nurse call bell and were waiting for staff assistance. The person told us, "I buzz and they come and turn it off and say they'll come back later. I go to bed at about 6pm so if I don't get up soon I only get about six hours in my wheelchair." We asked the person if this was a one-off or regular occurrence. We were told, "No, it's all the time."

We spoke with a person who tended to stay in their own room to eat their meals. They told us, "Because if I go downstairs, I have to wait an hour or so, sometimes up to two hours for them to help me back up to my room. They've too much to do." This person was complimentary about staff, in terms of their mannerisms and the way they assisted them, but felt staff lacked time to provide effective support.

Other comments from people regarding staffing levels included, "Sometimes there is not enough," and, "There is skeleton staff sometimes." Two relatives we spoke with told us there were not enough staff.

When we asked a member of staff whether they felt there were sufficient numbers of staff, we were told, "You can see there aren't. We struggle so much to get round everyone. You can hear the buzzers going off. We know people are waiting." Another staff member told us, "We struggle to do the basics. Not spending enough time with service users. The new dependency scores don't match."

We explained our findings to the manager, quality support manager and quality and governance director.

The manager explained they felt staff deployment was complex because people who required nursing care and those who required residential care lived across three different floors within the home and some chose to stay in their rooms. The manager was looking at the possibility of making changes to try and address this which they hoped would make staff deployment more effective. An additional care assistant had recently been deployed, with responsibility for assisting with meals and providing nutritional support. However, the above demonstrated a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because sufficient numbers of staff were not deployed in such a way to meet people's needs.

We inspected four staff recruitment files, including a registered nurse. We found safe recruitment practices had been followed. For example, the manager ensured reference checks had been completed, identification and nursing registration had been verified and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

The registered provider had an up to date safeguarding policy and the manager, and all the staff we asked, were aware of safeguarding procedures and knew what constituted potential abuse. The manager was aware of their duty to report incidents of safeguarding. The staff we spoke with told us they would report any suspected abuse and escalate their concerns if they felt they were not acted upon. This helped to keep people safe because staff had knowledge of appropriate action to take if they had concerns anyone was at risk of abuse or harm.

Risks in relation to the environment were assessed and these were specific to the individual person, such as whether the person could use their call bell or access their bedside lights. Bed rails were fitted to some beds, which helped to stop people from falling out of bed. We saw associated risks had been assessed and consideration was given in relation to whether this was safe for the individual. Having risk assessments in place helped to ensure people could be encouraged to be as independent as possible whilst associated risks were minimised.

Risks relating to falls were assessed and we saw these were regularly reviewed. These considered the person's gait, sensory needs, falls history and medical history for example. Care records contained detailed moving and handling instructions. Where equipment was used to assist people to move, the type of equipment and associated sling were detailed as well as information relating to the method of application and how to safely support the person. This helped to ensure risks were reduced and staff were given appropriate information to assist people to move safely. We observed staff assist people to move in a confident, safe and efficient manner.

Some people had specific air mattresses in place to assist with pressure relief. Records showed these were checked daily to ensure they were set correctly, which helped to ensure effective pressure care. Some people required assistance to reposition regularly, to reduce risks to their skin integrity. The records we sampled showed people received the required assistance. However we also observed a person, who was at risk of pressure sores, to be sat in their chair, without a pressure cushion, despite their care plan indicating this was required. We highlighted this to the manager who took immediate action.

We noted the front door to the home was not locked and there was not always a member of staff in the reception area. This posed a risk because people from outside could access the home, unchallenged. When we raised this with the quality and governance director, they told us they had already identified this and had arranged for appropriate door locks to be fitted.

Regular safety checks took place throughout the home in relation to, for example, water temperatures, nurse call bells, fire alarms and emergency lights. Tests such as gas and electrical safety and portable appliances had been completed. Records showed equipment was examined regularly, such as bedrails and wheelchairs. We saw equipment was repaired or replaced when this was identified as necessary. This helped to ensure the safety of premises and equipment.

Personal Emergency Evacuation Plans (PEEPs) had been devised for each person living at the home. The plans detailed the level of assistance required to evacuate the home in an emergency. There was a 'grab bag' which contained useful items such as a high visibility jacket and torch, emergency contact telephone numbers and PEEPs. This showed measures were in place to help keep people safe in the event of an emergency.

We saw accidents and incidents were logged. Records following incidents showed appropriate actions had been taken. The manager explained to us they had identified better systems could be in place to analyse trends and this work was ongoing. We saw the manager had identified a particular type of surface on a chair was potentially resulting in increased risk of falls so alternative options had been explored. This showed the manager was taking steps to reduce accidents and incidents.

The previous inspection in January 2016 found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because controlled drugs were not recorded and staff did not ensure people took their prescribed medicines. During this inspection we found improvements in the management and administration of medicines.

Medicines were administered in a calm, patient and kindly manner by either a nurse or a shift leader who had received specific training to ensure medicines were safely administered. We saw the member of staff observed people discreetly to ensure their medicines had been taken and only then did the staff member record the medicines as taken. The member of staff used an effective recording system which showed whether the person had taken their medicine or whether the medicine had been declined.

At the front of each medicines administration record (MAR) was a Medication Profile Format. This contained a photograph of the person and information relating to any allergies, preferred method of taking medicines, any contra-indications and any specific requirements. This helped to ensure medicines were administered appropriately, to the correct person.

Records indicated one person was refusing to take their medicines, with the exception of their painkillers. We saw this was appropriately recorded and contact had been made with the person's GP and the person was being monitored.

We observed the member of staff asked a person if they could assist them to sit upright before taking their medicines. This was done in a respectful manner and ensured the person consented and also helped to reduce associated choking risks.

Good infection control practices were observed. For example, medicines were popped into pots, without the member of staff touching the medicines.

Medicines were stored appropriately and were locked away securely. We counted random samples of medicines and the balance remaining reconciled with the records.

Some medicines, such as paracetamol for example, were administered on a PRN (or as required) basis. We

found PRN protocols were in place which helped to ensure these medicines were administered appropriately and at safe intervals.

We checked the controlled drugs, which are prescription medicines that are controlled under Misuse of Drugs legislation. These were stored securely and logged in the register as required. This showed controlled drugs were managed appropriately. We checked a random sample and found the amount of medicine remaining was correct, according to the register.

Some people were prescribed topical creams. The shift leader told us carers applied some topical creams and records for this were kept in people's room. However, when we checked records, some of these had not been completed, although staff assured us they did apply the cream and a person we asked confirmed this. We raised this with the manager and quality and governance director. We saw, through quality assurance processes, the recording of medicines had already been highlighted as an area for improvement and this was being addressed though a home improvement plan.

We observed the home to be clean and there were no malodours. However, the carpet was old and worn and in need of replacing. The manager had already identified this and showed us the carpet was due to be replaced. All of the people and relatives we asked told us they felt the home was clean.

Requires Improvement

Is the service effective?

Our findings

We asked people whether they felt staff had the necessary training and skills to provide effective care. One person told us, "They seem capable." Another said, "Staff are really nice. They notice if you are down and try to cheer you up. They make you laugh." A family members told us, "I trust the staff. They know what they are doing. They treat my relative well."

Although most staff told us they felt supported, there had been a lack of formal one to one staff supervision. Records showed only five care assistants had received formal one to one supervision out of 33 contracted care assistants since January 2017. The manager told us they were aware this needed to be addressed and had plans to introduce 'heads of departments' who would be responsible for staff supervision. In the meantime, the manager showed us a plan which was in place to ensure all staff had supervision by the end of the month. However, this meant staff had not received ongoing supervision and this demonstrated a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed four staff files and the training matrix. Staff had received training in areas such as safeguarding, health and safety, dementia awareness, moving and handling and the Mental Capacity Act 2005. The staff we asked told us they would feel able to ask for further training if they felt this was required. Staff received an induction into their role and this included shadowing more experienced members of staff. This showed staff received appropriate training prior to commencing their role. None of the staff recruited to work in the home, at the time of the inspection, were new to the caring profession.

All the people we asked told us they liked the food at Aden Mount. We were told there were two choices of meals offered for lunch and dinner and people could choose what they wanted to eat at breakfast time. Food menus had been discussed at a recent residents' and relatives' meeting. Menus were devised by the registered provider at a national level but people told us they had requested that regional differences be taken into consideration. The manager told us they were aware of this and it had been actioned. The manager told us they had recently interviewed for a new head chef and had offered the post to a chef who had specific skills in terms of food consistency, such as piping and moulding.

We observed a mealtime experience. Tables were set with table cloths, condiments and cutlery. People were given choices in relation to their meals and alternative meals were provided, if people did not wish to have the menu choices.

The home had been awarded a, 'Kirklees Healthy Choice Gold Award,' for being committed to good standards of food hygiene and healthy food options in April 2017. The Healthy Choice Award is a way of acknowledging businesses that practice good standards of food hygiene and offer healthy options.

The cook was aware of people who required specific diets, due to allergies or diabetes for example. Full fat milk and cream was used in order to fortify food where necessary.

One person's care plan indicated they required a specific type of cup to enable them to drink safely and we

observed this being used. We also observed adapted 'easy-grip' cutlery was used to help people to eat their meal. This meant people were able to eat and drink as independently as possible. We saw snacks and drinks being offered to people in between meals during our inspection.

Records showed, when a person's Body Mass Index (BMI) declined, food and fluid charts were implemented 'Until further notice'. BMI is a measure that uses height and weight to indicate whether weight is healthy. However, the food and fluid charts for this person ceased before the person was re-weighed and this meant there was a risk the person's BMI could continue to decline. The lead clinical nurse could not explain why the person's food and fluid intake had ceased to be monitored and said food and fluid charts should have continued until the person gained weight. We shared this information with the manager, quality support manager and quality and governance director. Following our inspection, we were sent an action plan which showed this had been addressed.

Records showed a dietician had recently visited a person and recommended the person eat their meals in the communal dining areas and be given encouragement with their meals. However, we observed the person eating their meal alone in their room. We asked the person where they normally ate their meal. The person told us, "It's best to let staff decide. Either they bring it or take me to the dining room." This meant the person was not receiving the support as advised by the dietician and therefore their nutritional needs were not being met.

The above demonstrated a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because people's nutritional and hydration needs were not always effectively met.

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 people 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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

A principle of the MCA is that mental capacity assessments are decision specific because some people may have capacity to make some decisions but not others. However, we did not see any decision specific mental capacity assessments, in line with the requirements of the MCA. For example, one person who lacked capacity to consent to residential care and treatment had bed rails in place. Whilst we saw records to show some people with capacity provided consent for bed rails, there was no evidence of mental capacity assessments or best interest decisions in relation to this decision for those people who lacked capacity to consent to bed rails. This meant the principles of the MCA were not being followed.

Where people had been assessed as lacking capacity, we found a lack of evidence to show decisions were being made in the person's best interests. For example, one person's care plan stated, 'I am lacking capacity due to my dementia.' The care plan indicated some decisions must be made by others in the person's best interests. However, there were no records of decision specific mental capacity assessments and no evidence of decisions being made in the person's best interests.

We saw, 'Consent on admission' forms were in use. These provided space for the person to consent to

information sharing, use of the person's documents and data for quality audit purposes, consent for photographs and bedrails where appropriate and consent for the home to manage and administer medicines. Some people had signed their consent forms and some were incomplete or not completed. The form indicated clearly a mental capacity assessment and best interest decision would be required if the person lacked capacity to make any specific decisions. However, this was not evidenced.

The manager told us one person living at the home had a DoLS authorisation in place and another had been applied for. We saw a DoLS checklist was in use, in order to help staff determine whether an authorisation would be required. However, one person's mental capacity assessment indicated the person lacked capacity to consent to residential care and treatment but the DoLS checklist contained contradictory information which indicated the person did have capacity and therefore a DoLS authorisation was not considered. This meant there was a risk the person was deprived of their liberty without appropriate safeguards in place.

The above examples demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because care and treatment was not always provided with the consent of the relevant person and staff did not act in accordance with the requirements of the MCA.

We saw evidence of referrals to other health care professionals such as speech and language therapists, physiotherapists, opticians, GPs and district nurses. All the people we asked told us staff contacted other health care professionals promptly when required. This showed people were referred for additional support in order to have their health care needs met.

Good

Is the service caring?

Our findings

We were told staff were caring. One person told us, "Staff are alright. I've not fallen out with one in five years. You can have a bit of fun with them." Another person said, "They are pleasant and nice." A third person told us, "Oh, they're caring. Very caring. You can't fault the staff."

A family member told us, "Staff are happy and caring, trying to accommodate. We come at different times, sometimes we phone our relative and we can hear the interaction between staff and our relative. It is always good." Another said, "There is a well established staff team here, they are pretty good and look after my relative well." A further family member said, "Most staff are friendly, there is just the odd one who is a bit sharp and overpowering."

All the people we asked told us staff respected their privacy and dignity. One person told us, "They treat me like normal. They cover me with a towel." Another person told us, "Staff respect your privacy and if they come to your bedroom to check on you and see you are on your phone, they do not come in." We were told staff always closed doors and curtains when they were assisting people with personal care and our observations confirmed this.

We observed staff interacted with people appropriately. Staff knelt to people's level and listened to them. Body language fitted with eye contact and appropriate touch and reassurance was offered. People chatted with staff in a relaxed manner and appeared comfortable in staff presence. This was apparent from people smiling and laughing with staff.

Whilst the manager was showing us around the home, they heard a person asking for assistance. The manager broke off from our conversation and went to assist the person. We observed the manager knocked on the person's door and asked if they could enter and then assisted the person in a helpful manner. This demonstrated the manager understood the importance of providing care and support to people as a priority and they were able to demonstrate good practice to staff.

The manager told us people, and their relatives where appropriate, were involved in their care planning. The relatives we spoke with confirmed this and one family member told us, "Our relative is a plain eater and we discussed all this, they were very accommodating."

We saw, in people's care plans, consideration had been given to people's needs in terms of sexuality. This was respectfully approached with an initial question of, 'Is the resident happy to answer the following questions?' The care plan then indicated details of the person's relationships, whether they had a spouse, civil partner or partner and included details regarding the level of privacy the person may require and whether visits would be preferred in their own room. Consideration was given during the care planning process to people's faith or religious needs and how or whether people wished to actively practice their religion. These examples showed people were enabled to express themselves and equality and diversity were embraced.

Staff told us it was important to ensure people stayed as independent as possible. People were encouraged to maintain their independence. For example, one person told us, "When I fell, staff tried to get me not to give in." Another person told us staff encouraged the person to do things for themselves.

No-one was receiving end of life care during our inspection. However, care plans contained information relating to people's choices in relation to end of life care. Information such as what the person would like to happen and, importantly, what the person would not like to happen were explored, as well as where the person would like to receive end of life care and what elements of care were important to the person. This showed people's end of life wishes were given consideration during the care planning process.

Requires Improvement

Is the service responsive?

Our findings

People told us they felt the home was responsive to their needs and there were sufficient activities and things to occupy their time.

The care plans we reviewed were person-centred and contained sufficient information to enable staff to provide appropriate care and support to people. Plans were regularly evaluated. Care plans included a photograph of the person and contained information relating to each person's needs, for example, in relation to the environment, personal hygiene and oral care, dietary needs, communication, mobility, activities, sexuality and mental health needs.

Care plans were individual and specific to the person. For example, one plan stated, 'I like to have a shave with my electric razor and require staff to do this for me.' When we spoke with the person, they told us staff assisted them to shave, using their preferred method. This demonstrated the person received care and support as outlined in their care plan and according to their preferences.

When we spoke with staff, some staff told us they did not always read people's care plans. They told us they were passed information by other staff and said, "The service user will tell you. It's common sense." This meant, although person-centred plans had been devised for people's care and support, staff were not always aware of the content of the plans. We raised this with the manager and quality and governance director and we were told this had already been identified. A new system was currently being introduced whereby staff would be required to complete a reflective piece after reading care plans and we saw examples of some of these.

People and relatives told us the manager and staff were responsive to their needs. For example, one person was in the process of moving rooms at Aden Mount. This was because a room had become vacant on a different floor, which was closer to the activities room and the person preferred this room. The person told us they were able to choose how the room would be decorated and they were due to make the move imminently. Another person had been unhappy with the noise their air mattress made, so alternative options were explored, with a satisfactory outcome being found for the person. This demonstrated the manager and staff were responsive to people's needs and people were involved in making decisions about their care.

Two activities coordinators were employed at the home. All the people we spoke with told us they felt there were enough activities at the home and there was nothing else they would like to do. People told us about a variety of activities such as painting, crafts, films, entertainers, birds of prey, games, exercises and massages. However, a relative we spoke with told us they felt the environment was not stimulating enough for people. We noted many people chose to stay in their rooms and the lounge and communal areas within the home were not well utilised. The manager told us they were taking steps to try and encourage people to use these areas and there were plans to convert an area into a bar/snug and to improve an outdoor area. Records showed these plans had been discussed at a recent meeting with residents and relatives.

An activities coordinator told us the weekly schedule of activities was in placed in each person's room and we saw these. There was an activities room which contained a large table and a range of resources, books and films. We noted, however, although films were shown at times, there was a lack of comfy chairs for people to sit and watch them.

We spoke with a person who chose to stay in their room. They told us, "I watch TV and go down occasionally to do activities but I like to spend time with my friends. Staff have always encouraged that." This person told us staff accompanied them on shopping trips and sometimes to the bank. Another person we spoke with told us staff helped them to keep in touch with their family and friends and this helped to reduce social isolation.

We saw records of when people were supported to bathe or have a shower. These records were provided to us by the lead clinical nurse. Twelve people's records were not completed to show whether they had been supported to have a bath or shower during the month of April 2017. Four people's records showed they had a shower on one day only during the month April. Three family members we spoke with told us there were problems with their relative having a bath or shower. We were told by family members they, "Quite often," needed to ask staff to assist their relative to shower because they felt this was not happening due to staff shortages. Records of a recent residents' and relatives' meeting showed this was raised as a concern. The people who lived at Aden Mount, however, told us they could have a bath or shower when they wanted to. The manager addressed this at a recent meeting and explained shift leaders should take the lead in ensuring people were assisted when required and that this was recorded.

People could choose whether they wished to have their bedroom doors open or closed and locked or unlocked. Their choices were recorded in care plans. The people we asked told us they could choose whether they wanted their doors open or closed.

The complaints procedure was displayed in the home. All the people we asked told us they would feel able to complain if the need arose. One person told us they had complained and, although initially the complaints procedure was not followed and the person did not receive a written response, they told us the area manager arranged to meet with them and the issue was satisfactorily resolved. We saw complaints were recorded and responded to.

Requires Improvement

Is the service well-led?

Our findings

The registered manager who was in post during our last inspection was no longer employed by the registered provider. There was a new manager in post, who was in the process of applying to become registered manager of Aden Mount. The new manager had been in post for three months at the time of this inspection.

The manager understood their responsibilities in terms of their duty to report specific incidents to the Care Quality Commission (CQC). The previous inspection ratings were displayed. This showed the registered provider was meeting their requirement to display the most recent performance assessment of their regulated activities.

Everyone we asked could tell us who the manager was and all the people we spoke with felt the manager was approachable. We were told by everyone we asked that the home was well managed. One person told us, "The manager talks to us. It's a lot better now." We were told the manager had, "different ideas and is approachable. They pop in to see me and know my name."

Comments from relatives included, "Things have improved under the new manager," and, "The new manager is trying to make a difference and is more hands on," and, "I feel comfortable here, it's an open culture. Nothing is hidden." One relative told us they previously had reservations but felt, "Optimistic things will improve under the new manager."

A member of staff told us they felt supported and said, "They're always open to ideas. There are staff meetings. The manager leads." However, another member of staff told us they felt the new manager did not have an open door policy and said, "The door is closed most of the day." We saw this had been addressed at a recent staff meeting, where the manager had explained to staff of the need to close the office door at times, in order to maintain confidentiality.

Everyone we spoke with told us they would recommend Aden Mount. We were told by a family member, "It's home from home rather than being a home. Visitors can go in the kitchen and make a drink, you can have a meal with your relatives in their own room. Everyone is open and honest and staff get on well together."

The previous inspection in January 2016 found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because contemporaneous records were not kept.

At this inspection we saw records of fluid intake were not always accurate. Records for one person, whose food and fluid was being monitored, showed their fluid intake was particularly low. However, we saw the person drinking fluids throughout our inspection and the quality and governance director assured us the person was drinking adequate fluids. The incomplete record meant it was not possible to determine whether the person's hydration needs were being met.

The manager was clearly making improvements to the home and we could see some areas identified during

our inspection had already been identified through quality audits. However, continued improvements were required to the governance systems within the home. Records relating to the care and treatment of each person using the service were not kept. We found consent records were incomplete. Decisions made on behalf of people who lacked mental capacity were not recorded and did not provide evidence these had been taken in line with the requirements of the Mental Capacity Act 2005. These examples demonstrated a continuous breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about our regulatory response to this breach will be added to the report after any representations or appeals have been concluded.

The manager told us they felt very supported by the registered provider. We were told, "Resources are not a problem. I asked for the carpet replacing and that was approved and when I requested some supernumerary time for staff that was approved too." The manager told us they felt New Century Care were a good provider and there were opportunities for leadership development and peer support. The manager told us it was important to develop a, "No blame," culture, where mistakes could be acknowledged and learned from.

The manager engaged with people, relatives and staff, through meetings and quality assurance questionnaires for example. We saw minutes of a staff meeting from April 2017. This was a forum for staff and the manager to exchange and share information. Meetings are an important part of a manager's responsibility to ensure information is disseminated to staff appropriately and to come to informed views about the service.

A notice board in the reception area displayed an, 'Employee of the month.' Some staff had been nominated by their peers and the winner received a token prize. Initiatives such as this can have a positive effect on staff morale and help to motivate staff.

Surveys had been sent to people and relatives in December 2016. We saw the results from these were analysed and some resulted in action being taken, such as new furniture and equipment being purchased. This showed the views of people were proactively sought and acted upon.

The manager had recently held a residents' and relatives' meeting. This had taken place at the weekend, to enable more people and relatives to attend. Furthermore, the manager had arranged for some open door sessions to take place at weekends, to enable people and their families to speak with the manager. People we spoke with were very positive about the meeting. One person told us, "There are now Saturday morning 'ask the manager' surgeries and you can go and see the manager when you want to."

A person told us, prior to the new manager being in post, they had stopped attending meetings because they felt they were not listened to. However, they told us they were now attending the meetings again because the new manager was attending and they felt listened to.

The manager told us two unannounced quality assurance visits by the registered provider had taken place since January 2017. Regular safety audits to ensure the building and environment were safe, for example in relation to water temperatures, bedrails and maintenance took place.

Monthly audit quality reports relating to people's dependency, weight, pressure ulcers, infections and any medication errors, accidents or incidents and hospital admissions for example were submitted to the registered provider. These were discussed at quality meetings and actions were taken to address any areas of risk or concerns.

A registered provider quality meeting was taking place at Aden Mount on the first day of our inspection. We saw monthly quality and risk meetings took place which considered the quality of service provision in line with the CQC's key lines of enquiry. Compliance visits resulted in action plans which were shared with home managers. There was a live Home Improvement Plan for Aden Mount, which was regularly updated and showed some areas identified for improvement during our inspection had already been identified and were being actioned, such as medicines recording, staff supervision and replacing some carpets. Any homes in the provider group which were a concern received further support and additional visits from the compliance team. This showed the registered provider was taking proactive steps to improve the quality of care and service provision.

The registered provider shared information with home managers across the registered provider group, in order to learn lessons from accidents, incidents and near misses which may have taken place in homes across the provider group or indeed at other homes nationally. As a result, specific information had been shared in order to reduce risks of similar incidents occurring at Aden Mount. This showed the registered provider was taking steps to improve the care and support provided and to reduce risks within the home.

We found the registered provider and manager and staff team to be receptive to our inspection and responsive to our findings. Following our initial feedback after the first day of our inspection, the manager and lead clinical nurse had taken action to address some areas. On the second day of the inspection, we saw evidence of a group supervision with staff to highlight the need for accurate record keeping.

The vision and values of the home were displayed in public areas and included, 'To act with integrity and respect, always provide care that is person centred, listen and learn.' From our discussions with the manager, their vision was aligned to this.

Up to date policies and procedure were in place, for example in relation to safeguarding, whistleblowing, complaints and infection control. This helped to ensure current, up to date, guidelines were being followed.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always provided with the consent of the relevant person and staff did not act in accordance with the requirements of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional and hydration needs were not always effectively met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of staff were not deployed in such a way as to meet people's needs. Staff had not received ongoing supervision.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	Records relating to the care and treatment of each person using the service were not kept. Consent records were incomplete. Decisions made on behalf of people who lacked mental capacity were not recorded and did not provide evidence these had been taken in line with the requirements of the Mental Capacity Act 2005.
Treatment of disease, disorder or injury	

The enforcement action we took:

A Warning Notice was served on the Registered Provider in relation to Regulation 17, (1) (2)(a)(b)(c), Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.