Aden House Limited

Aden Lodge Care Home

Inspection report

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Date of inspection visit:
19 December 2016
28 December 2016

Date of publication:
06 March 2017

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 Lodge Care Home took place on 19 and 28 December 2016. We previously inspected the service on 23 November 2015 and at that time we found the registered provider was not meeting the regulations relating to person centred care, dignity and respect, consent, safe care and treatment, premises and equipment, good governance and staffing. We rated them as inadequate and placed the home in special measures. On this visit we checked to see if improvements had been made.

Aden Lodge provides care and support for older people, some of whom are living with dementia. It is a purpose built home and provides single room accommodation with en-suite facilities. The home was divided into two units, one of which was an 11 bed unit, Ladybird Suite, for people living with dementia, and a 23 bed unit for people who were assessed as having residential care needs. At the time of inspection 33 people were living at Aden Lodge.

The home had a manager in post but they were not yet registered with the Care Quality Commission. 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 each of the staff we spoke with understood the different types of abuse and their responsibility to report any concerns.

There were a number of risk assessments in each of the care records we looked at although they did not record an adequate level of detail to ensure people were protected from the risk of harm, particularly in regard to their safety when bathing or showering. Staff told us some people could not be bathed due to the risk of harm to the person but this was not clear from their individual records. When there was an accident or incident, staff recorded this but we found two examples where this information had not been passed on to the manager. A bathroom had exposed pipework which was a potential hazard to vulnerable people; we told the manager about this but when we checked on the second day of our inspection we found this was still a concern.

There were procedures in place to check potential staff were suitable to work with vulnerable people. People we spoke with did not raise any concerns regarding the staffing at the home but staff told us, and we saw; times when people on the Ladybird suite were unsupervised.

We found there were systems in place to ensure the management of people's medicines were safe.

We saw evidence staff received an induction when they commenced employment along with training in a number of subjects. There was a programme of supervision but the manager acknowledged this was behind schedule.

Our discussions with the manager and staff showed they had a good understanding of the Mental Capacity Act and issues relating to consent. However where people lacked capacity to make complex decisions, mental capacity or best interests' documentation was not always evident within their records.

People received a choice of meals and drinks. Catering staff were aware of people's specific dietary needs including where people were at risk of weight loss and required the calorific content of their meals to be enhanced.

The layout and décor of the Ladybird suite was not dementia friendly. The lounges were not homely and the shape and size of the room meant chairs had to be arranged around the edge of the room. There was an absence of colour on the unit to assist people in differentiating between bedrooms and bathrooms.

People and their relatives told us staff were caring and kind. Staff spoke with people in a caring and inclusive manner, they respected people's privacy and supported people in a way which maintained their dignity.

We received positive feedback from people regarding the activities at the home, which included gardening, baking, singing, memory word games, crafts and external entertainers.

The care records we looked at were person centred but they had not all been updated to reflect people's current needs and they did not consistently provide an adequate level of information as to the support they needed. We found one person who had been at the home for approximately eight weeks did not have any care plans in place.

We saw evidence of two written complaints which had been logged, investigated and the complainant had received feedback regarding the issues they had raised.

We received positive feedback about improvements at the home. We saw evidence a number of audits. had been undertaken to assess and monitor the quality of the service provided to people, meetings had also been held with staff and relatives. During our inspection we found evidence of some improvement, however as evidenced within the main body of the report, there remain a number of areas where there is a need for further development to ensure the safety and well being of the people who live at Aden Lodge.

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

Not all aspects of the service were safe.

People's care records did not provide adequate details to reduce the risk of harm while staff were supporting them with bathing and showering. We saw exposed pipework which posed a potential risk of injury to people.

A number of pre-employment checks were competed on potential candidates prior to the commencement of their employment.

There were times on the Ladybird suite when people were left unsupervised.

Medicines management was safe.

Is the service effective?

Requires Improvement

The service was not always effective.

New staff completed a programme of induction and training which was periodically refreshed. There was a programme of supervision but not all staff had received a recent individual supervision with a more senior colleague.

Staff respected people's right to make decisions but where people lacked capacity decision specific capacity assessments and evidence of best interest's decisions were not always recorded.

People spoke positively about their meals, telling us they received a choice with snacks and drinks readily available.

Is the service caring?

Good

The service was caring.

Staff were caring and kind.

People were enabled to make choices in regard to their daily

activities.

Staff took steps to maintain people's dignity, privacy and maintain levels of independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People spoke positively about the activities provided at the home.

People's care records were not always complete and did not consistently provide accurate details of their care and support needs.

Where a formal complaint was received, this was investigated and feedback was provided to the complainant.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well led.

There was a manager in post but they were not yet registered with the commission.

Since the last inspection a number of improvements have been made to the service, although there remain some areas which still need attention to reduce the risk of harm to people.

A variety of audits were completed on a regular basis but these had not identified the issues we have highlighted.

Aden Lodge 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 took place on 19 December 2016 and was unannounced. The inspection team consisted of two adult social care inspectors 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. One inspector also visited the home again on 28 December 2016. This visit was announced, this was to ensure the manager would be available to meet with us.

The registered provider had been asked, during August 2016, 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. 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.

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 lounges and dining rooms observing the care and support people received. We spoke with seven people who were living in the home and four visiting relatives. We also spoke with the operations manager, compliance manager, manager, deputy manager, senior care assistant, three care assistants, two members of the catering team and the activities organiser. We reviewed four staff recruitment files, five people's care records and a variety of documents which related to the management of the home.

Requires Improvement

Is the service safe?

Our findings

Our inspection in 23 November 2015 found the registered person was not meeting the regulations relating to safe care and treatment, premises and equipment and staffing. On this visit we checked and found improvement although we still had some concerns regarding people's safety and staffing on the Ladybird suite.

People told us they felt safe. One person said about the home, "I feel safe here, they look after you properly", and a relative told us, "Now I feel safe and confident about (person) being here." The manager, deputy manager and each of the staff we spoke with understood their responsibility in keeping people safe from the risk of abuse. The manager and deputy both told us any concerns would be investigated and a referral would be made to the local authority safeguarding team. The training matrix recorded 100% of staff had completed an e-learning safeguarding training course and safeguarding information was on display in the reception area of the home. This showed staff were aware of their responsibility in keeping people safe from the risk of abuse.

The relatives we spoke with said staff managed risk well while encouraging people to be as independent as possible. One relative said, "(Person) did have a fall but they do minimise the risk with anti-slip mats and bed rails."

Each of the care plans we reviewed had a number of individual risk assessments, for example, mobility, skin integrity and bed safety rails. However, they did not always provide an accurate record of people's care and support. For example, the moving and handling assessment for one person did not adequately describe how the hoist sling was to be applied. We also noted the falls risk assessment for this person identified them as high risk of falls, but there was no falls care plan in place and the risk assessment had not been updated to reflect a recent incident. Ensuring this level of information is recorded helps to reduce the risk of people receiving inappropriate care.

People's moving and handling assessments did not always provide in-depth information regarding the equipment and method to be used to ensure the safety of both the individual and staff. On the first day of our inspection a member of staff told us about a person who required two staff for bathing or showering. They said "(Person) isn't safe, (person) leans forward". Another member of staff told us another person for whom it was unsafe to bath. They said, "They can't be bathed in this bath, (person) slips so they aren't safe. We shower (person)." We looked at the care records for these two people as well another person's records who we had identified as being dependent upon staff for their mobility needs. None of the records provided adequate information regarding the specific equipment staff were to use or how to use it safely to reduce the risk of harm to the person when bathing or showering. For example, the personal hygiene care plan for one person noted 'offer a bath or a shower' and their moving and handling documentation referred to the use of a hoist and sling for bathing. We could not see any reference to staff not bathing them. We spoke with the manager and deputy manager at the end of the first day of our inspection to enable them to take prompt action to address these concerns. When we returned for our second day of inspection, we checked one of these three care plans but found no changes had been made.

The registered manager told us that although staff had completed fire training they had not all attended a fire drill. Ensuring all staff attend regular fire drills helps to ensure staff have the knowledge and skills to enable them to take appropriate action in the event of a fire. The manager showed us a 'fire bag', to be used in the event of a fire or other emergency, which contained the personal emergency evacuation plan (PEEP) for people who lived in the home. We checked the PEEP for each of the people whose care records we had reviewed but found there was not a PEEP in place for one of them. We brought this to the attention of the manager and they emailed a copy of the PEEP dated the day of our inspection to evidence the matter had been rectified promptly.

The deputy manager told us accidents and incidents were all logged and a regular analysis was completed to identify possible patterns. We saw the registered provider's online management system and saw accidents and incidents were logged each month. When we reviewed two people's care records we saw staff had entered details of each of them having had a fall. We saw an accident form had been completed but this information had not been passed to the manager or deputy and therefore had not been logged on the registered provider's online management system. The manager said this was because accidents were recorded on individual forms rather than in a book and there was no duplicate copy. They said this matter had already been identified by the registered provider and the system for staff to record accidents was to change in January 2017.

One the bathrooms on the Ladybird suite had exposed pipework which protruded upwards where the floor and wall met which posed a risk of serious injury to people. The bathroom door was unlocked and we saw a person going in and out the bathroom freely. We brought this to the attention of the manager and they told us they would address the matter. On the second day of our inspection we found no action had been taken. We spoke with the manager again and they assured us the bathroom door would be locked until the maintenance team could take appropriate action to address the matter.

Where people used pressure relieving air wave mattresses it is important they are set correctly to ensure they are effective. We checked the records for two people and saw the document used to record the correct mattress setting had not been completed. However, when we asked a member of staff about the mattress setting for one of these two people, they were able to tell us what the setting should be and why. When we checked the mattress we found it was set as the staff member had told us. However, it is important this information is recorded so all staff have access to this information.

We saw evidence external contractors were used to service and maintain equipment, for example the gas safety and the fire detection system. We also saw evidence that moving and handling equipment had been serviced line with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). We reviewed the internal maintenance checks which were completed on, for example, the fire system, water temperatures and window restrictors. We found the checks had been completed frequently over the previous months although the time frame between the checks was not always consistent. For example, the emergency lighting and water temperature checks had not been completed since October 2016.

These examples demonstrate a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were recruitment procedures in place to reduce the risk of employing staff who may not be suitable to work with vulnerable adults. We reviewed the recruitment files of four staff and saw application forms had been completed and a record of the interview questions and answers had been retained. There were two written references in each of the recruitment files we looked at and DBS checks had been completed. DBS

checks return information from the Police National Database about any convictions, cautions, warnings or reprimands and help employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups

During our previous inspection we found there were insufficient numbers of adequately deployed staff available to meet people's needs. When we spoke with people and their relatives, no-one raised any concerns regarding the number of staff on duty. During our observations of the residential unit, we saw staff were busy but people's needs were met in a timely manner.

On the Ladybird suite there were only two staff on duty. One of the staff told us there were times when people were unsupervised as staff were supporting other people with aspects of personal care. Another staff member said they did not think there were enough staff on the unit, "We have a lot of people to assist and support, we get behind as so many need two (staff). If people are in bed they need more support, like with eating and drinking." During the afternoon we noted one of the staff was alone on the unit for approximately ten minutes. We asked the staff member how they would summon assistance in the event of an emergency and they said would press the nurse call on the emergency setting.

We spoke with the manager regarding staffing numbers at the home. They told us they had access to a dependency tool but they did not use it. They said a dependency tool was used as part of the pre-admission process but when we asked to see an example, they were unable to locate it. We did see people's dependency was logged on the monthly manager's report but this did not evidence any link to staffing ratios. We also spoke with the manager regarding the staffing on Ladybird suite and they said they would look at the need for a lone worker risk assessment and an additional method for staff to summon support in the event of the second staff member not being available. However, while we acknowledge the registered provider needs to ensure the safety and well-being of their staff they also need to ensure there are sufficient numbers of staff on duty to meet people's needs.

Failing to ensure systems and processes are established and operated effectively demonstrates a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of our inspection we checked to see if the management of people's medicines was safe. We asked one person if they received their medicines regularly, they said, "I get my pills at the same time every day." A relative told us their family member's medicines were administered properly, saying, "They (staff) do the medicines properly and on time and they have sorted out a problem with the prescription."

We observed a member of staff administering medicines to people which was done safely and included the staff member observing to ensure the person had taken the medicines they had been given. People's medicines were stored safely with the door to the treatment room being locked and the medicines trolley secured to the wall. There was a system in place to record the details of medicines when they were brought to the home and when they needed to be returned. Where people were prescribed a medicine to be taken 'as needed', a protocol was in place. Having a protocol in place provides guidelines for staff to ensure these medicines are administered in a safe and consistent manner.

We spoke with two staff who administered people's medicines. They both told us they had received formal training and their competency to administer medicines had been assessed by another staff member. We saw evidence of this when we reviewed their personnel files. This meant people received their medicines from staff who had the appropriate knowledge and skills.

A monthly medicines audit was completed. We saw this recorded findings, for example, a missing signature

on a medicine administration record (MAR) and also noted actions need. This included an entry on the December 2016 audit for all senior staff to complete the online training provided by the supplying pharmacist, by the end of February 2017. This showed there was a system in place to monitor how medicines were managed and administered.

Requires Improvement

Is the service effective?

Our findings

People told us staff were approachable and appropriately trained. One person said, "They know what they are doing." A relative told us they were happy with the quality of care and support the staff delivered saying, "(Person) was losing weight at the beginning but they monitored it and got it sorted out."

Staff who had recently been employed each told us they were happy with the induction and training they had received when started to work at Aden Lodge. One staff member told us they had completed training in a range of subjects when they commenced employment as well as shadowing a more experienced staff member for a number of shifts. We checked the recruitment files for three staff who had been employed for less than six months and saw documented evidence of their induction. This covered a range of topics including values of the organisation, empowerment, abuse, fire and service user care records but we did not see any evidence the induction process included the Care Certificate. We asked a senior manager who was visiting the home on the first day of our inspection and they told us the Care Certificate was not currently being used at Aden Court. The Care Certificate is a set minimum standard that should be covered as part of induction training for staff who are new to care work.

Each of the staff files we reviewed contained a number of training certificates to evidence staff's completion of e-learning. Topics included food hygiene, fire, life support, dementia care and health and safety. We also saw a certificate to confirm staff had received practical training in regard to moving and handling people. After the inspection we reviewed the training matrix. This provided an overview for each staff member's training and enabled the manager to easily identify where staff needed to refresher a particular aspect of their training.

At our previous inspection, on 23 November 2015 we highlighted a lack of formal training specific to the health needs of some people who lived at Aden Lodge, for example, falls awareness, stroke or diabetes care. We did not see evidence training in these areas had been provided to staff since the last inspection, either from the training matrix or certificates in staff files. However, during our inspection we did not identify concerns relating to a lack of staff knowledge in these areas but receiving training in specific health conditions can provide staff with enhanced knowledge and skills which when implemented can improve the quality of life for individuals living at the home.

One of the staff we spoke with told us they had received regular training and supervision, "We have supervision every six months or if (manager) sees something or something happens (manager) will do supervision. My last supervision was last month." The manager told us staff should receive three supervisions plus an annual appraisal per year but they explained this had not been achieved due to staff shortages. They told us they planned to ensure senior care staff received relevant training to enable them to assist the manager in ensuring all staff received regular supervision from a more senior colleague. We found evidence of a recent individual supervision in two of the staff files we reviewed but there was no supervision or performance review for a staff member who had no previous care experience and had been employed for less than six months. We saw a document entitled 'supervision' but this was a generic document and was in regard to reporting faulty equipment and timekeeping for staff. Regular, individual management supervision

help to monitor staff performance and development needs and ensure they have the skills and competencies to meet people's needs.

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.

Each of the staff we spoke with understood people's right to make decisions and understood some people may be able to make simple decisions but not more complex ones. The deputy manager spoke with us about one person and explained how the person had capacity to make daily decisions but lacked capacity in regard to risk management. When staff spoke with us they also referred to acting in people's best interests where people were unable to make a specific decision and told us how they respected people's right to say 'no'. One staff member told us, "We have to respect (persons) wishes, if (person) says no, we can't force them."

We reviewed the care plan for a person who lacked the capacity to decide they wanted to live at Aden Lodge and we saw a capacity assessment and evidence of a best interest decision meeting in their care plan regarding this decision. However, we reviewed the care plan for another two people who lacked capacity to make complex decisions, but there were no mental capacity or best interests' documentation evident within their files. Following this process demonstrates openness and transparency in providing services for people who lack capacity as prescribed in the Mental Capacity Act 2005.

This evidences a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS) as described in MCA. Paperwork relating to DoLS applications and approvals was kept in the office and the contents of the file indicated there were thirteen people who lived at the home were subject to a DoLS authorisation. There was no overview of the information, for example to summarise the names of people for whom a DoLS had been applied for, dates of applications, outcomes and when staff needed to re-apply for a DoLS if that was still appropriate. Having this overview helps to ensure senior staff have oversight of relevant information pertaining to DoLS authorisations.

We received positive feedback from people about the quality of the meals. People said the food was good, with a variety and people had plenty to eat and drink. Relatives also said they were happy with the care taken by staff to ensure people ate when they wanted and at a speed suitable for the individual. A relative said, "(Person) is very happy with the meals." Another relative said, "They are very flexible about meal times and they have a large variety of choice and plenty of snacks and drinks."

We spoke with a cook and a catering assistant. They were aware of people who required specialised diets, how people liked their meal presenting as well as individual likes and dislikes. They said they did not have written information about people's weights but said staff told them if there were any concerns. The cook told us food was fortified, for example, with cream in mashed potatoes, to enhance the calorific content of food, particularly where people were at risk of, or had lost weight.

The meals were plated up by the kitchen staff which meant people were not able to choose the individual components of their meal. However, people chose their food as it was served by staff and not in advance and the cook said they supplied two choices for the lunch and evening meal. The cook said staff had tried different methods for people to choose their meal, including choosing the day before and showing small sample plates. But they said this had caused confusion for people over the portion size they would receive and so no longer did this.

As part of our inspection we reviewed if people received the input of external healthcare professionals. A relative said, "They refer (person) to the GP and don't ignore anything." One person who lived at the home responded, "I see the chiropodist when I want to." We also saw evidence in people's care plans of the involvement of other healthcare professionals, including the GP, district nurse and dietician. This showed people received additional support when required for meeting their care and treatment needs.

On the ground floor there was a lounge and separate dining room. The seating in the lounge was arranged in clusters which enabled people to converse with each other and there was also access to the garden. The Ladybird suite was on the first floor and provided a home for up to 11 people living with dementia but we found the environment was not dementia friendly. There were two lounges, both of which had previously been bedrooms, and the size and shape of both rooms meant that the seating had to be placed around the edge of the room so neither lounge looked homely or welcoming. There was a cluster of seating arranged on the corridor for people to use. The dining area was two rooms with a connecting archway. The flooring, although practical, was very dark in colour. There was no use of colour for example to contrast between doorways to bedroom or bathrooms and although there were pictures on the walls these were placed at a height where people on the unit may not be able to look at them.

The operations manager acknowledged that the environment on the Ladybird suite was not conducive to the health and wellbeing of the people living there. They said this had been acknowledged by the registered provider and plans were being considered to make changes although they said it could be some time before this came to fruition. They said an audit of the environment had recently been completed by a dementia specialist but they had not yet received the report. We asked the operations manager and the manager to consider some low cost changes being made to the environment, in the interim, to make it more conducive to the people who were currently living there.

Good

Is the service caring?

Our findings

Our inspection in 23 November 2015 found the registered person was not meeting the regulations relating to person centred care and dignity and respect. On this visit we found improvements had been made.

Everyone we spoke with was positive about the staff and they were happy with the quality of the care they or their relative received. Comments from people who lived at Aden Lodge included "They (staff) treat me well" and "They are lovely and I get on with them alright." Relatives told us, "There is a good interaction and they treat (person) properly," and "Their attitude is brilliant. They are happy in their work and this reflects on the residents." People told us staff chatted to them and that they felt their opinions mattered. One person said, "They (staff) treat me properly and listen to me", and a relative said, "They listen to (person) and talk to them in the right way." Another relative commented, "They are sensitive to their needs and know how to talk to (person)".

The atmosphere in the home was warm, friendly and professional. We observed staff interactions with people were appropriate while remaining kind, friendly and inclusive. When staff entered communal areas they spoke to people, saying hello and asking how they were. We also observed staff lowered themselves down to ensure they were speaking to people at eye level. One staff member said, "I want to go home and feel I have done the best of my ability and made people happy and content." Another member of staff said, "We treat people as individuals." The manager told us, "I spent a lot of time with staff, promoting and reminding them about dignity and respect. Making sure staff don't talk over people and include them in their conversations."

Staff clearly knew people well. When we spoke to staff they spoke about people with respect and a good knowledge of people's likes and preferences. This showed people received care and support from people who knew them well. People were appropriately dressed and looked clean and well cared for. One of the staff we spoke with said, "We make sure glasses are clean, hair is brushed. Its common sense." This indicated staff had taken the time to support people with their personal care in a way which would promote their dignity.

People and relatives told us staff supported people to make choices and decisions regarding their daily routine, for example when they got up, went to bed or the clothes they wore. One person told us, "I can choose things like when I get up." We heard staff asking people where they wanted to sit and what they would like to eat and drink. At lunchtime staff asked people if they would like an apron and asked if they wanted any more to eat before removing their plate. Staff told us about one person who sometimes chose to stay up late at night but may then remain in bed for a significant part of the following day.

We asked staff how they encouraged people to retain their levels of independence. One staff member talked to us about a person who could mobilise short distances around the home. They explained how a member of staff would walk behind the person with a wheelchair so that if they became fatigued, they could sit down and ride the rest of the way to their destination. They also spoke about encouraging people to wash and dry themselves wherever possible. One of the care plans we reviewed noted, '(Person) is able to wash their face

with a flannel once they have been given it by the care staff'. Enabling people to be as independent as possible can promote a feeling of wellbeing.

Staff respected people's right to privacy and took steps ensure care was provided in a dignified manner. Staff told us and we observed them to knock on people's bedroom doors before entering and ensure people's dignity was not compromised when they were being hoisted. Staff on the Ladybird suite told us they ensured people doors were closed prior to the commencement of any personal care. They explained this was because a number of people walked around on the corridors and the doors were closed to ensure they could not see other people's care intervention.
We found communal bathrooms and toilets had locks which enabled people to lock the door without the assistance of staff.

Requires Improvement

Is the service responsive?

Our findings

Our inspection in 23 November 2015 found the registered person was not meeting the regulations relating to person centred care. On this visit we checked and found improvements in the provision of activities for people but we still identified a number of concerns relating to people's care records.

Most of the people we spoke with were positive about the planned activities at the home. One person told us, "The activities are brilliant now, there is something to do every day, gardening, baking. " Another person said, "A lady comes to do activities, we do all kinds of things." A relative said their family member was reluctant to participate, saying, "It is difficult to involve (person) but (name of activity co-ordinator) comes and sings with (name of person). Another relative said, "They have appropriate music on not just the radio and the floors are much calmer now."

We spoke with the activity coordinator who told us they worked eight hours a day between Monday and Friday. They explained they attended the staff handover so they knew about people's needs and well-being and they also used this opportunity to pass information on to staff regarding activities for the weekend. They said they aimed to actively involve everyone but said some people chose not to participate. They said activities could be either one to one or group sessions, and included chatting, singing, manicures, crosswords, skittles, memory word games, crafts, baking, gardening and group discussions. They also told us external organisations provided entertainment, such as choirs, singers and they had recently had a pantomime group perform at the home.

People who lived at Aden Lodge did not all feel they were involved in their care plan. One person said, "I haven't got a care plan and have never discussed my care", while some but not all of the relatives we spoke with said they did feel involved. One relative said, "The care plan is in place and we have contingencies covered", and another relative said, "When the care changes they discuss it."

People's care records were person centred and included information regarding their abilities, likes and dislikes. However, we found a number of concerns relating to people's care records. For example, we reviewed the care records for one person who had been living at Aden Lodge for approximately eight weeks. We found there were no care plans in place for any aspect of their care or support. We also saw a body map, dated 14 December 2016, which recorded the person had a wound on their sacral area. There was no record to evidence the wound had been re-assessed to see if there had been any improvement or deterioration nor was there any information as to the action staff should take to promote healing and prevent the wound from worsening. There was also an entry dated 9 December 2016 which detailed the person had been seen by the GP. The records noted staff were to refer the person to a specific external health care professional for further advice but there was no record this had been actioned. We discussed our findings with the deputy manager. They told us the person had an infection and was on antibiotics, therefore the referral was to be made once the antibiotic course had been completed but this information had not been recorded. When we visited for the second day of our inspection we found care plans were in place but there was still no record the person's wound had been re-assessed although the deputy manager assured us staff had assessed it but had failed to record this.

We looked at another care plan which contained a care plan summary from an external healthcare professional, dated 3 November 2016. This identified the person as being at high risk of choking and detailed they required a soft diet and a specific amount of thickening agent was to be added to their drinks. The eating and drinking care plan for them, dated 10 October 2016, recorded the individual's swallowing problems and their need for a soft diet and a thickening agent but the care plan had not been updated to reflect the increase in the amount of thickening agent now required. Although when we asked a member of care staff how much thickening agent the person needed, they told us the correct amount. We informed the manager and deputy manager of our findings on the day of the inspection.

During our inspection we detected an unpleasant odour in regard to one person. Staff told us the person often refused personal care interventions and had the capacity to make this choice. Their daily records made reference to them declining assistance with personal care and to care staff making repeated offers to support them as well entries where the person had agreed to staff assisting them with a shower, including the day prior to our visit. The care plan noted the person was unable to attend to all their own personal hygiene needs and needed staff support but it failed to detail the level of intervention the person needed or the behaviour management plan staff were to follow in the event the person refused care. This is important as it ensures people receive appropriate and consistent care that meets their individual needs.

These examples demonstrate a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived at the home and the relatives we spoke with said that they did not know what the complaints procedure was but felt this not an issue as they had no complaints to raise. One person said, "I have no complaints so I don't know the process." A relative told us they had recently raised an issue and got a positive response saying, "The matter was dealt with straight away." Complaints were recorded, by month and we saw details of two complaints which had been raised during March and April 2016. We saw a copy of an outcome letter for one of the complaints but there was no outcome letter for the other recorded complaint. There were however, details of telephone discussions between the manager and the complainant which evidenced the action taken to address the issues raised. There was no evidence that minor issues were recorded, for example, there was no record of the issue the relative told us about. Logging minor concerns can be helpful in identifying possible themes and therefore enabling early intervention to address the issues.

Requires Improvement

Is the service well-led?

Our findings

Our inspection in 23 November 2015 found the registered person was not meeting the regulations relating to good governance. The purpose of this inspection was to see if improvements had been made and to review the quality of the service currently being provided for people.

Not all of the people we spoke with told us they knew who the manager was. One person said, "I don't speak to the manager. I don't know who (manager) is." However, another person said, "I know the (manager) I think is in charge, (manager)'s very nice." Relatives did know who the manager was and generally felt they were doing a good job in addressing the required improvements. One relative said "It's well managed now there is a marked difference since the last CQC report." Feedback from staff was also positive; one staff member said, "(Name of manager) is a good manager, they know what they are doing."

The manager had been in post since June 2016. They told us they wanted a happy staff team and they said they had worked hard at building relationships with people who lived at the home, relatives, staff and other healthcare professionals. They added, "I want the home to run the same whether I am here or not." Throughout our inspection we observed the manager and the deputy manager to be visible in the home throughout the day, chatting with people, relatives and staff.

The manager told us they were supported by a senior management team and they had a weekly visit by the operations manager. They also said they submitted a report to senior managers on a weekly basis. This report summarised a number of key areas including falls, pressure sores, complaints and safeguarding matters. A matrix detailed the time frames in which a number of audits were to be completed, such as a monthly medicines audit and three monthly maintenance audits. We saw that since the arrival of the manager a variety of audits had been completed on a regular basis. We reviewed a selection of audits and saw that where issues were identified, these were either recorded as having been addressed or they were carried forward to the next audit. A review had been completed by a compliance manager employed by the registered provider in June, September and October 2016.The compliance manager was also present at the home on the first day of our inspection. Their report scored individual areas as red, amber or green and noted where areas requiring action had been addressed. An audit of the home had also been completed by an external company in June 2016.

A daily walkabout was completed by either the manager or the deputy manager on a daily basis, the findings of this were recorded on a report template and included observations of care and staff interactions with people. Staff also told us about daily 'flash' meetings involving representatives from different departments within the home, such as the manager, senior care assistant, and a member of the catering and ancillary team. The manager said these meetings lasted a few minutes but were an opportunity to ensure relevant information was shared amongst the staff team. We reviewed a random selection of meeting minutes and saw issues shared were in regard to staffing, people who lived at the home, maintenance and activities.

During this inspection we found a number of improvements had been made since our last inspection

relating to dignity and respect, premises and equipment, person centred care and governance. However, as evidenced within this report there were still a number of areas where significant improvements were needed, for example, assessing risk, care planning documentation and records. Some of the examples detailed in our report put people at risk of serious injury. Improvements were also needed to the systems of governance as they had failed to identify the shortfalls detailed within this report. These findings demonstrate a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us there were regular staff meetings and we saw minutes of meetings were retained, the most recent being 27 October 20016. Agenda items included activities, cleaning, training and duty rotas. Relatives told us meetings were held for residents and relatives. A relative said, "We go to relative and resident meetings quarterly." No one could recall having been involved in a survey or feedback questionnaire, but relatives felt that they could talk to the staff if they needed to raise any issues. One relative said, "I am actively involved and can influence things." We saw relatives' meeting minutes, dated 23 September 2016 were on display in the reception area.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents. During our inspection we identified one incident which the registered provider had failed to notify us about but we were satisfied that this was an oversight as other notifications regarding the home had been routinely submitted in a timely manner.

There is a requirement for the registered provider to display ratings of their most recent inspection and we saw the inspection ratings poster was on display in the reception area and also on the registered provider's website.

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 12 HSCA RA Regulations 2014 Safe care and treatment 12.(1) (2) (a)(b) Care and treatment was not always provided in a safe way for service users. Risks to the to the health and safety of service users were not robustly assessed.