Aberdeen House Care Limited

# Aberdeen House

## Inspection report

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## Ratings

| Overall rating for this service | Requires Improvement |
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| Is the service safe? | **Requires Improvement** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
Aberdeen House is a residential care home providing personal and nursing care to 12 people aged over 65 at the time of the inspection. The service can support up to 18 people.

Aberdeen House accommodates people in one building. People have access to a communal lounge, conservatory and garden space. There is not a separate dining room, but people are able to use tables in a visitor's room or the conservatory if they wish to.

People's experience of using this service and what we found
Staff were not always following government guidance and the service's procedures and policies around safely using personal protective equipment (PPE) upon entering and exiting the building. The service failed to ensure cleaning schedules of shared moving and handling equipment, and high touch point areas were in place and cleaned regularly. This meant there was a risk people and staff could be exposed to and transmit COVID-19.

People did not always receive their prescribed medicines safely and processes around the safe storage and administration of medicines were not always followed.

People's care needs and risks were assessed, but staff did not always follow care plans to keep people safe.

Relatives told us they felt their family members were safe and cared for. However, while quality assurance audits and governance measures were in place, they were not sufficiently robust at identifying safety concerns that needed to be addressed. This meant opportunities to improve the service and the quality of care people received were sometimes missed.

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

Rating at last inspection (and update)
The last rating for this service was requires improvement (published June 2019) and the provider was in breach of regulation 18: Staffing and regulation 17: Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the last inspection, the provider was asked to complete an action plan to CQC telling us what they would do and by when to improve. However, they did not submit an action plan to CQC.

At this inspection we found the provider was no longer in breach of regulation 18 but still in breach of regulation 17 as not enough improvement has been made.

We found at this inspection the provider was in breach of regulation 12: Safe care and treatment of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and regulation 15: Premises and equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Why we inspected
We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to the coronavirus pandemic and other infection outbreaks effectively.

We had received concerns in relation to staff not using PPE safely in line with government guidance. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

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| **Is the service safe?**<br>The service was not always safe. | **Requires Improvement** |
| **Is the service well-led?**<br>The service was not well-led. | **Inadequate** |

# Aberdeen House

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak.

Inspection team
One inspector visited the service and completed a site visit. An assistant inspector completed telephone calls to staff. An Expert by Experience also supported with telephone calls to relatives of people using the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider

sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.
We used all of this information to plan our inspection.

During the inspection
We spoke with six members of staff including the nominated individual registered manager, senior care workers, care workers and the housekeeper.
The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included three people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found and asked for relevant supporting information such as safeguarding policies, COVID-19 policies and universal infection control policies. We looked at three staff files in relation to recruitment and staff supervision.
We spoke with six members of staff including senior care workers, night care workers, care workers, laundry workers and the cook. We also spoke with eight relatives of people living at the service.

Requires Improvement

# Is the service safe?

## Our findings

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

At the last focused inspection this key question was rated as requires improvement. At this focused inspection this key question has remained the same.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

● Staff failed to wear personal protective equipment (PPE) properly. Staff did not follow government guidance and were inconsistent with putting on and taking off PPE. Some staff told us they walked through the service without wearing a face mask to access PPE in a communal lounge area where people sat. Others told us they put face masks in their car overnight which they would then use to enter the service at the start of their next shift. This meant people may have been placed at unnecessary and avoidable risk of contracting and transmitting COVID-19.

● Cleaning schedules for high touch points, such as light switches, door handles, and handrails were not in place. Staff told us cleaning of high touch areas were completed regularly through the day, but no cleaning records were available to evidence when this happened. In addition, no COVID-19 specific cleaning schedules were in place. This meant extra cleaning may not have been considered and completed to minimise the risk of COVID-19 and other viruses being transmitted and contracted. The registered manager told us they had considered implementing additional cleaning schedules, but it had been done.

● Contingency plans to cover staff shortages were not sufficient. Staff told us the service "can be short sometimes" and when this occurs "they pull the cleaning staff into the care work, and cleaning is completed by night staff." The registered manager acknowledged there had been some staffing difficulties and agency staff had been introduced to cover shifts. Assurances were not provided however to indicate cleaning tasks were always prioritised when staffing numbers were lower than expected which increased the risks of COVID-19 and other viruses being transmitted and contracted.

● Staff were not adequately trained in COVID-19 and infection and control practices. We found eight out of 17 staff had not completed hand hygiene training, six had not completed donning and doffing (the putting on and taking off of PPE) training, eight staff had not completed COVID-19 training, and nine had not completed training on how to use a pulse oximeter (equipment used to measure blood oxygen levels). The registered manager advised this training was not mandatory and part of Ecert and distance learning staff could complete in their own time. This meant staff did not have the appropriate skills and knowledge to safely care for people during the global COVID-19 pandemic.

● Staff did not follow COVID-19 risk assessments. People and staff did not have their temperatures taken daily as stipulated in the COVID-19 risk assessments. This meant early signs of COVID-19 symptoms may have been missed.

Using medicines safely

● People did not always receive their prescribed medicines safely. Supporting documents were not in place

to guide staff as to where medicated ointments and transdermal patches (which deliver drugs through the skin) needed to be applied to the body. This may have impacted upon how well some medicines worked which may have led to adverse effects for people. We also found when reviewing the medication administration records (MAR) there were instances where people had not received their medicines. The reasons why people had missed their medicine was not recorded and staff were not able to provide assurances people had received their prescribed medicines safely. Missing medicines may have impacted upon people's wellbeing.

● Medicine audits were completed but did not identify that surplus medicines were not always stored safely whilst awaiting disposal. Some surplus medicines were stored in an unlocked room, which people could have accessed. This may have placed people at unnecessary risk of harm.

● Processes did not always identify when MAR's were not completed. Some controlled drugs (CD) required two staff to monitor and administer the medicine. The records for CD medicines were not completed for one day for one person. This error had not been identified by the service.

The provider failed to ensure people received care in accordance with government guidelines, risk assessments and received their medicines in a safe and appropriate manner.
This was in breach of Regulation 12(1): Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● People's needs were recorded in care plans and risk assessments. Staff knew what people's needs were and where to find information about people's needs.

● Daily care record logs were kept but information recorded was task orientated rather than being about the person. Information was verbally handed over to seniors between shifts updating them on people's current needs.

● A staff locker room located near to a communal lounge was not locked which could be accessed by people. The room contained lockers, a box of surplus medicines and electrical boxes labelled 'high voltage' which could have posed a safety risk to people living at the service with dementia.

● Some areas of the service required maintenance. A bedroom had a damaged ceiling which led to the person occupying the room being moved to another for their safety. The registered manager explained the damage occurred in March 2020 but had not been repaired as it had been difficult to get contractors in through the pandemic. A relative described the service as being "not a pretty place, old fashioned".

● Some equipment was broken and had not been fixed. A standing aid had been broken for several months but had not been repaired. The stair lift was working but not in use as a rail had not been adjusted for several months. A thermometer used to take the temperatures of people using the service and staff was also broken. The registered manager had not identified this was broken but did replace it after it was highlighted at the inspection.

● Cleaning schedules for shared moving and handling equipment, such as hoists were not in place. Staff were not able to tell us how often hoists and standing equipment were cleaned. This meant staff were not following the service's COVID-19 policies around regularly cleaning equipment between use to minimise the risk of COVID-19 and other viruses being transmitted and contracted.

The provider failed to have safe systems in place to protect people from the risk of infection including COVID-19 and that equipment used to deliver care and treatment was clean, and suitable for the intended purposes. This was in breach of Regulation 15: Premises and equipment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People were safeguarded from the risk of abuse. Safeguarding polices were in place and staff told us they would raise concerns with the senior or registered manager.
● Relatives told us they felt their family members were cared for. Staff were observed interacting warmly with people at the service. One relative told us "I feel [person] is safe and not at risk." Another said "[person] is safe, [person] is very happy there."
● Staff felt confident to whistle blow and raise any safeguarding concerns outside of the company if required. A whistle blowing policy was in place and was updated after the inspection by the provider to include information that would assist staff to whistle blow. This made the policy more robust.

Staffing and recruitment
At our last inspection we found staffing levels were not adequate to provide safe care and treatment and the provider was in breach of regulation 18 (1) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Improvements and changes to staffing levels at night had been made at this inspection and the provider was no longer in breach of this regulation, however further work was needed to ensure staffing levels were consistently maintained.

● Waking staff members were in place at night. Changes to staffing had occurred since the last inspection and two waking staff members were available to support residents at night. This meant people's needs could be responded to quickly.
● Staff were recruited safely. Staff records were reviewed and indicated staff had been recruited following safe recruitment processes.
● Staff had access to training, but the registered manager told us not all training was mandatory. This meant staff had varying levels of knowledge around the needs of people living at the service. For example, the serviced employed 17 staff and records showed only ten had received dementia care training. Dementia care training was not mandatory, but there were people were living with dementia at the service. This meant not all staff had sufficient training to provide safe care and treatment to people living with dementia.
● We also found evidence of poor practice in relation to infection prevention and control which could be attributed to staff not having had adequate training and support to ensure they follow government guidance. The provider failed to ensure all staff had undertaken all training relevant to their roles to ensure people's needs were safely met.

Learning lessons when things go wrong
● Analysis of incidents after they occurred were not always robust. This meant the opportunity to truly learn from incidents and prevent things from occurring again were not always fully taken.

Inadequate

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to ensure systems and processes were in place to effectively assess, manage and communicate risk, as well as implementing processes to affect positive change. This was a breach of regulation 17: Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There had not been enough improvement made at this inspection the provider continued to be in breach of this regulation.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; and how the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The service had been in breach of regulations at the previous inspection and was required to submit an action plan advising how they would make improvements. The action plan did not address fully all of the concerns raised at the previous inspection, and we continued to find areas of concern in relation to governance of the service at this inspection.
- Quality assurance processes and systems were in place but did not robustly identify areas of practice that needed to be addressed. For example, systems and processes did not identify staff were not consistently following PPE procedures. Medicines were not safely stored, and not always safely administered. Equipment was not always maintained, and people's care plans and risk assessments were not always followed. This meant opportunities to improve the service and implement positive change were missed.
- The provider did not always have oversight of the service. Concerns had been raised at the last inspection around availability of the management team as the registered manager and deputy manager both left the service at 2pm. A senior care worker was on shift in the absence of the management team, but communication concerns were raised by partnership agencies. The registered manager did change the shift pattern a week prior to inspection, so a manager was in the service after 2pm, but it only occurred after it was highlighted again as an issue by CQC and partnership agencies.
- The local authority complained communication with the service after 2pm was problematic and had been a barrier to supporting the service and assisting to improve the quality of care people received.
- Staff felt supported by the management team. Staff told us the registered manager was supportive and approachable. A staff member said, "I can go to them and speak to them about anything at all."
- Relatives told us they were informed if their family member had a fall or injury. Incidents and falls were recorded and audited, but it was not always clear whether steps to reduce risk were taken and put in place by the service.

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

● Falls and serious incidents were not always reported to the local authority in line with their thresholds. At the last inspection how the service monitored and reported falls had been raised as requiring improvements. At this inspection the service had not always reported falls to the local authority or sought support from the falls prevention teams. For example, one person had experienced seven falls which were reportable, but the local authority had only been informed of two. This meant falls prevention support was not sought early and the person continued to experience falls which may have been avoided.

● Incidents and falls were recorded and audited, but there was little to no analysis of incidents. Analysis that had been completed was not always robust at identifying themes and trends. This meant preventative steps which could have mitigated the risks of further incidents, accidents and falls were not put in place, and some people continued to experience falls. Opportunities to improve care and reduce the risk of avoidable harm were missed.

● Audits and quality assurance were completed but it was unclear what actions had been taken to make improvements to the service.

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

● Relatives were not always kept updated. Some relatives told us communication was positive, others told us they had to contact the service for information as it was not always forthcoming. Some relatives told us problems stemmed from the service having only one phone line and poor connectivity to the internet around the service. This impacted on how and when relatives could speak to their family members.

● Staff told us they received supervision on a regular basis. Team meetings had been replaced by monthly newsletters and staff achievements were acknowledged.

● Staff told us they felt included and valued and involved in shaping the service. One staff member told us "People are open to change, and we can express our views." Staff commented the registered manager listened to their ideas on how to improve the service, but they were unable to give any examples of how their ideas had made positive changes to the service.

● The service had links with the local community. Local school children sang carols outside the windows for people living in the service to hear at Christmas time. A staff member described some people living with dementia as "coming alive" when the children began singing.

Continuous learning and improving care

● Quality assurance processes were not robust in identifying when improvement needed to occur. The registered manager was responsive to implementing change when it was brought to their attention. However, they were unable to consistently identify areas that required improving independently. This meant opportunities to learn and improve the service were not always identified.

● Accident and incident audits were completed but did not evidence any detailed analysis had taken place or any action plans implemented to minimise the likelihood of similar incidents occurring again.

Working in partnership with others

● The provider worked variably with partnership agencies. The local authority felt communication with the service was poor, which impacted upon how they worked together to improve the quality of care people received.

● The service had a positive working relationship with the local GP surgery. The GP held weekly telephone consultations to discuss people's health needs and was also available as required.