Aden House Limited

Aden Court Care Home

Inspection report

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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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection of Aden Court took place on 3 and 4 October 2017 and was unannounced. The home had previously been inspected during September 2016 and was found to require improvement in all five of our key questions at that time. The previous inspection found multiple breaches of regulations in relation to dignity and respect, safe care and treatment, good governance and staffing. During this inspection, we checked and found improvements had been made in all these areas.

Aden Court is registered to provide residential and nursing care for up to 40 people. The home has a reception area, a large dining room, a choice of lounge areas and an activities room. All bedrooms are ensuite. At the time of our inspection there were 37 people living at the home, with 14 people receiving nursing care and 23 people receiving residential care.

There was a registered manager in post and this was a different registered manager since the last inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe living at Aden Court. Appropriate safeguarding policies and procedures were in place, which staff understood, to protect people from abuse.

Risks to people had been assessed and a range of measures were in place to reduced identified risks.

Staff were recruited safely, with appropriate pre-employment checks taking place. Sufficient numbers of staff were deployed to keep people safe, however, some people felt improved quality of care could be provided if additional staff were deployed.

Regular safety checks took place such as those in relation to fire, gas and electrical systems. Plans and evacuation equipment were in place to safely evacuate people in the case of emergencies. Staff had been trained to use evacuation equipment effectively.

Actions had been taken to improve the management of medicines since the previous inspection. Medicines were managed and stored appropriately, although we did identify some missing information in relation to, 'as required' medicines on a small number of medication administration records.

People were supported to have choice and control of their lives and we observed staff supported people in the least restrictive way possible; the policies and systems in the home supported this.

Staff had received training in relation to the Mental Capacity Act 2005 and demonstrated a good understanding of the requirements of the Act. Decision specific mental capacity assessments had been

completed for people who lacked capacity to make specific decisions, as required by the Mental Capacity Act 2005.

Care and support staff told us they felt supported. Staff received regular supervision, although this was sometimes to address specific issues, as opposed to a supportive two-way discussion.

Our observations indicated staff treated people with kindness and compassion. People told us staff were caring and we observed people's privacy and dignity being respected. There was a pleasant atmosphere in the home. People's cultural and religious needs were considered.

End of life care plans had been developed where appropriate and, where people did not wish to discuss this aspect of care, this was recorded and respected.

Care records were person centred and reviewed regularly. A 'resident of the day' system was being introduced, which was not yet fully embedded, to help ensure people were regularly involved in reviewing their care and support. People told us they could make their own choices in relation to their daily lives.

Staff told us they felt supported by the registered manager and people and their relatives spoke positively about the registered manager. Regular audits and quality assurance checks took place. It was evident the home was continuing to improve since the last inspection and the registered manager acknowledged this was ongoing.

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.

People told us they felt safe.

Staff did not always follow people's care plans to ensure people were moved safely.

Staff were recruited safely and sufficient numbers of staff were deployed to keep people safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Most people felt staff had the necessary skills to support them.

The principles of the Mental Capacity Act 2005 were applied.

Staff had received induction and ongoing training and supervision, although supervision was sometimes to address specific issues rather than providing support. Clinical staff received specific relevant training.

People received support to access health care services and to meet their nutrition and hydration needs.

Is the service caring?

Good

The service was caring.

Positive interactions were observed between staff and people who lived at the home.

People told us, and we observed, privacy and dignity were respected.

End of life wishes were recorded and respected.

Is the service responsive?

Good

The service was responsive.

Care plans reflected people's choices and preferences and were regularly reviewed.

People and staff spoke highly of the activities coordinator and people were able to engage in activities, if they wished to do so.

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.

There was a registered manager in post. People and staff told us they had confidence in the registered manager.

Records relating to the care and support provided were not always accurate and complete.

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

Regular audits and quality checks took place which resulted in continued improvements in the home.

Aden Court 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 3 and 4 October 2017and was unannounced. The inspection was carried out by an adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home and we gathered information from the local authority, including the commissioning and safeguarding teams, and from 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 understand the experiences of people who lived in the home, including observations and speaking with people. We used the Short Observational Framework for Inspection (SOFI) to observe one of the communal lounge areas. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During our inspection we spoke with six people who lived at the home, five relatives, two visiting professionals, three care and support staff, the activities coordinator, a nurse and clinical lead, the quality support manager and the registered manager.

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 saw 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 Court and all of the relatives we spoke with confirmed this. One person told us they felt safe because, "The staff are all very nice." Another person told us the security of the building made them feel safe. We spoke with a visiting nurse who confirmed to us they had never seen anything that had concerned them at Aden Court.

The registered provider had an up to date safeguarding policy. All of the staff we spoke with, and the registered manager, were aware of safeguarding procedures and knew what constituted potential abuse. Staff were able to confidently tell us what actions they would take if they suspected anyone was being abused. The registered manager had made appropriate referrals to the local safeguarding authority and the Care Quality Commission. This showed staff would take appropriate action if they had concerns anyone was at risk of abuse or harm.

During our previous inspection of September 2016, we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because some risks to people were not assessed and managed effectively. We checked during this inspection and found improvements had been made.

A range of risks had been assessed and measures were in place to reduce risks, such as those in relation to malnutrition, mobility, falls and the environment and we saw these were reviewed regularly. The mobility and falls risk assessments we inspected were relevant and up to date and considered factors such as falls history, medication and sensory needs. In one of the care records we inspected, we saw risks had been assessed in relation to the use of bed rails for a person. This assessment identified bed rails were not suitable because there was a risk the person would try to climb over them. Therefore, other ways had been considered to help keep the person safe, such as use of a sensor mat, whilst consideration was given to measures which would be least restrictive for the person. This showed measures were in place to identify and reduce risks to people.

Some people were at risk of skin damage and required special mattresses to help maintain their skin integrity. We saw the required mattress settings were recorded in people's care records and daily checks took place to ensure mattresses were set correctly. We checked two people's mattress settings and found these correlated with the records. This further demonstrated measures were in place to reduce identified risks to individuals.

We observed staff assisting people to move, using equipment. Staff assisted people in a safe and confident manner. We did see staff assisting one person to move, without the use of equipment, and we felt this person's moving and handling needs would benefit from being re-assessed because, whilst the manoeuvre we observed was not unsafe, staff struggled to assist the person and needed to call a further member of staff to assist. Furthermore, the registered manager confirmed to us a recent allegation had been made that staff had hurt the person when they were being assisted to move. Staff and the registered manager told us the person's ability to weight bear varied daily and the person did not like the hoist being used. The registered

manager told us they were already considering reviewing this person's moving and handling needs prior to the inspection and they made a referral to a relevant professional during our inspection.

Moving and handling assessments contained information relating to the specific equipment staff should use to assist people to move. However, in relation to 'method of use,' one of the records we sampled stated, 'as per M&H [moving and handling] training.' This assessment of a person's moving and handling needs would be enhanced by including more detailed information relating to how staff should use equipment, such as information relating to the method of application. The registered manager was receptive to this and sought further advice and guidance during our inspection.

We observed one person who lived at the home assisted another person to move. Staff were aware this sometimes happened with specific individuals living at the home and measures were in place and documented in the care plans to reduce the associated risks. However, staff had not followed the plan on this occasion. We highlighted this to the registered manager and they took immediate action to address staff and remind them of their responsibilities.

Regular safety checks took place throughout the home. Records showed fire alarms, emergency lights and fire doors were checked regularly and actions were taken to rectify any identified faults. Water temperatures were regularly checked. A fire risk assessment was completed and up to date. This was due to be reviewed during the month of our inspection. Tests such as gas safety and portable appliance testing had been completed. Equipment such as lifting equipment and bed rails were regularly inspected to ensure their safety. Records showed equipment, for example, wheelchairs, were regularly maintained. This helped to ensure the safety of premises and equipment.

Personal Emergency Evacuation Plans (PEEPs) had been devised for each person living at Aden Court, including the person most recently admitted. 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, torch, first aid kit, foil blankets, emergency contact telephone numbers and PEEPs. Staff told us, and records showed, staff had been trained and shown how to use equipment such as an evacuation mat. This showed measures were in place to help keep people safe in the event of an emergency.

Staff were able to confidently tell us what actions they would take in an emergency, such as a fire or if they found a person had stopped breathing. This showed staff knew what to do in emergencies. Records showed accidents and incidents were logged and recorded. Appropriate actions were taken, such as applying first aid, additional observations or calling for emergency services when necessary. Analysis of accidents and incidents took place, for example the time of day when incidents occurred, which helped the registered manager to identify any trends and take action accordingly.

During our previous inspection of September 2016, we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people had been affected by a lack of care staff at Aden Court. We checked during this inspection and found improvements had been made.

People's dependency was regularly assessed and this helped to determine staffing levels. We asked to see rotas, in order to determine the numbers of staff deployed. Rotas showed the numbers of staff deployed were consistently below the number which had been identified as required. However, this was a recording issue and when we raised this with the registered manager, they were able to generate a payroll report which showed the numbers of staff deployed was in line with that which was required. However, this highlighted the system used within the home, for planning and recording staff levels was not accurate. By the end of our inspection, the registered manager had already begun to consider more effective ways of

planning and recording staff rotas, to ensure accurate records were kept.

Our observations on the days of our inspection were that people's needs were met by sufficient numbers of staff. We used the Short Observational Framework for Inspection (SOFI) to observe one of the communal lounge areas. This showed the people we observed, seated in the communal area, received many positive interactions from staff on duty.

Deployment of staff had improved since the last inspection. An allocation sheet had been introduced, which showed the duties staff had been allocated to. A nurse told us the introduction of this had resulted in improved communication between staff.

There were mixed views from people and their relatives regarding whether there were enough staff. We were told staff were, 'very busy' and one relative felt staff sometimes did not have time to talk to people. More than half of the people we spoke with told us they felt they did not have to wait long in response to call bells, although one person told this could vary between one minute and half an hour.

All of the staff we asked told us they felt there were sufficient numbers of staff to keep people safe. One member of staff said, "There are enough of us to talk to people as well, yes." Another staff member said, "When we're fully staffed there's enough. It's hard if people phone in sick. But I have to say, they're good at covering the rota. They always try to get sickness covered. We're always told not to rush [when assisting people.]"

We inspected four staff recruitment files. We found safe recruitment practices had been followed. For example, reference checks had been completed, identification 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.

During our previous inspection in September 2016, we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because protocols were not always in place for 'as required' medicines, topical creams were not recorded by care staff and medicines were not always stored at recommended temperatures. We checked during this inspection and found improvements had been made.

Medicines were administered in a kindly manner and in a person centred way. The staff member administering medicines sought consent from people and helped people, at their own pace, to take their medicines. Where people refused, this was respected and appropriate action was taken. Appropriate infection prevention and control practices were followed, such as placing tablets into individual pots, without touching. The member of staff administering medicines ensured people had swallowed their medicines before recording them as being administered. Medication Administration Records (MARs) contained photographs of each person. This helped to reduce the risk of medicines being administered to the wrong person.

Medicines were locked securely in a room specifically for this purpose and temperature checks were made twice daily. The clinical lead was responsible for the oversight of medicines management. Medicines were administered by either a nurse or a senior carer who had received specific training to administer medicines safely.

One person was administered their medicines crushed, in a covert manner. Appropriate safeguards were in place and relevant advice had been sought from the prescriber and pharmacist, in line with the National

Institute for Health and Care Excellence (NICE) guidelines to ensure the medicine was safe to administer in this way.

We checked the controlled drugs, which are prescription medicines controlled under Misuse of Drugs legislation. These were stored securely and logged in a 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. We found the application of creams were appropriately recorded and body maps were used. Body maps help to ensure staff know exactly where to apply the cream. We noted some records indicated creams should be applied, 'When required.' We raised this with the clinical lead because this meant staff responsible for applying the cream may not know when or how much to apply. However, the clinical lead was already aware of this and had contacted the local GP practice in order to request more detailed prescribing instructions.

Some people were prescribed PRN, or 'as required' medicines. We found PRN protocols were in place, including for people who used an inhaler. PRN protocols help to ensure these medicines are administered appropriately and at safe intervals. Although PRN medicines were recorded when administered, where some medicines were prescribed in variable doses, such as, 'two to four 5ml spoonfuls every four to six hours,' the amount administered was not always recorded on the MAR. We highlighted this to the registered manager and they took immediate action to address this. Pictorial notices were then displayed in the clinical room as a prompt for staff to ensure they recorded this correctly.

Some people were prescribed a specific medicine which required their pulse to be checked prior to administration. The records we inspected showed their pulse had been checked each time prior to administration. This meant the guidelines were being followed and risks to the person were reduced as a result.

All of the people and relatives we spoke with told us the home was clean. We observed staff using personal protective equipment appropriately in order to reduce risks associated with infection. The home looked and smelled clean and fresh.

Requires Improvement

Is the service effective?

Our findings

All of the relatives we spoke with and most of the people we spoke with told us they felt staff had the skills and knowledge to perform their duties effectively. One person we spoke with told us new staff were supported in their role and other staff were, "Always on hand to advise and help them."

However, one person felt care and support staff lacked some skills and they provided specific examples of when they felt staff could have provided more effective care or used their initiative. We shared this feedback with the registered manager who confirmed staff continued to receive training in delivering person centred care and we saw this was ongoing.

In relation to the food at Aden Court, comments included, "It is home baked stuff," and, "The food here is very good," and, "The food is excellent. You're well looked after."

Staff told us, and records showed, staff received an induction into their role, which included shadowing more experienced colleagues. Records also showed agency nurses received an induction, which included information regarding the registered provider's policies and procedures and confirmed the agency staff member had completed training in moving and handling, safeguarding and infection prevention and control.

Staff had received training in areas such as safeguarding, fire safety, infection prevention and control, moving and handling, dementia awareness and medicines management where appropriate. Staff told us they felt they had good access to training. A member of care and support staff told us, "I've just done NVQ3 (National Vocational Qualification). They [the registered provider] supported me through that." A registered nurse told us they kept their clinical skills and training up to date. A nurse told us, "We did tissue viability training, specifically aimed at clinical staff, the other day. It focussed on the clinical aspect and was really good." The nurse also told us they had been provided with training in other areas of clinical practice such as syringe drivers. A syringe driver is a small portable machine that is able to provide medicines constantly via a small needle under the skin.

One person we spoke with told us when they were first admitted to the home, they had specific needs in relation to their care. They told us staff had received specific additional training in order to provide the care this person needed. We saw staff training certificates which confirmed this.

Staff confirmed to us training was a mixture of practical and on line training (done on a computer). One member of staff told us, "I didn't do any moving and handling until I'd done all my training and, even then, they watched me do it to make sure I knew what I was doing." This showed staff received the training they required.

Records showed staff received regular supervision and annual appraisal and all of the staff we asked told us they felt supported. Some supervision records we inspected indicated this was a two way discussion with the opportunity for staff to discuss any concerns and whether they felt supported. However, some of the

supervision records for care and support staff lacked this element and one to one supervision was often to address specific issues or shortfalls in practice. A member of care and support staff also confirmed this. We highlighted this to the registered manager, who acknowledged this was the case and advised the more supportive format would be put in place for all staff.

Following our inspection, the registered provider forwarded evidence to show a further record of supervision which acknowledged a staff member for providing good care and a record which showed positive feedback had been given to a staff member, following a night visit. The registered provider advised us that behaviours and team dynamics were well established since the last inspection and the registered manager had moved into a professional development supportive approach.

Some staff were dedicated dementia friends and there was a dementia champion. A Dementia Friends Champion is someone who encourages others to make a positive difference to people living with dementia.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. All of the staff we spoke with showed an understanding of the MCA and the registered manager was clear about the requirements of the MCA and DoLS. Where people had been assessed as lacking capacity to consent to living at Aden Court and where they were being deprived of their liberty, DoLS applications had been made to the appropriate authority.

Where people lacked capacity to make specific decisions, we saw decision specific mental capacity assessments had been completed. One mental capacity assessment we inspected identified a person lacked capacity to consent to bed rails. Therefore, the least restrictive options had been considered and a decision had been made in the person's best interests, in consultation with relevant people. We identified one person was given their medicines in a covert manner, that is, without their knowledge. Their mental capacity to consent to this specific issue had been assessed and the decision had been made in the person's best interests in consultation with relevant people. This showed the principles of the MCA were being followed.

Throughout our inspection we observed staff obtaining consent from people. A member of staff we spoke with told us, "I always ask for consent. I know that's really important. It's important to keep people's independence as much as possible." All of the people and relatives we spoke with told us staff always asked for their consent before providing care and treatment. People told us staff explained what they were doing and gave people enough time to digest information. This showed staff sought consent prior to providing care or treatment.

However, on one occasion, staff approached a person to assist them to move with the use of moving equipment. We saw the staff member began to apply the moving equipment whilst the person's eyes were closed and they appeared to be not fully awake. The person did arouse and was moved safely. However, we

shared with the registered manager we felt staff needed reminding of the importance of ensuring people were fully engaged and consenting to assistance.

Care files contained formal, signed consent forms. The registered manager showed they understood that only those people with appropriate powers could consent on behalf of others and work was ongoing to ensure all consent forms were appropriately completed.

We looked at how people's nutrition and hydration needs were met at Aden Court. All of the people and relatives we spoke with told us the food at Aden Court was very good. People confirmed they had a choice of meals and their individual choices and preferences were catered for.

Nutrition and hydration plans contained a 'Resident dietary profile' which outlined the person's needs such as whether they were diabetic, the required texture of their food and any allergies. We noted an initial choking risk screening tool was completed in order to identify people at risk of choking and we saw referrals had been made to speech and language therapists. The head cook had been involved in developing these profiles and had a good understanding of people's needs.

Some people were at risk of malnutrition or dehydration. We saw food and fluid charts recorded people's intake and all of the records we reviewed were up to date. Regular analysis took place to ensure any concerns were acted upon.

We saw jugs of juice or water in people's own rooms and drinks and snacks were readily available in communal areas throughout our inspection. People told us they had snacks at set times, in between meals, but they could access further snacks whenever they wanted.

There was a head cook who was passionate and very knowledgeable about people's preferences and individual dietary needs. They were able to describe how they fortified some people's diets to ensure extra calories were consumed. Records showed the head cook regularly engaged with people and asked people about their choices and preferences.

We observed a meal time experience and this was a pleasant, social occasion. Staff provided appropriate assistance to people. Some people ate their meals in their own rooms. There was a system in place for ensuring everyone was served their meal. However, one person did tell us they sometimes had to wait up to 45 minutes for their dessert after lunch or dinner. The registered manager told us they were considering implementing a new system at mealtimes, because they had identified some people, particularly those who may require assistance, would benefit from this. However, the registered manager acknowledged people needed to be consulted about this prior to implementing any changes. Records showed this had been recently discussed during a heads of department meeting.

Following the inspection, the registered provider shared with us records which demonstrated 'food survey questionnaires' had been sent to people in January 2017 and nine of these had been completed and returned. Everyone who responded indicated they could choose what to eat from the menu and confirmed alternatives were offered if the food was not to their liking. Everyone who responded confirmed they 'always' spoke with the chef and eight of the nine people rated the food as, 'good,' or, 'excellent.'

Some environmental improvements were ongoing at the home. New flooring had recently been laid in the corridors and this had replaced some old patterned carpets which were in place at the last inspection. Corridors were light, bright and appeared clean. We noted people's names were displayed on their bedroom doors. However, the text was small and would be difficult to read for anyone with sight difficulties. We also

noted the environment would benefit from further signage to make navigating around the home easier, particularly for people living with dementia. The registered manager told us they had identified the home had a, "clinical feel" in some areas and this was an area which was being addressed. The quality support manager contacted us following the inspection and advised improved signage had already been ordered and was due to be erected following the inspection, once decoration and flooring had been completed.

We found people had access to additional health care professionals, such as GPs, district nurses and speech and language therapists. Records showed a person had been registered at a local GP surgery upon moving to Aden Court in order to have their health needs met. People told us staff acted promptly if they required access to healthcare professionals. This showed people received additional support to meet their health care needs.

Good

Is the service caring?

Our findings

Most of the people and all of the relatives we spoke with made positive comments about staff, describing them as friendly, approachable and caring. We were told people were treated with dignity and respect. Two people told us, "99% of the staff are good."

One person told us, "Staff treat everyone absolutely fantastically. Some people take a lot of looking after and I have not heard anything amiss. They are so patient and good." Another person said, "Staff are really, really lovely. Two of the young carers come and sit with me and chat. They are all chatty and friendly." A further person told us, "I cannot fault them [staff] and [name of manager.]"

A family member told us, "Staff are very good with my relative, very conscientious. I have never seen my relative unhappy since they have been here." This family member went on to say staff would come back in half an hour if their relative was not engaging with them.

We heard staff engage with people throughout our inspection. Staff showed they cared for people and pre-empted people's needs. For example, a member of staff was heard saying, "Can I put your slipper back on for you so your foot's not cold."

Staff offered to assist people to the dining area at lunch time. We noted staff identified a person may require assistance with their continence needs prior to eating their lunch, although the person had not requested this. The person was asked, very discreetly, whether they would like assistance with their continence needs prior to eating their lunch. Staff treated the person with dignity and respect.

The previous inspection during September 2016 found a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people's privacy was not always respected. We checked and found improvements during this inspection. People told us their privacy was respected. We observed staff knocked and waited before entering people's rooms and the people we spoke with confirmed this. We asked staff how they ensured people's privacy and dignity were respected. One member of staff told us, when they were assisting a person with personal care, "I always keep doors closed and close curtains." This member of staff told us they used a towel to ensure the person was covered as much as possible. The people and relatives we spoke with confirmed privacy was respected and one person told us, "People come and knock on the door until I call them in."

We observed staff approach and saw body language was appropriate and staff spoke with people in respectful, caring tones. People appeared comfortable in the presence of staff and, throughout our inspection, we heard chatter and laughter.

The registered manager told us people's diverse needs were discussed upon admission to the home and we saw evidence of this. Consideration was given to people's religious needs and religious leaders had provided services where this was people's wish. A member of staff told us, "You can find out about people's culture from their care records but I like to talk to people. I'm very open about learning. I like to learn about different

people."

People told us they were encouraged to retain their independence. A relative told us staff had encouraged their family member to walk before the person lost their mobility. At mealtimes we observed people were encouraged by staff to be as independent as possible. For example, people who required assistance to eat their meals were stimulated to do this for themselves. Adapted equipment was used which enabled people to eat more independently.

Some care plans we sampled included comments such as, 'Staff to show [Name] how to wash [their] body, including hands and face, which empowers [Name] to conduct personal care [themselves].' This showed independence was considered during the care planning process.

Details for an advocacy service were displayed in a communal area. An advocate is a person who is able to speak on another person's behalf when they may not be able to do so, or may need assistance in doing so, for themselves. Although at the time of this inspection, no-one was receiving support from an advocate, the registered manager was clear about when it may be appropriate to arrange for an advocate.

We saw end of life care plans were in place and these were relevant and up to date. This helped to ensure people's wishes could be respected at the end of their lives. Furthermore, where a person had indicated they did not wish to discuss this aspect of their care, this was respected and recorded in their care record.

Good

Is the service responsive?

Our findings

Most people and relatives told us staff understood people's needs and were responsive to them. One person, who chose to stay in their room, liked to sit and look out of their window. Items in their room had been arranged to suit the person to enable them to do this in their preferred way. One person told us, "Staff know how I like my pillows at night and know how to follow my routine."

Another person told us staff had been responsive to a concern they had in relation to the level of noise the buzzers [nurse call bells] were making. Actions were taken to resolve this, whilst ensuring staff could still hear the nurse call bells.

However, one relative told us they felt their family member's care plan was not reflective of their need and they felt some staff lacked knowledge about their relative. We shared this information with the registered manager who told us staff training was ongoing in relation to providing person centred care.

We looked at six care records. These were well organised, clear and easy to read and regularly reviewed. The care plans we inspected contained sufficient information to enable staff to provide appropriate care and support to people and plans were regularly evaluated. Care plans included a photograph of the person and contained information relating to each person's identified need and associated risks, expected outcomes, actions required to meet those outcomes and individual preferences and abilities. People's needs such as those in relation to the environment, personal hygiene, equality and diversity, nutrition and hydration, mobility, activities and mental health were considered.

The care records we inspected included information to enable staff to provide care and support specific to the person. For example, one of the care records we sampled indicated, 'Staff to be aware to offer only two choices at a time – if more, [Name] can become confused.' Information relating to individual preferences were included in care plans such as preferred time to rise and retire, preferences regarding privacy and night-time routine.

The staff we asked told us they read people's care plans and also made use of the 'twist and turn' boards in people's rooms. 'Twist and turn' boards contained a homely picture on one side, akin to the type you may find in a person's home, but on the other side there was information which staff could refer to in relation to the person's needs, choices and preferences. A person we spoke with also confirmed this was useful and staff could refer to the information on this board. This further provided a way for staff to provide care and support which was personalised to individuals.

Most of the records we inspected clearly showed the care and support people had been provided and highlighted where support had been offered but declined. These records were completed daily and included information such as personal care, food and fluid intake where this was appropriate, daily checks made and pressure relief care. In one record, however, we found information lacking in relation to the assistance a person had received to reposition regularly. We shared this with the registered manager, who agreed to address this with staff and advised some training was currently ongoing in relation to the importance of

recording information accurately.

People and relatives we spoke with told us they were aware of the activities at the home. Activities included bingo, dominoes, quizzes, reminiscence, singers and exercises. People told us they had enjoyed barge trips and outings to a brass band concert and opera. The activities coordinator spent time with people who preferred to stay in their own rooms, either playing cards, reading or chatting with people. The home had contacts with local churches who provided a regular church service and choirs had performed at the home.

We observed some armchair exercises taking place. People appeared to enjoy the session and we heard laughing and saw people joining in enthusiastically. A member of staff told us they felt the activities and occupation for people at Aden Court was, "Good."

The activities coordinator was very enthusiastic and keen to develop their role further. They were clear about their aim of stimulating and engaging people and involving people in the development of activities. The activities coordinator had begun to develop family trees which were pictorial, with the help of some relatives. Reminiscence boxes had been purchased which consisted of sounds and scents (for example, the smell of the sea) which helped to stimulate reminiscence. This showed the activities coordinator made use of resources to facilitate appropriate activities.

The activities coordinator kept comprehensive records which outlined the activities people had attended and people's individual responses to activities. This enabled activities to be planned according to people's preferences.

People were able to make their own choices in their daily lives. We observed people were given choices in relation to food and drink for example. The last inspection found people had allocated days when they bathed or showered. During this inspection, staff told us people could choose when to bathe or shower. All of the people we asked confirmed this.

People's rooms were personalised and we saw photographs and items of sentimental value. People could choose whether they wished to have their bedroom doors open or closed and locked or unlocked and the people we spoke with confirmed this. Their choices were recorded in care plans.

The complaints procedure was clearly displayed in the reception area. We looked at how the registered manager handled complaints. These were acknowledged, investigated and responded to. Appropriate referrals were made to safeguarding. Verbal complaints were also logged and recorded and responded to. A relative told us, "If we have any concerns they are sorted out and the staff are very friendly." Another relative told us if they had any problems or complaints, the registered manager always tried to find a solution. This showed the registered provider had systems in place for managing complaints and these were being managed effectively.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager in post, who had been registered with the Care Quality Commission (CQC) to manage the home since September 2017. They had not been in post during the last inspection.

The previous inspection ratings were displayed at the home. This showed the registered manager was meeting their requirement to display the most recent performance assessment of their regulated activities.

A local authority contract monitoring visit took place during our inspection. We received information which confirmed any previous defaults in relation to the local authority contract had been rectified.

All of the people and relatives we spoke with told us they felt the home was well-led. One person told us, "It runs beautifully." Another person told us they felt the home was well-led because, "It's not a mad rush. Staff seem to know their jobs and get on with it." A further person commented, "It's warm and friendly. The staff and management are people you can talk to."

People and relatives described the registered manager as, "Brilliant," and, "Lovely," and, "Committed." A relative we spoke with told us, "The manager is implementing a lot of changes, is well organised and has high standards which she transmits to staff. If she is not happy they know about it."

Many 'thank you' cards had been received and were displayed at the home. Feedback from one family member stated, 'I would like to thank you for your care, your kindness and understanding in looking after [Name]. I have nothing but admiration for the carers.'

A member of staff told us, "It's good team work here. We all help each other out." Another staff member said, "This is the first home where I've felt supported. I constantly ask questions and the management are really supportive. We're human. If we make mistakes we have to say. We have to be open." A further member of staff said, "It runs well here. It's organised. You know what you're doing but it's not set in stone."

The clinical lead and registered manager had worked together to implement improved systems at the home since the last inspection and this was evident during our inspection. The registered manager acknowledged there had been challenges to delivering the required improvements at Aden Court and this had taken time. They told us they hoped to create an open culture, where staff could be open and learn from mistakes. The registered manager told us they felt supported by the quality support manager and the quality director.

The staff we spoke with told us they felt there was an open culture at the home. One staff member said, "If I had a problem, I wouldn't be scared to say," and another told us, "If I made a mistake, I'd feel comfortable saying so, yes."

Regular meetings were held with different groups of staff, such as carers, kitchen staff and heads of departments. Records showed learning was shared during these meetings and different issues were addressed such as ensuring people's privacy and dignity was maintained. Meetings are an important part of

a registered manager's responsibility to ensure relevant information is disseminated to staff appropriately and to come to informed views about the service.

Records from a recent relatives' coffee morning showed relevant issues at the home were discussed and shared with relatives. A relatives' meeting had taken place during August 2017. Discussions took place regarding the most effective way to engage with relatives and, as a result, the registered manager was in the process of communicating using alternative methods, such as email. This showed the registered manager listened and acted upon feedback from relatives.

Records we inspected showed the most recent residents' meeting was held in March 2017 and, during this, items such as activities, housekeeping and meals were discussed. All of the people we spoke with, although were happy with how the home was run, did not feel involved in how the home was run. People and relatives told us feedback was on an, 'informal basis,' outside of residents' and relatives' meetings. This meant, although relatives' meeting were held regularly, people living at the home felt they had not been formally involved in the running of the home.

Following the inspection, the registered provider shared with us some minutes of a more recent residents' meeting dated 14 September 2017. This record showed six people attended the meeting and items were discussed such as suggested staggered mealtimes and activities. This showed, although some people told us they did not feel involved in the running of the home, a recent meeting had been held which showed some people had been involved in the running of the home. Further, the registered provider advised us that minutes of meetings were displayed in the foyer of the home for residents and relatives to see and, following our inspection, the registered manager had implemented a system for a copy of all minutes to be given to people living at Aden Court.

A 'Resident of the day' system had been introduced, whereby each day the head of department such as domestic, maintenance and clinical lead would review the person's needs, discuss with the person their preferences and ensure care plans were up to date and reflective of their need. The registered manager had contacted families and invited them to be involved where this was appropriate. This was a new initiative and work was ongoing to ensure this system was fully embedded. Following our inspection the registered provider advised us that the 'resident of the day' system was now fully embedded into the home.

During our previous inspection in September 2016, we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to good governance because some care plans had not been reviewed, the quality of daily records was poor and audits had not identified that accidents and incidents were not being followed up effectively. We checked during this inspection and found improvements had been made.

Records showed a range of quality audits took place, for example in relation to mattresses, bed rail safety, infection prevention and control and medicines management, in order to drive improvement and safety at the home. We noted where some actions had been identified, the audit records did not always indicate whether they had been actioned. For example, some audits identified missing signatures on medication administration records (MARs). The MARs we sampled did not have any missing signatures, which indicated this had been actioned. However, we queried how the registered manager could have effective oversight if these actions were not recorded once they had been identified. The registered manager agreed to consider this further with a view to implementing clearer auditing systems within the home. This showed, although improvements were evident in the quality of audits, ongoing improvements were required to ensure these were fully effective.

We discussed with the quality support manager the systems in place for auditing different aspects of the service. Monthly audit quality reports relating to people's dependency, weight, pressure ulcers, infections, 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. The quality support manager told us they also checked actions had been taken such as appropriate referrals being made to other health care professionals where appropriate and we saw these were recorded on the report.

The registered manager told us regular compliance visits from the registered provider took place. These visits resulted in action plans which were shared with the registered manager. There was a Home Improvement Plan and this was regularly updated. The registered provider sent us their Home Improvement Plan following our inspection and we could see some of the issues highlighted during our inspection were included and had been actioned immediately. Other areas had been identified by the registered provider and these were also being acted upon, in order to improve the quality of service provision. This showed the registered provider was taking proactive steps to improve the quality of care and service provision.

Although positive developments were evident since the last inspection, continued improvement was required to ensure the registered manager had sufficient oversight of the home, for example in relation to the areas we highlighted such as staff rotas, audits, moving and handling plans and medicines management.

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 happened in homes across the provider group or at other homes nationally, such as a fire for example. As a result, specific information had been shared in order to reduce risks of similar incidents occurring at Aden Court. This showed the registered provider was taking steps to improve the care and support provided and to reduce risks within the home.

We looked at the registered provider's policies and procedures, for example in relation to managing medicines, safeguarding and whistleblowing and saw these were relevant and up to date. It is important for registered providers to have up to date policies to ensure staff are following current guidelines. The registered provider had a business continuity plan in place. This helped to ensure procedures were in place in the event of specific events such as a bomb threat, fire, flood or gas leak.