## Aaroncare Limited

# Aaron Lodge Care Home 

## Inspection report

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## Ratings

## Overall rating for this service

## Is the service safe?

Is the service effective?
Is the service caring?
Is the service responsive?
Is the service well-led?

## Overall summary

Aaron Lodge Care Home provides accommodation and personal care for up to 48 people who are living with dementia. The home is owned by Aaroncare Limited.

There were 47 people living in the home at the time of our inspection.

This was an unannounced inspection which took place over two days on 19 \& 23 November 2015.

There was a registered manager in post. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found the service was not always safe. There were not enough staff on duty at all times to help ensure people were cared for in a safe manner.

The manager was able to evidence a series of quality assurance processes and audits carried out internally and externally to the home. We found the quality assurance system not currently developed to ensure the most effective monitoring.

## Summary of findings

## The concerns we identified are being followed up and we will report on any action when it is complete.

There was a risk medicines were not administered safely. Medication administration records were not always clear. Monthly medication audits had not identified these issues.

We made observations at meal times. We saw that people did not always receive support from staff. Meal times were disruptive and were not a positive experience for people.

We asked people if staff were polite, respectful and protected their privacy and dignity. We received mixed responses. Our observations of care evidenced that, at times, staff compromised the respect and dignity shown to people.

We found people and their relatives were not always involved in planning their care to help ensure it was more personalised and reflected their personal choices, preferences, likes and dislikes. We looked at the care record files for people who lived at the home. We found that care plans and records lacked detail and were not personalised to individual care needs.

## You can see what action we told the provider to take at the back of the full version of this report.

We toured the environment of the home. The designed and adaptation of the premises could be developed and improved for people living with dementia.

## We made a recommendation regarding this.

There were effective monitoring/checking systems in place to ensure the home's environment was maintained safely. We found there had been appropriate liaison with the local authority environmental health regarding a recent risk.

Staff understood what abuse meant and knew the correct procedure to follow if they thought someone was being abused.

Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

We looked at whether the home was working within the legal framework of the Mental Capacity Act (2005) [MCA]. This is legislation to protect and empower people who may not be able to make their own decisions. We found
examples of good practice in supporting people with decisions in their 'best interest'. The registered manager understood the need to extend the use of mental capacity assessments for key decisions for people. The manager said this would be developed with further staff training.

There was some information available in the home for people. This included information on advocacy services and the complaints process.

We found people were provided with social activities and were encouraged to participate in the daily life of the home. We thought this aspect of care could be developed to provide more positive experiences for people.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12

## Summary of findings

months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

## Is the service safe?

The service was not safe.
There were not enough staff on duty at all times to help ensure people were cared for in a safe manner.

There was a risk medicines were not administered safely. Medication administration records were not always clear. Medication audits had not identified these issues.

Arrangements were in place for checking the environment to ensure it was safe. We were shown a range of environmental checks carried out by the manager and maintenance person.

Staff understood what abuse meant and knew the correct procedure to follow if they thought someone was being abused.

Appropriate checks had been undertaken before new staff were recruited to ensure they were suitable to work with vulnerable adults.

## Is the service effective?

The service was not always effective.
We saw people's dietary needs were not managed effectively as people did not receive adequate support from staff at mealtimes.

The design and adaptation of the premises could be developed and improved for people living with dementia.

We found the home was consistent in supporting people to provide effective outcomes for their health and wellbeing.

We saw that the main principles of the Mental Capacity Act (2005) had been followed but there could be more consistent evidence of people's mental capacity being formally assessed with regard to key decisions.

Staff said they were supported through induction, appraisal and the home's training programme.

## Is the service caring?

The service was not always caring.
Some of the observations we made of the support offered by staff were not consistently positive and compromised the respect and dignity shown to people.

People and relatives we spoke with told us they were encouraged to give their views regarding the running of the home.

## Summary of findings

## Is the service responsive?

The service was not always responsive.
People's care was not planned so it was personalised and reflected their individual preferences and routines.

There were activities planned and agreed for people living in the home.
A process for managing complaints was in place and people we spoke with and relatives were confident they could approach staff and make a complaint if they needed.

## Is the service well-led?

The service was not well led.
The systems for auditing the quality of the service needed further development so there is more effective review of actions taken as well as identifying areas for improvement.

We found the registered manager to be open and caring and they spoke about people as individuals.

There was a system in place to get feedback from people so that the service could be developed with respect to their needs and wishes.

# Aaron 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 checked 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 was an unannounced inspection which took place on 19\&23 November 2015. 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 for the inspection at the Aaron Lodge Care Home had experience of services who supported older people.

Before the inspection we liaised and received feedback from Liverpool City Council safeguarding team and environmental health department. We also reviewed other information we held about the service.

During the visit we spoke with six people who lived at the home. We spoke with five visiting family members. As part of the inspection we also spoke with, and received feedback from, two visiting health care professionals who worked with the home to support people.

We spoke with six staff members including care/support staff, the registered manager and the area manager for the provider. We looked at the care records for six of the people who lived at the home and other records including medication records, two staff recruitment files and other records relevant to the quality monitoring of the service. These included safety audits and quality audits carried out by the manager.
We undertook general observations and looked round the home, including some people's bedrooms, bathrooms and the dining/lounge areas. Our observations included using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

## Is the service safe?

## Our findings

We spoke with five family members of people living at the home. All of the relatives said they thought their loved ones were generally safe living in the home. The responses to staffing levels were mixed with three relatives commenting that the home was short staffed. One relative said, "I think they struggle at times, they have a lot to do." Another relative commented, "No, they're always doing something, sometimes when I bring [person] back in an evening there's nobody in the lounge." These comments were echoed by a third relative; "No they're too busy to stop and have a conversation."

Prior to our inspection visit we received some information of concern regarding the staffing levels in the home. We were told that quite a few of the people living in the home were starting their day very early and there were not enough staff available to carry out routine personal care and ensure safe observation of people.

In response to these concerns, Liverpool Social Services safeguarding team carried out an unannounced visit to the home on 11 November 2015 and reported that they also had concerns regarding the carrying out of care early morning, and the provision of sufficient staff at all times to ensure safe care. This was mainly due to the fact that many of the people living at the home were up and sat out of bed in the lounge or their bedrooms at very early times in the morning.

When we carried out our inspection we also visited the home unannounced early morning to carry out observations. At 6.35 am we found four care staff on duty to look after the care needs of 47 people accommodated at the time. We were told by staff that this was the usual number of staff and this was confirmed by the duty rota. Staff were divided into two staff for each floor of 24 people.

We saw 11 people up at this time. We saw some people were walking about in the corridor areas; some were sat out by their beds and others were sat in the lounge areas. At 7.10am there were seven people sat in the ground floor lounge. All of these were dressed apart from one person. There was no staff present and one person was banging on a table and shouting for a drink. After two to three minutes staff responded with a drink of juice but left immediately following this to carry on work elsewhere. We made observations until 7.40am and were concerned that people
received minimal staff support over this period. Only on one more occasion, at 7.32am did a staff appear; supporting a person into the lounge. Again, they left immediately after settling the person.

We continued our observations in this lounge using SOFI from 7.40 until 8.10 am ; a period of 30 minutes. Over this time there were two staff interactions with people. These were brief, lasting less than a minute. There were no further staff interactions with people in the lounge.

During the time from 7.10 until 8.10am we were concerned that only two people out of seven being observed had a drink offered to them. One of these people had had to shout for a drink. One person was not appropriately dressed and was restless and anxious, continually getting up and going to the lounge door. They were talking to themselves in a slightly agitated manner, and at times were inadvertently exposing themselves so their dignity was being compromised. Three people we observed in the lounge were asleep for nearly all of the observation period.

We were concerned that this highly vulnerable group of people living with dementia had been left unobserved for long periods of time.

We spoke with staff about the morning routine. They explained that, "We start at 6.00am and check everybody to make sure they are comfortable." Staff told us that some people would not settle back to bed and so would be facilitated to get up over this period from 6.00-8.00am. With only two care staff working on each floor we were told there was 'no time' to make people a cup of tea so staff would try and ensure that people getting up had a drink of juice. We were told some people could be up from 5.00am. There was a jug of juice seen in the lounge. At a later stage we saw charts recording fluid intake for seven people that indicated a cup of tea was given to six people between 8 am and 10am (at breakfast). On three of the charts it was recorded that three of the seven people had been given a drink of juice prior to this time.

We were told by night staff that there was a lot of additional paper work to complete as many people were on observation charts for diet/fluid intake or for some form of personal care (mainly 'positioning' charts) indicating many of the 24 people on the ground floor needed a lot of monitoring. We saw that 15 of the 24 people accommodated on the ground floor were on observation/ monitoring charts. The observation charts were not
completed until just before the night staff completed their shift. Staff were therefore relying on their memory to record care given rather than recording observations as they happened.

For day duty we were told by the registered manager that there were six care staff for 48 people living in the home (ratio of 1:8 staffing). This worked out as three care staff for each floor of 24 people. The registered manager was in addition to these numbers. There was also an activities coordinator who was employed for 25 hours a week.

We spoke with four staff on day duty. We were told that the 'workload' was very high and the dependency of people requiring care was described by all staff as 'very high'. We asked staff to explain what they meant by this this and they told us on one floor of 24 people there were five people requiring the use of a hoist to move them and five people requiring full assistance with their meals. All 24 people required support with personal care and all of the people required observation; most of them due to their level of cognitive impairment (dementia). One member of staff told us, "We have staff meetings and have raised the need for more staff and [the registered manager] said she would get extra staff but it doesn't seem to happen."

We made observations of care over the day and saw that care was compromised at some key times as there was not enough staff to ensure care needs were being fully met. For example, we made observations over the breakfast period on one of the units. There were two staff supporting the 24 people with breakfast; 12 of whom were in the dining area. Staff were seen to be in and out of the dining room serving food. There were times when no staff were available in this area and people were unobserved. We saw one person was very agitated and shouting. Others were getting distressed and shouting back. Another two people were agitated and were having brief 'low level' arguments and small verbal altercations, which were unobserved by staff and could have escalated. The care plan for one of these people told us they could be aggressive at times and stated, 'maintain a safe environment at all times for (person)'.

Staff were seen to vary in their ability to respond to people in a timely way. Interactions were wholly task orientated and responsive to situations occurring. Staff appeared to be 'firefighting' in their responses.

Both the lounges were left unattended on numerous occasions. On the ground floor at 11.25am a female resident was asking to go to the toilet but no staff were available. We went to find a carer to assist.

We were told that only senior staff were qualified to administer medications and there was one senior allocated on each floor (two seniors daily). If one senior was off, however, the other senior had to cover medicine administration for the home. The medicine round could take up to three hours. Staff spoken with told us that on these occasions not all medicines could be given at the correct time (if due at breakfast) as the medicine round would go on until midday.

We spoke with the area manager and registered manager about these observations. To assist with planning staffing to meet the care needs of people, there was a 'dependency' assessment tool which could be used. We saw these in care files for people. We saw that none of the dependency scores were rated as more than 'medium' care needs. Nobody was assessed as 'high' needs. We looked at one assessment for a person with the registered manager. The assessment had been carried out on 12 November 2015 and the score indicated 'medium' dependency for the person. The registered manager advised that some of the scoring may not be accurate. For example, the person scored low for assistance at meal times but the registered manager described care requiring some assistance. In terms of behaviour only one score had been indicated but it was clear that other scores should have been made in addition which would have resulted in a higher dependency rating.

We asked what happened to the dependency ratings and how these were used. The registered manager and the area manager indicated that figures were given monthly to be collated centrally but there was no regular feedback to the home. It was not clear if the dependency tool was accurate or how scores fed into the assessment of staffing levels. We were told, anecdotally, by all staff we spoke with that dependency of people living at the home had increased over the last few years.

Both the registered manager and the area manager said they would review staffing levels in the home. The area manager commented that the need for more staff had been identified on previous management audits and we were shown these. We were told 25 additional hours had been allocated in April 2015 but the registered manager

## Is the service safe?

explained that these had been 'eaten up' with providing staff for escort duties and had not made any difference to the provision for day to day care (on both days of the inspection there were escorts out of the home). We were told before we completed our inspection that staffing levels would be increased from the night of the 19 November 2015 on both nights and days.

## These findings are a breach of Regulation 18(1) of the HSCA 2008 (Regulated Activities) Regulations 2014. Staffing.

At our last inspection in November 2014 we commented that the service required improvements to medicines management and audits linked to this. Although overall, medicines were managed satisfactorily, we had found an example of a discrepancy with one medicine indicating the medicine may not have been given.

At this inspection we looked at 11 medication administration records [MARs] for people. We reviewed these with two senior carers who were carrying out the medicine round. We found some anomalies with the MARs which meant that they were not always clear. This meant there was risk that some medicines may be missed or given in error. We found some people's records very difficult to follow. For example, there were handwritten entries on the MAR charts that had not been signed by two staff as a correct entry. We discussed with two of the senior care staff the 'best practice' of ensuring hand written medicine chart entries were signed by two staff as this helped ensure entries had been copied correctly.

We reviewed two medicines with staff to see if the record matched the stock in storage. We found a slight discrepancy and staff were not able to indicate why this had occurred [for example the medicine stock for one person was one extra indicating the medicine had not been administered on one occasion]. On another MAR one medicine had been signed as given when the stock had not arrived until the following day. The record was further complicated on one MAR we saw where the 'carried forward' box had been completed for a number of medicines and the amount received was recorded as a separate number. Staff were not able to say where the 'carried forward' number had originated as it did not correlate [together with the amount recorded as received] with the current stock. It was not clear therefore, from the record, what medicines had been carried over and what medicines had been received from the pharmacy.

We saw that some people were prescribed topical medicines such as creams. We saw that senior staff had signed for creams, which they had not applied. Some of these were administered by care staff who had not then signed the record. We discussed the need to record this and the deputy manager said this would be addressed.

Accurate and easy to interpret records are important to ensure safe practice. The medication administration records did not fully support a safe practice.

## These findings are a breach of Regulation 12(2) (h) HSCA 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We observed the medications being given out on day one of the inspection and these were completed in good time with all the people living in the home getting their medicine on time. On the day of our visit this was carried out safely so people got their medicines and they were recorded as per the home's policy; following each individual administration the records were completed by the staff. All medicine administered were recorded on the MAR.

Although there were no people in the home who were having medicines given covertly [without their knowledge but in their best interest] we were able to see that the registered manager and senior staff understood the principals involved in how this would be managed.
We looked at records for people who were prescribed medicines to be taken 'PRN' [when required] and also medicines which could be administered in 'variable' doses, including medicines prescribed for when people may be in pain. We found that information was available to guide staff how to administer medicines prescribed in this way. The importance of a PRN care plan to support administration is that staff had a consistent understanding of why and in what circumstances the medication is given and administration can be consistent and can also be regularly reviewed. There was also an accurate record of when a variable dose had been administered so that staff had an accurate record for any future administration.

The home had a medication policy which we saw. We found the policy needed reviewing as it referred to outdated standards pre April 2014 [essential standards] and did not reference some areas of medication management such as guidance around PRN medicines and 'covert' administration of medicines.

## Is the service safe?

Only senior care staff were designated to administer medicines. This followed appropriate training. Staff told us that their practice was monitored by the registered manager or another senior to ensure they remained competent to administer medicines. We saw a staff supervision record where this had been recorded.

We looked at how medicines were audited. The current system included a monthly audit; we saw the last one completed on 18 October 2015 which did not identify any issues requiring action to be taken.

Arrangements were in place for checking the environment to ensure it was safe. We were shown a range of environmental checks carried out by the registered manager and maintenance person including, safety checks for windows, hot water and fire safety checks such as alarm testing, fire drills and safety checks for equipment. There was a system for staff to report general repairs. We checked safety certificates for electrical safety, gas safety, fire safety, mobility equipment and kitchen hygiene and these were up to date.

There was a fire risk assessment available for the home and personal emergency evacuation plans [PEEP's] were available for the people resident in the home.

We received information prior to the inspection of an infection control issue within the home. We liaised with the
environmental health department at the Local Authority who told us they had conducted visits to the home and were satisfied the home were taking appropriate action, particularly in key areas such as food preparation areas.

The general environments, including the day area, bedrooms and toilet / bathrooms were clean and hygienic. There were no offensive odours in the home. We saw that there were adequate domestic staff for the size of the home and they were supplied with necessary equipment and cleaning preparations.

The staff we spoke with clearly described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. We spoke with staff who told us they had undergone specific training in safeguarding and how to report abuse. All of the staff we spoke with were clear about the need to report any concerns they had.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We looked at two staff files for staff recently recruited and asked the manager for copies of appropriate applications, references and necessary checks that had been carried out. We saw these checks had been made so that staff employed were 'fit' to work with vulnerable people.

## Requires improvement

## Is the service effective?

## Our findings

We asked the relatives if people enjoyed the food. One relative said, "[Person] enjoys the food, she's put weight on. I know they have a good variety." This was echoed by other relatives we spoke with who commented, "The food's lovely, [person] eats everything" and "As far as we know, Mum tends to say she's full or not hungry. I hope the staff encourage her."

We made some observations over two meal times and found there were concerns regarding the availability of staff and the planning, and timing of meals.

We observed lunch time on the first floor unit. People were sat waiting their meal at 12.25 pm ; however, lunch wasn't served until 1.15 pm . When we spoke to the cook they said the food had been in the heated trolley since 12.15 pm . Lunch was mashed potato, fried egg and baked beans.

We saw one person only had the use of one arm and was struggling to eat their food. They did not have any equipment, such as a plate guard to help them to keep the food on his plate. We did not see any of the staff encouraging people to eat; those that left food were asked if they had finished and food was taken away.

We asked the relatives if they had seen a menu. One relative said, "No, we told staff what [person] liked and didn't like. We saw they were given something they didn't like (eggs) that was overlooked. We let it go, but [it was a concern] if she had had an allergy, that would have been a different story."

There was a written menu displayed in the upstairs dining room, however it bore no resemblance to what was served. When we looked at the menus in the kitchen they didn't correspond to any Thursday on the three week rota. The cook told us this was changed because there had been a problem with the meat delivery. There were no pictorial menus displayed.

We were told by staff that a mid-morning drink was supposed to be served at 11.00am; however, the serving of this was only started at 11.30 am , so it was nearer 12.00 when all of the people had been served. There was a jug of juice observed in the downstairs lounge by the sink, but there weren't any glasses. We didn't see any people being
encouraged to have additional drinks during the day. We were concerned that when we made observations early morning we saw some people were not offered a drink when they got up.

We made observations at breakfast on one day. We were similarly concerned that staff were not available to support people at key times. Some people were agitated and distressed on occasions but staff did not always have time to respond in a timely way or spend time needed to observe and support people.

## These findings are a breach of Regulation 14(4)(d) of the HSCA 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

The cook told us that all the meat was fresh and delivered four times a week. The cook used both fresh and frozen vegetables, and mostly made all their own soup. We also saw an example of good practice where a person's cultural background had been taken into account when assessing and giving choice of diet.

We made general observation of the environment to assess whether there had been any adaptations and good practice with respect to accommodation for people living with dementia. We saw the home was clean and had some good facilities such as easily accessible bathrooms and toilets. We also saw that people's bedrooms were personalised to some degree and showed evidence of people pastimes and family history.

Given the fact that there were many people who were mobile and able to make their own way around the home there was little in the way of orientation aids such as clear signage and use of colour to identify areas. The signage seen could have been better defined. Information boards in corridors contained information such as activities offered but these were in small print.

## We would recommend that the environment of the home is further developed with reference to good practice for 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.

Because all of the people at Aaron Lodge were living with dementia, their ability to understand and make certain key decisions regarding their care and wellbeing were limited. We saw examples where people had been supported and included to make key decisions regarding their care. For example, people had a 'best interest' meeting after a period of assessment following discharge from hospital to Aaron Lodge. These were attended by health care professionals, staff, the person and their representative so that a decision could be made regarding future placement in the community. We also saw that people's care plans showed evidence that they, or their representative/relative had been included and people had been supported to give their consent to care when they could. This showed the person or person's representative had been consulted and followed good practice guidance in line with the MCA.

The home had developed an assessment tool - a 'best interest decision tool' which incorporated the standard two stage mental capacity assessment to assess people's mental capacity when making key decisions. We could not find any examples of where this had been used. It was not possible to evidence whether people's mental capacity had been formally assessed with respect to making key decisions. One person we reviewed had bedrails in place, which could be interpreted as a restrictive care practice. Staff were able to explain why the rails were in place 'in the person's best interest', but there had been no formal recorded assessment of the persons capacity to give consent or not. The registered manager said the current training plans for senior staff would include further updates on the MCA.

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).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the manager understood the process involved if a referral was needed. Because of the nature of their care needs, all of the people living at Aaron Lodge
were on an authorisation from the Local Authority or were in the process of being applied for. The registered manager showed us some examples of authorisations already in place.

We spoke with two visiting health professionals who supported people at the home. They told us care staff worked hard to ensure people received the right care and ensured they were reviewed regarding their health care needs on a regular basis. There were regular reviews where people's health needs were assessed by the community matron together with a local GP in liaison with the senior staff in the home. This ensured that people's health needs, including medication could be routinely monitored. This was particularly important as there were a number of beds available in the home to support people on 'respite', some of whom were directly out of hospital. This meant these people could receive further assessments and review before returning home or being placed at the home. We were told that an extra staff member was made available for the reviews.

We looked at three peoples care records in some depth and saw that there were regular entries showing that people had received input for a range of health care professionals when required. These included chiropody, optician, district nurses and the community mental health team [CMHT]. We saw that all three of the people we reviewed were being monitored on various observation charts completed by staff. For example, diet and fluid intake charts as well as 'positioning' charts if they were spending longs periods in bed.

People we spoke with, relatives and health care professionals told us that staff had the skills and approach needed to ensure people were receiving the right care. We looked at the training and support in place for staff. The registered manager supplied a copy of a staff training matrix and we looked at records of staff training for some individual staff members. We saw training had been carried out for staff in 'mandatory' subjects such as health and safety, medication, safeguarding, infection control and fire awareness. All of the senior staff we spoke with had a qualification within the QCF (Qualifications and Certificates Framework) which gave them a good baseline to support their care practice.

Staff spoken with said they felt supported by the registered manager and the training provided. They told us that they had had appraisals and there were support systems in

## Requires improvement

## Is the service effective?

place such as supervision sessions and staff meetings. Staff reported they were asked their opinions and said that the registered manager fed through any concerns to a senior manager in the organisation. Some staff said however that
they did not always receive any feedback and that some issues, such as staffing levels, were not always acted on. One staff commented, "The manager said she would get extra staff but that was a while ago."

## Our findings

Aaron Lodge provides accommodation and personal care for people living with dementia. This group of people have particularly complex care needs and require support that is timely and not rushed.

We received varying responses from relatives we spoke with regarding staff support and interactions. Most felt that staff were appropriate and responsive but two made less positive comments. One relative commented, "Three quarters of them [staff] are good, but others are variable; some are lovely, some not so lovely."

We saw many positive interactions from staff providing support but were concerned that these were not consistent. Some examples we observed showed staff did not interact in a positive manner to support people or seemed abrupt in their approach. For example, one person asked to go for a shower. A carer said, "In five minutes." When the carer came back into the lounge the person got up and started shouting and swearing and again requested a shower. Two other people started shouting. The carer kept telling the first person, "Five minutes" but did not spend time to reassure the person or diffuse the escalating situation. Another carer arrived but neither tried to calm the situation down.

There were other examples of care staff not spending time to communicate effectively with people and reassure them. Two care staff were observed assisting a person into a wheelchair without explaining what they were doing. They continued and wheeled the person down the corridor without speaking or offering any reassurance. The person was visibly distressed and was shouting to go to the toilet. Support was not carried out in a caring manner.

We saw two carers assisting a person to transfer using a standing aid. The only communication was when a carer said, "Put your bad arm on first". Other observations
included one person left lying in their bed on the bare mattress all morning. They were still on the bare mattress at 11.30 am and 12.20 am . This compromised the person's dignity. Staff told us the normal routine was for beds to be made later in the day.
We asked the relatives if staff had time to sit and chat with them. One relative said, "They do every now and again, they take [person] out as well to McDonalds." Another relative commented, "I don't know, they always seem to be on the go". One relative said "No."

We did observe many other more positive interactions, particularly when staff had more time. For example, the activities coordinator was able to spend some quality time with people and staff in the afternoon were observed to be able to spend more time and display a 'caring' approach to the support they gave. When we spoke with staff they commented that the workload involved in providing care meant they were often rushed and under pressure.

## These findings are a breach of Regulation 10(1) of the HSCA 2008 (Regulated Activities) Regulations 2014. Dignity and respect.

Visitors and relatives were welcomed and we observed five visitors/relatives visiting during the course of the first day of our inspection. We were told relatives were encouraged to attend meetings to discuss issues at the home. We saw minutes from a relatives/residents meeting held in October 2015 which was well attended. This helped ensure people and their relatives had some say as to the running of the home.

We saw some information was provided for people on notice boards and through a newsletter. The notice board also contained information regarding local advocacy serves available for people. Staff gave some examples of people accessing advocacy services including the use of Independent Mental Capacity Advocacy (IMCA).

## Is the service responsive?

## Our findings

We asked people and their relatives how staff involved them in planning their care to help ensure it was more personalised and reflected their personal choices, preferences, likes and dislikes. People and their relatives told us they were asked about their care and felt individual choice was respected to some degree but care was generally organised around daily routine.

We saw this with specific reference to the routine early morning and leading up to dinner time. We had received concerns before the inspection that raised issues such as people being able to get up when they wanted to and care being organised to facilitate this. When we reviewed this aspect of care we saw that any people were up and about from very early morning. We saw that some of these people were sat in day areas and some were asleep in their chairs. This followed the routine of staff waking people at 6 am to check whether they required attention to personal care. We saw some people sat out in their bedrooms who were also asleep in their chairs. Staff spoken with said that they facilitated people to return to bed if they were tired but we saw that beds had been stripped and not re-made so people could not return to bed. This indicated care routine that did not take into account the needs of individual people living at the home.

We looked at care records to see if they reflected people's choices regarding, for example, waking times. None of the care records we reviewed contained this information although we saw some indication of people's preferences with the separate records completed by the activities coordinator. The records we saw were not detailed or specific.

We asked relatives if they or the people concerned had been given a choice about whether male or female staff provide personal care. One relative commented, "No we were not given an option". Another relative said they were not asked and a third said, "We were not asked, we would have requested a female as a preference."

Care plans we reviewed were likewise lacking in detail and personalisation. For example, we looked at a care plan that had been written for a person who experienced periods of agitation and aggression. The actions for staff to carry out were generalised and not specific to the individual concerned. The plan contained ambiguous instructions
such as 'maintain a safe environment', 'give reassurance' and 'promote independence'. None of these instructions related to how these were to be achieved for this individual.

Another plan for a person said that staff must ensure '[person] has suitable day and night clothes on at all times'. We saw over the two days of the inspection this was not being achieved with the individual concerned. There were three evaluations of the plan over three months but these had not addressed the issues or made any changes/ additions to the plan of care.

There were other examples of lack of detail regarding aspects of care. For example, all of the care files we saw had a care plan titled 'end of life care/decisions'. Again the care instructions were 'for [persons] wishes to be met' with little or no detail regarding this aspect of individual care for each person.

We found this lack of detail was mainly around people's personal and social care which reflected the task orientated care we observed based on routine and the needs of the care home rather that specific individuals. We saw care plans for people's medical care were more detailed. For example, a plan for a person with diabetes was clear about how staff were to support the person and what observations to make.

We discussed some of the observations with staff and the manager. We were told that all of the 'activities of daily living' had to have a care plan recorded. This meant that even if the person had no particular care need in this area there was still a plan written. For example, one person had a care plan for 'pain' and another under 'breathing' although both individuals had no care needs in these areas [which was what the plan told us]. This made the care records rather bulky and difficult to follow at times when trying to identify the primary care needs for people.

We saw daily records maintained by care staff. These were held separate to the care plans/files. The daily records were made with no reference to the person's care plan. We discussed ways in which this could be addressed so that staff had better reference to a record of peoples care needs.

We saw that people's social preferences and history were recorded by the activity coordinator. The records we saw contained some good detail. We were told these records

## Requires improvement

## Is the service responsive?

were not looked at by care staff. The activity coordinator advised us that they updated staff on people's preferences regarding activity but his seemed to be on an adhoc basis and lacked any consistency.

Overall we found that the designing of peoples care did not reflect their individual preferences in any consistent way. This was reflected in some of the care we saw.

These findings are a breach of Regulation 9(3) (b) of the HSCA 2008 (Regulated Activities) Regulations 2014. Person-centred care.

We asked about activities for people and how people spent their day. One relative said, "[Person] has stopped reading and watching TV now; they have singing of a night and bingo." Another relative said, "I don't know, the telly's on and we know mum likes to walk around." Other comments were not as positive; "Nothing at all. There's no communication, the only thing [person] gets joy out of is a man coming in to play (some music) every fortnight" and "I haven't seen any activities."

We spoke to the activities coordinator who told us they arrange to paint ladies nails on a Thursday when they have their hair done. We were told there was an activity plan outside the downstairs dining room but this was for

October as November's was ‘still on the computer'. The activities coordinator also wrote a monthly newsletter and facilitated the resident's meetings. There were organised picnics in the park in the summer, sing-a-longs and dancing. Some more activities included darts (magnetic), cards, armchair exercises quoits and bean bags.

We were also told that when the weather was bad, the dining room was turned into a pub and staff served sherry, beer and lager [always with lemonade]. There was money available for taxis for outings. We spoke with one person who spent a lot of time alone in their bedroom. They told us that the activities coordinator had spent time reading to them and they had enjoyed this.

We found that these activities were examples of more personalised care at Aaron Lodge and could be developed further. Currently the activity coordinator had limited time to include most people living in the home on a regular basis due to the hours allocated.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. We saw examples of complaints which had been addressed by the registered manager. None of the people or visitors we spoke with wanted to complain.

## Is the service well-led?

## Our findings

We reviewed some of the current quality assurance systems in place to monitor performance and to drive continuous improvement. The manager and area manager were able to evidence a series of quality assurance processes and audits carried out internally, and also by senior managers supporting the home. We looked at two key audits in particular; the 'Manager Care Home Monthly Visit Report' dated 12 November 2015, completed by the area manager and the 'Report of Mock Inspection and Management Review' completed on $2 \& 4$ march and 8 April 2015. We also reviewed the last 'Home Development Plan' for the service dated 29 June 2015.

We saw from the two audits that many of the issues of concern we observed during our visit had previously been identified by these audits. This was particularly the case with the 'Mock Inspection' report from March 2015, which highlighted; the need for making additional staff available at key times such as meal times, issues around recording on medication records [MAR's], the need to develop the use of mental capacity assessments for specific decisions, staff being disrespectful at times to people living in the home, the need to further develop the environment of the home for people living with dementia, and the need to develop a more person centred approach to care, which 'was not the focus of the current care planning format'.

Some of these findings were echoed by the development plan dated June 2015 where it was noted a 'lack of supervision observed in lounges' and the need to 'review meal time delivery - ensure all staff are focused on supporting the delivery of meals'; also to ensure 'residents are assisted as necessary'. The development plan tells us these observations had first been made in January 2015.

We were concerned that, although these issues had been identified by the management audits, some as far back as January 2015, there appeared to be no current actions to address them. We spoke with the home manager and with the area manager. The area manager pointed to the recent monthly visit report dated 12 November which stated that 'staffing levels had been reviewed and we highlighted the need for additional coverage between 7.00 am till 1.00 pm and 5.00 pm to 10.00 pm '. We saw this had followed a visit by the area manager in the early morning of 11 November 2015 following the concerns raised by the visit by social services.

We asked why a response had not been made earlier in the year when the issues had been first identified. The area manager reported staffing had been increased by 25 hours a week in April 2015. The home manager reported that these hours had been used to cover escorts and not on general daily staffing of the home. The area manager had been unaware of this and said it was up to the home manager to ask/make a case for more staff.

We were concerned that since April 2015 when staffing had been increased, there had been no real review of the effectiveness of the staff changes until the last few days following concerns raised by social services.

This lack of management review regarding staffing was further highlighted from discussion with both managers. For example, we were made aware that some key information such as the dependency scores submitted to the company by the manager were not fed back in terms of how this may or may not impinge on staffing levels in the home.

We found that some areas of concern we identified on the inspection had not always been reflected in the internal audits conducted. For example, medication issues highlighted in the 'Mock Inspection' in April and by this inspection, were not picked up on other internal medication audits carried out in each month in-between. We discussed the need to review some internal audits regarding their effectiveness.

## These findings are a breach of Regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014.

The manager of the home was registered with CQC. All the people living at the home and relatives we spoke with knew who the manager was. They all thought the manager was a very visible presence and felt confident and happy to approach them with any concerns they may have. We saw that the manager interacted politely with people who lived at the home and people responded well. The manager was supported by a deputy. Both staff and people, including visitors, we spoke with were positive in their opinion of the registered manager.

A process was in place to seek the views of people who stayed at the home and their families. This was based around residents' meetings which relatives also attended. The manager had also collected feedback via

## Is the service well-led?

questionnaires in January 2015 for both people living at the home and their relatives. This helped ensure people's views of the service were taken into account when planning any changes.

Staff spoken with said they were generally happy to be working in the home and felt supported by the registered manager. They said the registered manager worked hard and provided a good lead. Some staff told us that information fed upwards by the manager did not always see to get responded to. This was the case with comments regarding staffing levels in the home.

We found the manager to be open and constructive regarding our feedback. Following our feedback the registered manager and area manager told us staffing would be provisionally increased starting that evening and reviewed ongoing.

The manager was aware of their responsibility to notify us [The CQC] of any notifiable incidents in the home.

## Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

## Regulated activity

Accommodation for persons who require nursing or personal care

## Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Some of the observations we made of the support offered by staff were not consistently positive and compromised the respect and dignity shown to people.

Regulation 10(1)

## Regulated activity

Accommodation for persons who require nursing or personal care

## Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

There was a risk medicines were not administered safely. Medication administration records were not always clear. Medication audits had not identified these issues.

Regulation 12(2) (h)

## Regulated activity

Accommodation for persons who require nursing or personal care

## Regulation

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

We saw people's dietary needs were not managed effectively with reference to staff support required.

Regulation 14(4) (d)

## Enforcement actions

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

## Regulated activity

Accommodation for persons who require nursing or personal care

## Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing
There were not enough staff on duty at all times to help ensure people were cared for in a safe manner.

Regulation 18(1)

## The enforcement action we took:

We issued an enforcement notice [warning notice] requiring the provider and registered manager to take action to meet the regulation.

## Regulated activity

Accommodation for persons who require nursing or personal care

## Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Some of the systems for auditing the quality of the service needed further development so there is more effective review of actions taken as well as identifying areas for improvement.

Regulation 17(1) (2) (b) (f)

## The enforcement action we took:

We issued an enforcement notice [warning notice] requiring the provider and registered manager to take action to meet the regulation.

