Four Seasons (Bamford) Limited

Aarondale Care Home

Inspection report

Sunny Brow
Off Chapel Lane, Coppull
Chorley
Lancashire
PR7 4PF

Date of inspection visit:
27 November 2018
03 December 2018
11 December 2018

Date of publication:
23 April 2019

Ratings

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

Summary of findings

Overall summary

Aarondale is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Aarondale is registered to provide personal and residential care for up to 48 people. At the time of the inspection 35 people were living at the home.

We undertook an unannounced focused inspection of Aarondale Care Home, Chorley on 27 November, 3 December and 11 December 2018. This inspection was undertaken due to concerns raised with us about the safety of people using the service. We wanted to be sure people were safe and concerns raised were being managed. We inspected the service against two of the five questions we ask about services; is the service safe and is the service well led.

No other risks or concerns were identified in the remaining key questions through our ongoing monitoring or during our inspection activity between 27 November 2018 and 11 December 2018 so we did not inspect them. The ratings from the previous comprehensive inspection for these key questions were included in calculating the overall rating in this inspection.

At the time of the inspection the service did not have a registered manager in place. 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.

The former registered manager had resigned their position in September 2018 and the provider was in the process of recruiting a home manager at the time of the inspection. In the absence of a registered manager, the CQC had spoken with the provider prior to the inspection around concerns in the management of the home. As a result of this, the provider had put an area manager in place who was managing the home. This person was present at the time of the inspection.

We initially became concerned about safety at the home when we were alerted about a significant medications error on the evening of 19 November 2018. We entered into dialogue with the registered provider around the measures that were to be put in place to avoid a repeat of the concerns. Thereafter, we received information from people's relatives and the provider that supported that there had been further failings in the delivery of safe, quality care. As a result, we conducted a unannounced inspection on 27 November 2018. This part of the inspection process resumed on 3 December 2018 when we were assured by the provider around the implementation of robust systems to avoid any further concerns and the recruitment of a new home manager who was to apply for registration with the CQC.

We were further alerted around a repeat of the 19 November 2018 medications issue on 7 December 2018.

Immediate steps were put in place to ensure that people received their medicines as prescribed by health care professionals and we received documentation from the provider that supported a robust set of systems and the temporary recruitment of qualified nurses to supervise the medicines' administration processes. The unannounced resumption of the inspection process on the evening of 11 December 2018, was to check that the assurances that we had been provided were in place and effective. On that occasion, we noted that two registered nurses were involved in the administration of medicines and that the processes that we had been assured about were working effectively.

During the course of these concerns, the registered provider had kept in regular contact with the CQC and had made notifications to the authorities and CQC consistent with their legal obligations. However, during this inspection we found that the service was in breach of regulations in relation to medicine's management, poor recruitment processes, concerns around staffing and poor management and governance. These breaches are under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and are summarised below. For full details, please refer to the 'safe' and 'well-led' sections of this report. You can see what action we told the provider to take at the back of the full version of the report.

The service was not safe because medicines administration had been chaotic and there had been three significant errors that put people at risk of harm. Risk management systems around this were inadequate and the registered provider only established a robust system after people had been put at risk.

Staffing arrangements were not appropriate. The service relied heavily on agency staff and had only managed to retain one senior carer who was qualified and trained in medicine's administration. The significant issues where people had not received their medicines as prescribed by health care professionals was because of a breakdown in communications between permanent and agency staff. There was also a lack of management oversight and supervision during these processes.

The service had a recruitment policy in place to guide the temporary manager on recruitment processes but failures to adhere to policy and legislation may have meant that staff had not been safely employed.

Records we looked at also showed that checks of staff competence and suitability was monitored through supervisions and appraisals. However, staff said that they had not been involved in a formal supervision session since the former registered manager had left the home in September 2018.

We noted records were kept in relation to any accidents or incidents that had occurred at the service, including falls. There was however a lack of checking and investigation around these matters.

All of the staff we spoke with told us the service was not well run. They said that in the absence of the registered manager there had been a lack of supervision and oversight at the service.

All the staff we spoke with confirmed they had received safeguarding training and that safeguarding policies and procedures were in place to guide them in their roles. Training records we looked at showed that safeguarding adults was an annual, mandatory course. Other safeguarding records we looked at showed the registered provider had notified the appropriate authorities when a safeguarding concern had been raised.

We looked at how risks to people's individual safety and well-being were assessed and managed. Care records contained risk assessments in relation to areas such as pressure ulcers, skin integrity, medicines and moving and handling.

Some people who used the service required equipment such as hoists to assist them to move. All the staff

we spoke with told us they had received moving and handling training. We noted that there was regular maintenance and safety checks on the equipment that was in use at the home.

All the staff we spoke with, told us they had received training and were aware of their responsibilities in relation to infection control. The service had an infection control policy to guide staff in their roles and to reduce the risk of cross infection.

Throughout our inspection we were assisted by the area manager and a nurse specialist who had visited the home to complete a full review of medicines practices. We found that these senior staff were knowledgeable about the service and people who lived there but that these senior members of staff had only been put in place on a full-time basis after the first significant medicines issue had been established on 19 November 2018.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Aspects of the service were not safe.

People were not always receiving their medicines as prescribed by health care professionals.

Appropriate recruitment checks did not always take place before staff started work.

There was a lack of suitably trained, competent and skilled staff on duty.

Staff were aware of signs of abuse that could occur in a care home and what action they should take.

There was a whistle-blowing procedure available and staff said they would use it if they needed to.

The registered provider had assessed and considered the risks to people within the environment.

Individual risk assessments for people, such as falls, had been completed and updated.

There were arrangements in place to deal with foreseeable emergencies.

Is the service well-led?

Requires Improvement

The service was not well-led.

Insufficient support and management had led to a series of substantial medicines errors.

Staff were not appropriately supported and supervised.

Some audits and checks that were in place were not picking up the issues seen at the inspection.

In recent months, staff were not involved in providing feedback so that the registered provider could monitor the service and make improvements.

Aarondale 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 27 November 2018 and 3 and 11 December 2018 and was unannounced.

The inspection was conducted by an adult social care inspector.

This was a focussed inspection and was prompted by concerns raised with us about the safety of people who used the service. These concerns had also been brought to the attention of the local safeguarding team. We wanted to be sure people using the service were safe and that risks were being managed.

We visited the home on 27 November 2018 to see the area manager and staff and to review care records and policies and procedures. This part of the inspection was concluded on 3 December 2018. Thereafter, we became aware of further concerns and this resulted in a visit to the home during the evening of 11 December 2018. All of these visits were unannounced.

In preparation for the inspection, we reviewed the information we held about the service such as notifications, complaints and safeguarding information. We also spoke with the local safeguarding team.

We reviewed a range of records about people's care and the way the service was managed. These included the care records for five people, medicine administration records, staff training records, four staff recruitment files, staff supervision and appraisal records, minutes from meetings and records relating to the management of the service.

We also spoke with the area manager, the provider's representative, five care staff and three health care professionals.

Inadequate

Is the service safe?

Our findings

Before the inspection we received information of concern that included poor management of medicines and staffing issues. This information had been received from relatives and from the service itself by way of its regulatory obligation to make notifications of events that may have led to the abuse and neglect of people. At the inspection we found medicines were not managed safely and people did not always receive their medicines as prescribed.

We established that prior to the inspection there had been three sets of medications errors that could have affected the health and well-being of people. The first was on the 19 November 2018 when 19 people did not receive their evening time medicines. The documents we considered, and the accounts from staff, supported that this error related to people who lived on the ground floor of the home. The home's own staff and management did not communicate effectively to the senior agency staff around administration of medicines. Upon realising the error the following morning, health care professionals were contacted and, where appropriate, extra precautions were put in place to ensure that people were safe.

A further concern was established on the evening of 25 November 2018 when an agency worker omitted to complete medicines administration records (MARs) for a number of people and failed to administer medicine to one person. On this occasion the agency worker's competence and training around medicine's administration had not been checked by the home prior to starting their duties.

In view of the concerns around safety and especially medicine's administration, we conducted an unannounced inspection on the morning of 27 November 2018. We met with the provider's area manager and a representative of the provider. The provider had commissioned a full audit and check of medicine's procedures at the home that was in the process of being conducted by a senior and medically qualified manager from another home owned by the provider. At this stage of the inspection process, it was accepted that the home was heavily reliant on agency staff especially at night. This was because in the autumn of 2018 a large quantity of senior staff had left the service to work elsewhere. At the inspection, assurances were provided to CQC that supported that additional safeguards would be put in place to ensure that the previous medicines issues would not be repeated. This included a formal 'handover' between home and agency staff and additional supervision and communication about the need for medicines to be administered to staff starting the evening shift.

A further and third alert around medicines issues was received on the afternoon of Friday 7 December 2018 in relation to issues during the evening of 6 December 2018. The issues were, in effect, a repeat of the matters of 19 November 2018 where a floor of 10 people had missed their evening time medications because of a breakdown in communications between the home's own internal staff and a senior agency carer. The additional precautions that the provider had put in place following the second concern were ineffective.

Conversations with CQC and the registered provider around these further concerns concluded on the afternoon of Monday 10 December 2018 when we received written assurances about further and robust

measures that had been put in place. This included the recruitment of qualified agency nurses who were to administer medicines during the evening shift in the absence of trained senior in-house staff.

This meant that there was a failure to administer medicines safely and this series of issues is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The resumption of the unannounced inspection on the evening of 11 December 2018 was to check that the additional precautions after the third set of issues were working and that people were now receiving their medicines as prescribed by health care professionals. On this occasion we were satisfied that people had and were in the process of receiving their medicines and two qualified nurses were in place administering medicines. A senior carer from the home's own staff was present and had provided a written handover to the nurses of the need to administer medicines to people and any further matters that had developed with people during the day-time shift. This also included the location of fire exits and fire evacuation procedures. We spoke with both nurses who confirmed the details of the handover and how they had been reminded by staff to ensure that people received their medicines. We also noted that the correct documentation and process was being used to record the administration of medicine (MARs).

During the course of this evening visit to the home, we noted that people were settled. Some had got ready for bed and were watching TV and others were eating supper. The home was clean and tidy and there was sufficient number of staff to care and support people at night-time.

We looked at the recruitment systems and processes in place to check these were sufficiently robust. We considered the recruitment files for four staff who had been recruited since the last inspection in February 2018. Although we saw that everyone had been asked to complete an application form and the provider had requested enhanced disclosure and barring checks (DBS), the provider had not made sufficient enquiries of previous employers before employment in all four cases. In addition, some safety checks into staff member's histories had not been made particularly around issues disclosed by recruits in their application forms.

We noted that, on occasions, the provider was relying on references from applicants' work colleagues and friends. This meant that insufficient checks had been made to ensure that the provider was employing staff suitable to care and support vulnerable people.

There was a failure to recruit staff safely and this is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised these concerns with the area manager who undertook to speak with the provider's HR department to ensure that further checks were made to ensure that the employees had been safely employed.

Concerns were raised with CQC about the staffing situation prior to the inspection. This included concerns about the reliance on agency staff. At the inspection we found that the competency and skill of staff was not at an appropriate level to ensure that people were kept safe. Relatives of people who used the service had expressed concern at the competency of staff. One relative said, "Staff don't seem to be engaged and often have to go away from a situation and summon help. I question their competency and training." Staff told us that some staff had not been trained in essential areas of care and support such as medicine's administration and that this had contributed to the issues seen earlier this report. Some staff members said that they hadn't received any support or supervision sessions since the registered manager left the service in September 2018. The records we reviewed supported this and that the last staff meeting had been on 18

September 2018. A visiting social care professional said, "I have a concern that not all staff are aware of the need to refer some cases to specialists and worry that there is insufficient guidance to inexperienced staff."

There was a failure to train, support and supervise staff to care and support people effectively. This issue is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of this inspection there were two safeguarding concerns being investigated by the local authority. This was in addition to the concerns raised around medicines administration detailed above. We cannot report on these at the time of this inspection. The CQC will monitor the outcome of the safeguarding investigations and actions the provider takes to keep people safe.

People who used the service told us they felt safe. Comments we received included, "I am really safe here. There is always someone about day and night." Views from relatives were mixed with one relative said, "Yes my relative is in good hands as the staff are dedicated and very caring." Another said, "I worry about the state of care at the home and have raised my concerns with the management."

Risks to people were appropriately assessed and managed. We reviewed people's care files which had a section with risk assessments which related to their care and support. These covered areas such as nutrition, continence, falls, mobility, moving and handling and mental capacity. Assessments were complete and they had been reviewed annually by the previous registered manager or when people's needs had changed. Where there was a change in a condition or support requirements, we noted that referrals had been made to health and social care professionals. For example, we noted that a person's weight had been monitored since they started living in the home and a gradual deterioration had been noted. We saw documentation supporting consultation with a GP and thereafter a referral to a Speech and Language Therapist (SALT).

Staff told us they completed relevant documentation whenever there was an accident or incident. We saw records around this but there was a lack of checking and investigation around these matters. The area manager told us that they were in the process of reviewing the records as there had been a period of two months when they had not been considered. This had coincided with the former registered manager leaving the service. Reviews of all accidents' and incidents' records should identify where action should be taken to help prevent any repeat events and learn lessons.

The home had a policy for safeguarding adults from abuse. The area manager was the safeguarding lead for the home. All of the staff we spoke with demonstrated a clear understanding of the types of abuse that could occur. They told us about the signs they would look for, what they would do if they thought someone was at risk of abuse and to whom they would report any safeguarding concerns to. One member of staff told us, "I would report any concerns I had to the temporary manager or provider." Staff were also sure of the correct reporting procedures. Staff we spoke with told us they had received safeguarding training and said that they would have no hesitation about reporting concerns. They all said they knew how to escalate any safeguarding concerns they had outside of the home.

At the inspection we considered records relating to the maintenance of equipment in the service. We noted that there were annual records of maintenance for moving and handling equipment such as hoists. We physically considered this equipment at the service and noted that they appeared to have been examined or serviced in line with the Lifting Operations and Lifting Equipment Regulations 1998 and the associated Code of Practice.

There were contingence plans in place to deal with issues such as a loss of power. Contingency

arrangements were in place to utilise sub-contractors and head office staff and their details were available for staff to contact in the event of an emergency. We were told that in the event that some people had to leave the home in an emergency, accommodation for some residents could be provided at a nearby care home owned by the provider.

People lived in a safe and clean environment. We looked at certificates and service records such as gas installation, electrical wiring and fire safety equipment; these showed checks had been carried out to make sure the premises and equipment were safe. Weekly fire alarm tests were recorded and the home had been inspected by a specialist fire safety consultant on 25 September 2018 when some structural safety issues had been established. We considered the issues contained in the expert's report and noted that most had been addressed or were in the process of completion. These included the fitting of an additional alarm near to the kitchen and adjustments to fire doors in communal areas. The area manager said that any remaining issues would be concluded within the next seven days.

Equipment for preventing the spread of infection, such as disposable gloves and appropriate handwashing facilities were readily available. The home was clean and tidy and a cleaner was engaged cleaning people's rooms and communal areas on all of the days of the inspection.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager in place as the former registered manager had left the service in September 2018. The provider had tried to recruit a manager with a view to registration with the CQC but at the time of the inspection, a manager had not been formally appointed. It was evident from the inspection findings that there were weaknesses in the leadership and management of the service.

The provider's systems for assessing, monitoring and improving the quality and safety of the services that people were receiving were not always effective. The failures around this and the lack of appropriate support, had led to the substantial medications administration issues described earlier in the 'Safe' section of this report.

In the absence of a registered manager, some audits were being carried out by the area manager. They accepted that since the start of October 2018, there had been an absence of some management checks around essential issues at the home including staff training reviews, supervision of staff and care plan reviews for 25% of people who lived at the home. Significantly, there was an absence of medicines administration competency checks since the registered manager had left the service in September 2018.

The reviews and audits that were taking place had failed to identify shortfalls in recruitment processes and the need for robust measures to support staff in the absence of senior staff. There was a paucity of senior staff who were capable of supervising inexperienced and agency staff who were not familiar with the home. The absence of staff meetings and supervisions during this period was a particular concern as some staff had no formal way of voicing their concerns around the lack of support and supervision. The area manager said, "There have been some omissions around supervision that I am addressing. I have an open door policy and held a meeting recently with senior staff because of concerns at the home seeking their input to address the issues."

There was a failure to manage and govern effectively and this series of issues are a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Health care professionals who had visited the home recently had noted positive changes in the running of the home. One said, "Things have improved in the last couple of weeks. Before that there was a lack of supervision and management. We noted that staff were stressed and there was heavy reliance on agency staff." Another visiting health care professional who had attended the home during the inspection to deal with someone who had become unwell said, "Things are definitely improving and I've been really well supported today by staff who really care. We were called out appropriately and the home did the right thing."

People and their relatives spoke positively about the area manager and staff. One person told us, "I miss the old manager but can call on the management and staff anytime I want to." A relative said, "The area manager and provider have been wonderful with me and my relative. I've travelled from abroad and the home have put me up in a bed whilst I stay with my relative who is really unwell. I can't praise them enough."

The provider, management and senior staff had been open and transparent around the problems in relation to the medicines issues and had fulfilled their regulatory obligation by making appropriate notifications to the authorities. They had also kept people's families involved in the matter and had written to people apologising for the errors. In the lead up to the inspection, there had been daily communication with the lead inspector and as soon as an issue had been realised, CQC had been contacted by phone before written notifications were made. This contact, amongst other factors, led to CQC making the decision to inspect to check that people were safe.

We spoke with staff on most days of the inspection about people's food and drink requirements. The meals served looked appetising and people told us they enjoyed their meals. Staff said that when a new person stated to use the service, they met with them to discuss their preferences and needs as far as food and hydration was concerned. They said that they were supported by the registered provider to provide high quality food and meals with a good range of choice and variation.

At the inspection we noted that the home had links with other organisations to enhance the services they delivered and to support care provision, service development and joined-up care. They worked with organisations such as local commissioning group, local pharmacies, advanced nurse practitioners, specialist doctors and local GPs. The regional manager and provider had systems to ensure the home shared appropriate information and assessments with other agencies for the benefit of people who lived at the home.

We saw that residents' meetings were held and the last was on 15 November 2018. The meeting involved discussion about future activities at the home, the home's facilities and meal preferences. The meetings were chaired by the home's activities coordinator who told us that it was important for residents' views to be heard and for staff to be aware of people's preferences. They said that they were supported by the provider with this.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines management was unsafe and meant that people did not always receive their medicines as prescribed by health care professionals.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Unsafe recruitment processes that did not check history and previous performance in health and social care roles

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff not trained, supervised and supported

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failed to operate an audit and review system that would pick up on issues seen at the inspection. Failed to introduce sufficiently robust measures to reduce risks to people

The enforcement action we took:

Requirement Notice