Aaron House Care Limited

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Inspection report

Aaron House
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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Aaron House Care Limited is a care home registered to accommodate up to 6 adults with a learning disability or autistic spectrum disorder in 1 adapted building. At the time of our inspection 4 people were using the service.

People's experience of using this service and what we found
Since our last inspection, the provider had made some improvements to the service. However, not all of the requirements of the warning notices had been met.

The new manager had implemented some systems to monitor some aspects of the service such as medicines stock and people's finances. However no other systems to monitor, assess and improve the quality of the service delivery had been implemented. Concerns we identified at this inspection had not been identified by the provider's own systems.

People's care plans had not been reviewed to reflect the concerns we identified at our last inspection. Care plans were not always current and reflective of people's needs.

People's individual risks were not always identified, assessed and mitigated. Staff were not given clear guidance or information on how to protect people from associated risks. People's medicines were not always managed safely. A robust system was not in place to ensure the provider had oversight of all incidents or accidents.

We received mixed feedback from people and their relatives in relation to people's safety at Aaron House.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies highlighted these practices, however the systems in the service did not support this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted.

Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and/or who are autistic.

Based on our review of safe and well led, the service was not able to demonstrate how they were meeting some of the underpinning principles of Right care, Right support, Right culture.

Right support: The provider was not always able to demonstrate how they planned the needs of people with a learning disability in line with best practice guidance. People's care records did not reflect the support that had been planned and delivered.

Right care: Care was not always person-centred and did not always promote people's dignity, privacy and human rights.

Right culture: The lack of quality audits did not support the development of an open and transparent service. The new manager was engaging with people's relatives for feedback.

At the last inspection, the provider was signposted to the Right support, Right care, Right culture information on the guidance for providers page on our website, however at this inspection we found that the provider was unable to demonstrate how they met the underpinning principles of the guidance.

Improvements had been made to the management of the risk of fire, however there were still actions required to ensure people were fully protected from the risk of legionella.

Improvements have been made to infection and prevention control, however there were still some actions required to ensure people were fully protected.

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

Rating at last inspection
The last rating for the service was Inadequate (published 26 April 2023).

Why we inspected
We undertook this targeted inspection to check whether the warning notices we previously served in relation to Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. The overall rating for the service has not changed following this targeted inspection and remains Inadequate.

We use targeted inspections to follow up on Warning Notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Follow up
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. CQC took enforcement action against the provider.
Following the inspection, the local authority took action to keep people safe by removing them from the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question Inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question Inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

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Detailed findings

Background to this inspection

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

This was a targeted inspection to check whether the provider had met the requirements of the Warning Notice in relation to Regulation 12 (Safe care and treatment) and Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 2 Inspectors.

Service and service type
Aaron House Care Limited is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Aaron House Care Limited is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. Since the last inspection, a new

manager had been appointed. They had started their application to register with CQC and were in the process of resubmitting a revised application with the outstanding information required following initial application.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service, as well as information from 2 safeguarding meetings organised by the local authority. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke to the owner/provider of the service who was also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke to one of the directors, the manager of the home, the service's team leader and 1 support worker. We spoke to 1 person who uses the service and 3 relatives of people who use the service.

We reviewed 2 people's care documentation and a range of medicine records. A variety of records relating to the management of the service, including governance systems, policies and procedures were reviewed.

Inspected but not rated

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. We have not changed the rating as we have not assessed all of this key question area. We will assess all of the key questions at the next comprehensive inspection of the service.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice in relation to Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection while some improvements had been made, the provider had not fully met the requirements of the warning notice and was still in breach of the regulation.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Since the last inspection people's care documentation had not been reviewed to provide staff with an effective assessment and management plan of people's risks. This placed people at risk of not receiving safe care.
● Staff did not have clear information of the action they should take to keep people safe if they were experiencing a seizure or became distressed. Risk management plans had not been updated following changes in one person's epilepsy presentation.
● Although consideration had been given to the risk of legionella by the provider, a risk assessment, in line with the provider's policy and recognised guidance, was not in place.
● The manager had updated the system for staff to record accidents and incidents, however this was not always used by staff and information had not been analysed or used to minimise the potential risk of avoidable harm.

The provider did not always assess and do all that was reasonably practicable to mitigate the risks to people who received care. This placed people at risk of harm. This was a continued breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had made some improvements to the management of environmental risks since our last inspection, including, fire safety and window restrictors had been addressed.

Using medicines safely;
● The provider did not always ensure medicines were stored securely to ensure only authorised staff had access to the medicines cabinet key.
● Where people were prescribed medicines on an 'as required' basis individual protocols were not in place to guide staff on how to safely administer these medicines. This put people at risk of not receiving their "as required" medicines as prescribed.
● Good practice was not always followed when staff transcribed people's medicines onto their Medicine

Administration Records (MAR). This increased the risk of people not receiving their medicines as prescribed.
● Staff had not always documented when people had received homely remedies such as pain relief in line with the provider policy. This placed people at risk of not receiving their medicines safely.

The provider did not always ensure people's medicines were managed safely. This placed people at risk of harm. This was a continued breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were somewhat assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were somewhat assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
The provider was following current government guidance in relation to visiting at the time of the inspection.

Inspected but not rated

Is the service well-led?

Our findings

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

At our last inspection this key question was rated inadequate. We have not changed the rating as we have not looked at all of the well-led key question at this inspection.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice in relation to Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection while improvements had been made, the provider had not fully met the requirements of the warning notice and was still in breach of the relevant regulation.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider had purchased new policies and procedures which were being made available to staff to familiarise themselves with, however systems and processes in relation to these policies had not been fully developed and implemented within the service. These related, for example, to people's epilepsy management, the risk management of legionella, people's finance management and medicines management.
- Some monitoring systems had been introduced such as weekly medicines stock checks, auditing of people's finances and fire safety checks. However, these systems were not always effective. Weekly medicines stock checks were not always capturing the actions taken when stock discrepancies were identified.
- No other quality monitoring systems had been introduced since out last inspection; therefore, the provider and manager had not identified the concerns we found at this inspection. This included concerns in relation to systems to monitor staff training and support, accidents and incidents monitoring, safeguarding concerns recordings and people's care documentation.
- The manager talked to us about their plans for the implementation of quality monitoring audits and systems to support people be more involved in the management of their finances. However, in the absence of a service improvement plan we were unable to ascertain a timescale of when these improvements were planned to be completed by.

The registered provider had failed to implement and operate effective systems to maintain and monitor the safety and the quality of the service. This placed people at risk of harm. This was a continued breach of regulation 17 (1) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Since the last inspection a system was introduced to monitor Depravation of Liberty Safeguards (DoLS) applications.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;

● Since the last inspection, the new home manager had organised meetings with people's families. However, there was limited evidence of people and their representative's involvement in planning their care and how they would like to have their independence encouraged. This has been recognised by the manager and shared with the provider.

● The new manager had held 1 meeting with people since they started working at Aaron House.

● One person told us about the support they were receiving from the manager in relation to their personal wellbeing.

● A staff meeting had taken place since the new manager started and another one was planned for the week following our inspection.

● Relatives provided mixed feedback about their relative's care and support. A decision was taken by the local authority to move people out of Aaron House before we were able to share this feedback with the provider.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not fully met the requirements of the warning notice and was still in breach of the regulation.

The enforcement action we took:

We have issued a notice of proposal to cancel registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not fully met the requirements of the warning notice and was still in breach of the regulation.

The enforcement action we took:

We have issued a notice of proposal to cancel registration.