Aden House Limited

Aden Court Care Home

Inspection report

Birkhouse Lane
Moldgreen
Huddersfield
West Yorkshire
HD5 8BE

Tel: 01484425562

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Aden Court Care Home is a nursing home providing personal and nursing care to older people. The service can accommodate up to a maximum of 40 people. At the time of our inspection there were 30 people using the service. The nursing home accommodates people in one adapted building with bedrooms on the ground and first floor. The main communal areas are on the ground floor.

People's experience of using this service and what we found
People who were more able had a more positive experience than those who had higher dependency needs. People who relied mostly on staff to support them had inconsistencies in their care and support. Risks to individuals and within the service were known by staff, although systems and processes for managing and responding to risks needed to be improved.

Staffing levels were kept under review and a dependency tool was used to assess the numbers of staff needed. People, staff and relatives gave mixed feedback about whether there were enough staff available to meet people's needs in a timely way. We made a recommendation the provider continues to keep people's needs under review, along with the deployment of staff within the home, to ensure people's needs are attended to in a timely way. Recruitment was ongoing to ensure staffing levels were adequate, although checks had not always robustly been completed before staff started working at the service.

Staff did not always follow correct procedures to control the spread of infection with regard to their own symptoms of illness. The home was visibly clean and mostly free from odours. Where more through cleaning was needed, this was identified by the management team and scheduled.

People were mostly supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. People were supported to make decisions, although at times, some people felt they did not have a choice about whether they came out of their room if they relied on staff to help them.

Care and support not always planned in a way that met people's needs. Care plans were not always person-centred and did not always guide staff on people's current care needs. People's preferences around end of life care were not recorded. Daily care records were not completed or sufficiently reviewed to show personal care was managed in line with people's needs and wishes.

Systems to assess, monitor and improve the service were in place but not always effective. Quality checks and audits did not always identify actions or timescales, or result in sufficient improvements where actions were identified. There were systems in place to gather feedback about the service. There was evidence of the service working in partnership with health and social care professionals.

The provider was responsive to the inspection findings and sent information to show they were taking action to address the areas of risk identified at the inspection.

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 this service was good (published 14 January 2019).

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels, quality of care and management of the home. A decision was made for us to inspect and examine those risks.

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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Aden Court Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to risk management and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Details are in our safe findings below

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our responsive findings below

Is the service well-led?

Requires Improvement

The service was not always well led

Details are in our well led findings below

Aden Court Care Home

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.

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 1 inspector, a specialist professional adviser 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.

Service and service type
Aden Court Care Home 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. Aden Court is a care home with 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 a registered manager in post.

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, the local health and care partnership, Healthwatch and professionals who work with the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spent time in communal areas observing the care and support provided by staff and visited people in their rooms. We spoke with 11 people who used the service, 3 relatives and 8 members of staff including representatives of the provider, registered manager, care staff and ancillary staff. We reviewed a range of records. This included 3 people's care records and multiple people's medicine records. We looked at 2 staff recruitment files and reviewed a variety of records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating at this inspection remains requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection; Assessing risk, safety monitoring and management;

- We were not assured the systems and processes to prevent people from catching and spreading infections were being operated safely.
- One member of staff was symptomatic during the inspection, and the relevant procedures were not followed. We brought this to the attention of the management team who reacted to reduce the risk of infection. However, this incident resulted in a COVID-19 outbreak in the service, which put people at risk.
- We found there was no available PPE in a bathroom area and staff said they were looking for what they needed. Staff reported PPE being unavailable causing delays to people's personal care. We discussed this with the registered manager who told us there was an abundance of PPE and staff needed to ensure this was prepared before they carried out their tasks.
- Risks to people's health and wellbeing were not robustly monitored and managed. These included risks associated with skin integrity, nutrition and pressure care. Although care plans satisfactorily identified risks, daily records of individual care were not sufficiently completed to show people were supported safely.
- Where people were at risk of malnutrition, the service had identified they needed to monitor how much they were eating and drinking. However, this was not being effectively done. One person's records showed they had repeatedly refused their food and fluids over several days, yet there was no evidence of this being identified as a concern, or action taken.
- Our observations with the mealtime showed staff removed people's plates even if they had not eaten, but without question or encouragement. Where people ate well, further helpings were offered. People told us they had enough to eat and drink and the management team had introduced a staggered lunch time to improve staff's availability to support them.
- There was a system in place to assess risks with premises and equipment, although this was not always robust. For example, a bath which was broken had been identified for repair on the provider's environment plan, but this was not made inaccessible and posed a hazard because of sharp exposed parts.

Systems were not sufficiently robust to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This is a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- The home was visibly clean and mostly free from odours, although we noticed one area had a lingering odour. The management team told us they were aware of this and were taking steps to address it. There was cleaning taking place and cleaning staff were knowledgeable of procedures. Relatives told us they found the home was clean when they visited.
- Staff understood how to respond to the fire alarm and role play was used to simulate evacuation

procedures in training. The management team observed staff practice to ensure this was safe, such as for moving and handling techniques.

Using medicines safely

● The service had systems and processes in place for the storage, administration, and use of medicines, although staff did not always work safely.

● On one occasion we saw the medicines trolley was left unattended and unlocked for several minutes. The management team took immediate action and the member of staff completed self-reflection to identify lessons learned.

● Where people needed topical medicines, such as creams, there was a lack of evidence this was happening in line with the prescribed directions. There were significant gaps in the recording and staff told us they did not always have time to complete the records. One family member told us their relative needed cream applied every day and told us, "But they don't do it every day".

● Written guidance was in place when people were prescribed medicines to be given 'when required' (PRN). However, for the application of creams the guidance was not always clear. For example, one person's record stated 'apply twice daily when required' but there was no other information to guide staff.

● The service used an electronic medicine administration record (EMAR) when people were supported with medicines other than topical medicines and controlled drugs (CDs). Although the EMAR was used correctly, we identified missing staff signatures in CD records for 2 occasions.

The proper and safe management of medicines was not consistently demonstrated. This placed people at risk of harm. This is a breach of regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff who administered medicines had their competency assessed and they were confident in their abilities.

Learning lessons when things go wrong

● The management team welcomed opportunities to improve practice where concerns had been identified. However, systems and processes to identify opportunities for learning were not always applied.

● Information was not always rigorously analysed to consistently identify root causes of incidents and prevent re-occurrences. For example, one person had sustained bruising due to an unwitnessed fall from bed, yet there had been no in-depth review carried out to establish how this had happened. The registered manager said this had been referred to the safeguarding team, but they would complete a more detailed investigation.

● Where there had been incidents of falls from beds, the provider ensured equipment was available to minimise the risks of repeated incidents. For example, through the use of low beds and sensor mats where appropriate.

● Team meetings and complaints investigations were used as opportunities to discuss better ways of working and share any lessons learned from the provider's other homes. The management team said they were looking to develop further opportunities to share learning across all the provider's homes.

Staffing and recruitment

● The provider used a tool to help calculate staffing levels which indicated the service had sufficient staff, and there were clear directions for staff. However, feedback from people who used the service, relatives and staff was very mixed, along with our observations.

● Some people and relatives told us there were enough staff to support them. However, others, particularly those more physically reliant on staff, said staff were not always available and did not always respond to call

bells. People who remained in bed raised concerns about the time they had to wait for staff to attend to them, such as for continence care.

● One person told us, "Almost straight away staff answer the buzzer, they might be a bit longer at night" although another person said, "On Sunday I buzzed at 10 past 2 and they came at 5 o'clock". Another person said, "I'm waiting now, I've asked someone [for assistance] half an hour ago and [staff] have gone to someone else". We waited with this person for 20 minutes and a member of staff had still not arrived.

● Staff told us they did not always have enough staff to meet people's needs sufficiently. For example, staff said they often did not have time to support people to bathe and shower, or complete documentation. One staff said, "We just try to at least make sure each person has had some kind of care, but it's a struggle."

● We heard people's call bells sounded continuously on occasion and the inspection team had difficulty locating staff to support individuals. There was an allocation sheet which showed staff duties and break times at each part of the day, although one person told us staff only did the tasks they were allocated to. They said, "Yesterday I asked for a [continence] pad change and asked [staff] to tidy up my bed." They said 2 staff came and tidied up the bed but said "We're not on pad duty". We brought this to the attention of the management team who agreed to look into this.

● The management team told us the service was overstaffed according to their dependency assessment. They assured us this was regularly monitored and recruitment was ongoing. Staff rotas showed consistent numbers of care and ancillary staff on duty.

We recommended the provider continues to keep people's needs under review, along with the deployment of staff within the home, to ensure people's needs are attended to in a timely way.

● The recruitment process had not always been thoroughly followed, although this had been identified through the provider's own checks. We reviewed 2 recruitment files for staff working in the home, 1 of which did not have complete references in place. The provider produced an audit to show this had already been identified by their own scrutiny check, although this was some time after the person was employed. The management team gave assurances they had strengthened their processes.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

● Care records mostly reflected people's capacity around specific decisions, and staff understood people's needs, although some written information was contradictory on occasion. People said they were supported to make decisions, although some people who remained in bed said they would prefer to have more daily choices about whether to get up.

● The management team told us they were encouraging staff to continuously consider how to support people's choices by increasing opportunities throughout the day to engage with people who remained in bed or in their room.

Systems and processes to safeguard people from the risk of abuse

● People and relatives told us they or their loved ones felt safe living at Aden Court Care Home. One relative told us, "Yes [feel safe], there's always somebody around."

● Staff understood safeguarding procedures and had received safeguarding training. They were confident the management team would deal with allegations of abuse appropriately.

● The management team told us staff were encouraged to speak out where they had concerns. Staff told us where they had any concerns they were able to report these appropriately.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care was not always planned in a way that met people's needs. Many people remained in their bed or in their rooms and it was not always clear about the reasons for this. Some people told us this was their choice and they had autonomy, although others said they would prefer to have more involvement in deciding where they spent their time. One person said, "I've never been out of bed, nobody offers to sit me in a chair."
- The provider had completed an overview of people's needs in relation to them staying in their bed/rooms, to determine whether this was a physical need or a preference. Some people were deemed to 'prefer to remain in bed at all times' although there was no indication of whether this was discussed daily with each person.
- We received feedback from people, staff and relatives, that people's care was not person-centred and insufficient time was spent responding to their needs and requests for support. Where people relied on staff for continence care or physical transfers, we were told they were often asked to wait long periods of time for staff support.
- Some people and relatives told us personal care choices were not always met. For example, one person said they would prefer to have a bath or a shower. They told us, "I've never been near running water since I came here [several months ago]. They [staff] always wash me in bed." Relatives expressed concerns in relation to timeliness and consistency of people's personal care, such as continence care and teeth cleaning.
- People looked well cared for. For example, people's hair was neat and their clothes were clean. However, people's personal hygiene records had gaps which suggested people had either not been consistently supported, or records were not completed. In some records, staff had stated people had refused personal care, but there was no evidence of any further intervention for repeated refusals.
- Care plans contained sufficient information for staff to understand people's physical needs. However, some person-centred information sheets in people's care records were blank. This meant staff did not always have access to information about people's likes, dislikes and preferences.

End of life care and support

- There was information in people's care records about their end stage of life plans. However, there was no information to show people's individual personal wishes and preferences had been considered, other than reference to practical arrangements.

Improving care quality in response to complaints or concerns

- There was a system for receiving, recording, handling and responding to complaints and people and relatives knew how to raise concerns and to whom.

● Many people and relatives we spoke with said they were satisfied with how to raise concerns. One person said, "[We] would talk to staff, they're very helpful, they've always got time for you" and other people agreed. One relative told us, "I've no reason to make complaints" and said when matters are raised they are usually addressed. However, they said sometimes things lapse afterwards.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● Systems were in place to meet people's communication needs. Information in people's care plans identified how their communication needs should be met.
● Staff were patient when they interacted with people and supported people to communicate in their own ways. Staff knew which people has sensory loss, such as poor eyesight.
● Some written information was not accessible to everyone, such as the menu displayed in very small print.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● There was a very attentive activities coordinator, who worked with individual people on a one to one basis where possible to enhance opportunities for conversation where care staff were otherwise engaged in physical care tasks.
● Activities in groups, such as a reminiscence session took place in the lounge area. There was an activities board in one of the corridors. People told us they enjoyed the activities. One person said, "A [member of staff] has started here, doing an entertainment programme. Gives us something to do, an interest, yesterday arts and crafts and ended up playing dominoes and bingo." People said they had been planting hyacinths.
● Since our inspection visit, there was a change to the activities coordinator and the management team told us they had appointed a new member of staff to this role.
● People and relatives gave mixed views said care staff were often too busy to support with conversations. One person said, "I can praise certain carers, the ones I've been talking about who pop in, I can praise them up to the sky". Some concerns were expressed in relation to some staff's attitude and approach.
● We discussed this with the management team who told us they were looking at ways to develop staff's skills and confidence in how to improve their engagement with people.

Requires Improvement

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 we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- There was a system to ensure regular quality checks took place, and a framework to identify who was responsible for which parts of the governance process. However, checks sometimes lacked rigour and did not always identify actions, or result in improvements where actions were identified.
- The process of recording people's care did not include effective trigger points to identify and escalate concerns about people's health and well-being. For example, where daily records showed people had repeatedly refused personal care or food/drinks, there was no system for staff to report this. This meant information was not always passed on, such as through handovers or flash meetings and therefore did not result in timely action taken.
- There were some inconsistencies in the regularity and quality of the audits, and the actions they identified sometimes lacked clarity. For example, medication audits for one month contained timescales for actions, yet subsequent audits did not. Monthly reviews of a person's care plan showed these were done only a few days apart, towards the end of 1 month and at the start of the next month.
- Accidents and incidents were recorded and the management team summarised these in a monthly review. However, there were some inconsistencies of which events were recorded as accidents and which were incidents, which prevented an accurate evaluation of trends and patterns.
- There were regular checks of equipment and premises and these helped inform the service improvement plan. Hazards in the environment were identified although not always made inaccessible. The registered manager had a daily walkaround system. However, this was not always consistently completed or robust enough to identify and address issues found at the inspection.
- Where the management team had repeatedly identified improvements needed, such as for completion of daily records, 'ongoing monitoring' was stated, rather than specific actions with clear timescales and accountabilities for improvement.

Systems were not sufficiently robust to assess, monitor and improve the quality and safety of the services provided. This is a breach of regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

- Some concerns were expressed in relation to some staff's attitude and approach. We discussed this with

the management team who told us they were looking at ways to improve the culture in the service, develop staff's skills and confidence in how to improve their engagement with people and with the management team.

● The management team carried out regular checks of staff practice and monitored performance through spot checks and supervision. Some staff said they had the right support to carry out their roles and to approach the management team at any time. However, some staff said they did not find the management team to be approachable.

● The provider ensured the registered manager had support from senior managers. There were regular visits from the senior management team who worked alongside the registered manager to support the running of the home and the staff team. Staff were encouraged and reminded of the open-door policy in the service and that they had access to the management team whenever they needed.

● Surveys were used to gain feedback from staff, people and their relatives, as well as visiting professionals. Where feedback was received, there was evidence of actions taken through a 'you said, we did' summary.

Working in partnership with others; Continuous learning and improving care; 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

● There was clear evidence of the service working closely with others and there was regular engagement with the local authority, other professionals and relatives in support of people's care.

● The provider welcomed suggestions and ideas about how the service could be improved. They responded to local authority feedback and developed action plans to help drive improvements where needed.

● The provider understood their responsibilities under the duty of candour and the need to make statutory notifications to CQC.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not sufficiently robust to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. The proper and safe management of medicines was not consistently demonstrated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not sufficiently robust to assess, monitor and improve the quality and safety of the services provided.