Aden House Limited

Aden View Care Home

Inspection report

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Date of inspection visit:
05 June 2017
06 June 2017

Date of publication:
14 July 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection of Aden View took place 5 and 6 June 2017. The location had been previously inspected during January 2016 and we found a breach of regulation at that time, relating to good governance. The service was found to require improvement. We received an action plan from the registered provider to show how they would address the breach. During this inspection, we checked to see whether improvements had been made. We found the areas identified in the action plan had been addressed and improvements were evident. However, we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to consent.

Aden View Care Home is registered to provide personal care and accommodation for up to 46 older people. The accommodation is provided over two floors, the first floor being accessed by a passenger lift. All bedrooms have en-suite facilities. There are a number of communal areas and dining rooms. There is a unit called Primrose for people living with dementia and other cognitive impairment. At the time of the inspection there were 43 people living at the home.

There was a registered manager in post and this person had been registered with the Care Quality Commission since March 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe living at Aden View. The registered manager and staff were aware of relevant procedures to help keep people safe and staff could describe signs that may indicate someone was at risk of abuse or harm. Staff had received safeguarding training.

Staff were recruited safely and there were sufficient numbers of staff deployed to meet people's needs. Staff told us they felt supported and we saw evidence staff had received appropriate induction, training and ongoing support.

Risks to people had been assessed and measures put into place to reduce risk. The building was well maintained and regular safety checks took place.

Medicines were managed, stored and administered safely and appropriately, by staff who had been trained to do so.

People were supported to have choice and control of their lives and we observed staff supported people in the least restrictive way possible; however, the principles of the Mental Capacity Act 2005 were not always followed.

We observed staff to be kind and supportive and people told us staff were caring. We observed people's

privacy and dignity was respected. There was a pleasant, relaxed atmosphere in the home.

Care records were person centred and reviewed regularly. A 'resident of the day' system helped to ensure people were regularly involved in reviewing their care and support at Aden View. People told us they could make their own choices in relation to their daily lives. Appropriate information was shared between staff to enable continuity of care.

Staff told us they felt supported by the registered manager and people and their relatives spoke positively about the registered manager. Meetings such as staff meetings and residents' and relatives' meetings were held regularly. The compliance review undertaken by the registered provider's internal team highlighted the need to improve Mental Capacity Act 2005 associated work. The registered provider had developed an action plan to address this work, which was ongoing at the time of the inspection.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe.

Medication was managed well and was administered in a safe way by staff that had been trained to do so.

Risks to people were assessed and measures were in place to reduce risks.

Sufficient numbers of staff were deployed to help keep people safe.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the Mental Capacity Act 2005 were not consistently applied.

Staff had received induction and training; however our observations showed some staff lacked effective dementia care awareness.

The service had received an award for being committed to good standards of food hygiene and providing healthy food options.

Is the service caring?

Good

The service was caring.

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

People's privacy and dignity were respected.

Advocacy support was provided for people where this was appropriate.

Is the service responsive?

Good

The service was responsive.

Care plans reflected people's needs, preferences, choices and personal histories.

We observed people making their own choices relating to how they wanted their care to be provided.

People knew how to complain if the need arose and complaints were well managed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered provider had not ensured compliance with all of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt supported by the registered manager.

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

Up to date records were kept in relation to the care and support provided.

Aden View Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 5 and 6 June 2017 and was unannounced. The inspection was carried out by two adult social care inspectors and an expert by experience on the first day of the inspection and an adult social care inspector on the second day of the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home and gathered information from the local authority, including the commissioning and safeguarding teams, and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The registered provider had been asked to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help plan and inform our inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home, including 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. We spoke with 15 people who lived at the home, two relatives, three care and support staff, an activities coordinator, a cook, a senior shift leader, the registered manager and a visiting health care professional.

We looked at seven people's care records, four staff files and training data, as well as records relating to the management of the service. We looked around the building and saw people's bedrooms, bathrooms and other communal areas.

Good

Is the service safe?

Our findings

People told us they felt safe living at Aden View. We were told, "I feel very safe here, they look after me very well." Another person said, "They have to use the hoist with me all the time but they have never hurt me and they are so reassuring when I'm in it." A relative told us, "I'm 100% confident about my [relative]'s safety here. I have not had a minute's worry since they have been here."

The registered provider had an up to date safeguarding policy and the registered manager, and all the staff we asked, were aware of safeguarding procedures and knew what constituted potential abuse. This helped to keep people safe because staff had knowledge of appropriate action to take if they had concerns people were at risk of abuse or harm.

Risks in relation to the environment were assessed and these were specific to the individual person, such as whether the person could use their call bell or access their bedside lights. Risks relating to falls were assessed and we saw these were regularly reviewed. These considered the person's gait, sensory needs, history of falls and medical history for example. Risk reduction measures were in place to reduce identified risk, such as bed rails, pressure mats and call bells.

Other risks, such as those relating to nutrition or skin integrity, were assessed using recognised assessment tools. These were regularly updated. Care records contained detailed moving and handling instructions. Where equipment was used to assist people to move, the type of equipment and associated sling were detailed as well as information relating to the method of application and how to safely support the person. This helped to ensure risks were reduced and staff were given appropriate information to assist people to move safely. Staff assisted people to move in a confident, safe and efficient manner. Having risk assessments in place helped to ensure people could be encouraged to be as independent as possible whilst associated risks were minimised.

We reviewed the care record for a person who had recently been admitted to the home, within the last two weeks. We found a detailed care record for the person, including assessments of risks and an emergency evacuation plan personalised to the individual. Their food and fluid intake was being monitored in order that the person's initial intake could be assessed. This showed measures were in place to assess and reduce risks to people in a timely way.

We observed safe care and treatment being provided. For example, people were sitting on pressure cushions when this had been assessed as required, in order to maintain their skin integrity. Other pressure relieving equipment was also in use, such as heel pads and pressure relieving mattresses. When staff assisted people to move, for example from wheelchairs to armchairs, staff ensured pressure cushions were moved with the person.

The door to the home was secure upon arrival and a member of staff granted entry, after checking our identification. This helped to keep people safe because access to the home was controlled.

Regular safety checks took place throughout the home, such as fire alarms and emergency lights. Tests such as gas and electrical safety and portable appliances had been completed. Records showed equipment was examined regularly, such as bedrails and wheelchairs. This helped to ensure the safety of premises and equipment.

There was a 'grab bag' in the office containing a high visibility vest and a torch and personal emergency evacuation plans (PEEPs), together with a plan of the building. This helped to provide staff with information they would need in order to ensure people could be evacuated in an emergency situation.

We saw accidents and incidents were logged and records showed appropriate actions had been taken. We saw trends were analysed, such as in relation to the time or place of falls.

The registered manager used a dependency tool, which was used to help calculate the numbers of staff required in order to meet people's needs. The tool considered needs in relation to mobility, personal hygiene, continence and the required level of assistance for dressing and for eating for example. We observed people's needs being met in a timely manner by staff during our inspection. Staff took time to speak and interact with people. All of the staff we asked told us they felt there were sufficient numbers of staff to keep people safe, although some staff told us they would prefer there to be more staff so they could, "Spend more time with residents." We observed the number of staff identified as being required were deployed throughout our inspection.

We inspected four staff recruitment files. We found safe recruitment practices had been followed. For example, the registered manager ensured reference checks had been completed, identity had been verified and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

Medicines were administered in a calm and patient manner by a senior shift leader who had received specific training to ensure medicines were safely administered, and their competency had been regularly assessed. We saw the member of staff observed people discreetly to ensure their medicines had been taken and only then did the staff member record the medicines as taken. The member of staff used an effective recording system which showed whether the person had taken their medicine or whether the medicine had been declined

At the front of each medicines administration record (MAR) was a 'medication profile format.' This contained a photograph of the person and information relating to any allergies, preferred method of taking medicines, any contra-indications and specific requirements. This helped to ensure medicines were administered appropriately, to the correct person.

Some medicines, such as paracetamol for example, were administered on a PRN (or, as required) basis. We found PRN protocols were in place which helped to ensure these medicines were administered appropriately and at safe intervals. Medicines records included a pain scale which helped the staff member to identify whether a person was in pain, by observing their body language. This further helped to ensure PRN medicines were administered appropriately.

Good infection control practices were observed. For example, medicines were popped into pots, without the member of staff touching the medicines.

We checked the controlled drugs, which are prescription medicines that are controlled under Misuse of Drugs legislation. These were stored securely and logged in the register as required. We checked a random

sample and found the amount of medicine remaining was correct, according to the register. This showed controlled drugs were managed appropriately.

Some people were prescribed topical creams. Records showed when these had been applied and body maps were used, which helped to ensure creams were applied correctly.

The home looked and smelled clean and fresh. Cleaning schedules and records showed regular cleaning took place. Specific risk assessments were in place to reduce risks associated with particular infections such as MRSA. We observed staff using personal protective equipment, such as gloves and aprons, throughout our inspection. This helped to prevent and control the risk of the spread of infection.

Requires Improvement

Is the service effective?

Our findings

We asked people and their relatives whether the service was effective. One person told us, "They [staff] help me clean myself. They're very good. When I go to appointments they help me." However, some other comments were not as positive. A further person told us, "The food doesn't seem to be as good as it used to be," and a relative felt, "No-one is trained to deal with dementia as a specialist." A further relative told us their family member was, "Occasionally dressed in other people's clothes, although they are in keeping with their style."

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

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

We checked whether the service was working within the principles of the MCA. People who lacked capacity to consent to their care and treatment, and who were being deprived of their liberty in order to receive care and treatment, had DoLS authorisations made to the relevant supervisory body.

A principle of the MCA is that mental capacity assessments are decision specific because some people may have capacity to make some decisions but not others. However, although mental capacity assessments had been completed, we did not see decision specific mental capacity assessments, in line with the requirements of the MCA. For example, one person who lacked capacity to consent to residential care and treatment had bed rails in place. Whilst we saw records to show some people with capacity provided consent for bed rails, there was no evidence of mental capacity assessments or best interest decisions in relation to this specific decision for those people who lacked capacity to consent to bed rails. This meant the principles of the MCA were not being followed.

One of the mental capacity assessments we inspected stated the person had, 'fluctuating capacity,' but did not refer to any specific decision for which the person's capacity was being assessed.

Two of the care records we inspected indicated the person had capacity to consent to their care and treatment. However, these care plans also contained a record to show a decision had been made in the person's best interests in relation to their care and treatment. If a person is able to consent to their own care and treatment it is unlawful for a decision to be made by others in their best interests.

We saw written consent to care had been sought and provided by family members in some cases. However, the section of the form which indicated whether the family member had Lasting Power of Attorney had not

been completed and the registered manager could not confirm this. This meant some family members were providing consent when they may not have had the power to do so.

The above examples demonstrated lack of awareness of the MCA and a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because care and treatment was not always provided with the consent of the relevant person and staff did not act in accordance with the requirements of the MCA.

We looked at staff induction and training records. We found staff had received a thorough induction into their role, which included shadowing more experienced members of staff. Records showed staff knowledge was assessed once their induction had been completed, which helped to ensure staff had the knowledge and skills required to perform their duties effectively. A member of staff told us, "I shadowed others and wasn't count in numbers at first. Other staff are very supportive and always encouraging me." Another member of staff told us, "People are safe, we're all trained properly."

Records showed staff had received training in areas such as safe administration of medicines where appropriate, safeguarding, life support, fire safety, diet and nutrition, safe moving and handling and dementia awareness.

The registered provider's policy indicated staff would have supervision a minimum of six times each year and records showed staff received regular supervision. However, this was not evidenced as a two-way discussion and records showed this was often a forum for the registered manager to address specific concerns, as opposed to an opportunity for staff to reflect and discuss any of their needs or concerns. We shared our findings with the registered manager who was receptive to this and advised they had an 'open door' and staff could speak with the registered manager at any time about any concerns. However, the registered manager agreed this was not recorded as supervision. Staff told us they felt supported in their roles and would feel able to request further support or training if they felt this was required.

We asked to see appraisals of staff performance. The registered manager told us these had not taken place but were being planned. Records showed the registered manager was in the process of arranging this and we saw staff had completed their own contribution to the appraisal of their performance. This included an appraisal of staff performance, strengths, weaknesses, development needs and progress. This meant staff had not received a formal appraisal of their performance. However, the registered manager had already begun taking actions to address this.

People living with dementia can experience difficulty with orientation. Displaying information such as the day, date and time can be beneficial in reducing anxiety. A notice board was displayed, showing the day and date, names of staff on duty and the available choices from the menu. We saw this was up to date and correct on each day of our inspection.

The activities coordinator had received dementia awareness training and demonstrated a sound understanding of how to deliver person centred care and was a 'Dementia Friends Champion.' The registered manager told us the home was working to improve their dementia care. We saw a 'dementia strategy implementation plan' had been developed, with input from an external consultant, engaged by the registered provider. Actions such as developing skills in cognitive therapies, developing dementia champions and a dementia refurbishment plan were underway.

Although staff were enthusiastic and caring, we felt some staff would benefit from further dementia specific training. For example, on the Primrose unit which provided care and support to people living with dementia,

we saw two people attempting to eat their meal with a knife. Although staff attempted to verbally advise both people, staff did not intervene when people did not appear to understand what staff were saying. One person's plate was taken away having eaten only a little.

Some people living at Aden View, at times, displayed behaviours seen as challenging to others such as verbal or physical aggression. An ABC chart was in place for one person living at the home, whose behaviour may have challenged others. The ABC approach is a way of characterising events and resultant behaviours. However, we saw the charts had not been completed to enable effective analysis. For example, in nine out of the 17 entries made from 1 June 2017, staff had not completed section 'B' which referred to, 'the behaviour itself and a description of what actually happened or what the behaviour looked like.' Some other entries lacked information relating to staff intervention. We shared our concern with the registered manager and area manager who agreed to consider this further. The area manager told us they were considering mentoring for staff in order to improve practice.

The home had been awarded a, 'Kirklees Healthy Choice Gold Award,' during April 2017 for being committed to good standards of food hygiene and healthy food options. The Healthy Choice Award is a way of acknowledging businesses that practice good standards of food hygiene and offer healthy options.

There were two choices of meals offered twice a day and people could choose what they wanted to eat at breakfast time, including a cooked breakfast. We saw people being given choices during our inspection.

The cook and kitchen staff were made aware of people's individual dietary requirements, such as those people with any allergies or diabetes. Some people's foods were fortified, to promote extra calories.

We observed a mealtime experience at Aden View. Meals were served in the dining area on each unit, but with some people choosing to stay seated in the lounge area. Tables were set with cutlery, tea cups and saucers and jugs of water or juice. Flowers were also displayed on tables which helped to create a pleasant atmosphere. People were given a choice in relation to drinks and meals and were able to choose for themselves whether or how much sauce or gravy they wanted. We heard staff asking people, "how much would you like?" and "is that okay for you?" This demonstrated people were able to make their own choices and retain some control over their mealtime experience.

People who chose to stay in the lounge area were brought tables and their meals were placed within reach.

On the residential unit, we saw staff offered assistance to people without taking away people's independence and without being obtrusive. For example, staff could be heard saying, "Would you like me to cut this up for you?" and, "Just let me know if you want some help with that."

The mealtime experience on the Primrose unit, which provided care and support to people living with dementia, showed some staff lacked some of the skills and knowledge required to support people living with dementia such as providing appropriate assistance with eating meals.

There was a homely atmosphere and environment at Aden View. Appropriate pictures were placed on walls, including some pictures of activities which had taken place at the home. As well as the larger communal areas, there were smaller, quieter areas where people could sit and relax or chat to others. There was access to a well maintained garden area.

Records showed referrals were made to appropriate health care professionals such as doctors, district nurses, community psychiatric nurses, diabetes specialists and the care home liaison team. The care home

liaison team is a liaison service which offers care home staff support in their care planning to enable them to better meet the needs of their residents, improve their well-being and minimise risks. We spoke with a healthcare professional during our inspection, who told us they felt the staff and registered manager at Aden View were receptive to their input and acted upon their advice. We were told, "I've never seen anything of concern. They [staff] are proactive in seeking support when required. They put an additional member of staff when this was required." This showed people living at the home received additional health care support to meet their care and treatment needs.

Records showed a person had been visited by a community psychiatric nurse (CPN) and advice and information was provided by the CPN. We saw this advice was documented and incorporated into the person's care plan immediately, to enable staff to follow the advice. Staff confirmed to us they accessed care plans and regularly refreshed their knowledge in relation to the care and support people required. This further demonstrated people received appropriate health care support because staff followed the advice and directions of health care professionals.

Good

Is the service caring?

Our findings

People told us staff were caring. One person told us, "The staff are absolutely marvellous. I need a lot of looking after and the staff are always on the ball. When they're doing anything really personal, I always have a laugh and a joke with them, it helps to take away my embarrassment." Other comments included, "Staff are lovely, they really care," and, "Everyone's so friendly and lovely."

There was a happy, pleasant atmosphere within Aden View. This was evident through the sound of people singing, laughing and talking and people were smiling. We observed staff spontaneously burst into song with people and dance with people.

We heard a person asking a member of staff about their family. The member of staff took the time to share photographs with the person and we saw caring and mutually respectful conversations taking place.

Staff pre-empted people's needs which helped people to be more comfortable. For example we saw staff identified a person was not wearing their glasses so they asked the person, "[Name], can I put your glasses on?" The person agreed and was assisted by the staff member. On another occasion staff identified that a person may be more comfortable with a blanket so they asked the person and brought them a blanket. This showed staff were attentive and tended to people's wellbeing.

Staff were aware of people's needs and treated people with respect. When staff were writing records or updating documentation, they broke off to converse with people and interact in a positive caring way.

When staff assisted people to move, they offered appropriate reassurance and ensured people's dignity was maintained. We heard a member of staff ask a person if they were ready to be assisted to move. Once the person confirmed they were ready, staff supported the person appropriately and could be heard saying, "Are you okay?"

We observed staff protected people's dignity when providing care and support. For example, staff were discreet when offering people assistance with continence care. People's privacy was also respected. We observed staff knock on people's doors.

We saw, in people's care plans, consideration had been given to people's needs in terms of sexuality. This was respectfully approached with an initial question of, 'Is the resident happy to answer the following questions?' The care plan then indicated details of the person's relationships, whether they had a spouse, civil partner or partner and included details regarding the level of privacy the person may require and whether visits would be preferred in their own room. Consideration was given during the care planning process to people's faith or religious needs and how or whether people wished to actively practice their religion. The registered manager was engaging with local religious leaders in order try to ensure people's needs were met in terms of practising their religion, should they wish to do so. These examples showed people were enabled to express themselves and equality and diversity were embraced.

Care plans reflected the need for people to make their own choices and decisions where possible. For example, one care plan stated, '[Name] is not always able to choose what [Name] would like to wear but staff need to show [name] different outfits and they may indicate yes or no to that outfit.'

Two people living at the home had accessed an advocate when this was appropriate. An advocate is a person who is able to speak on another person's behalf when they may not be able to do so, or may need assistance in doing so, for themselves.

Care plans contained information relating to people's choices in relation to end of life care. Information such as what the person would like to happen and, importantly, what the person would not like to happen were explored, as well as where the person would like to receive end of life care and what elements of care were important to the person. This showed people's end of life wishes were given consideration during the care planning process.

Good

Is the service responsive?

Our findings

People told us the service was responsive to their needs. One person told us the registered manager had arranged for support for the person so they could attend an event that was very important to them. Another person told us a specific table had been obtained for them so they could access their necessities whilst using their wheelchair. A relative told us, "They know my [relative] intimately, all of their little foibles and that means they can spot when something's not quite right."

We reviewed seven care records and saw people's needs were assessed prior to them moving into Aden View. The records we inspected included relevant information about people's health, support and care needs. Plans contained a photograph of the person and details of their life history, including previous occupations and likes and dislikes. People's needs, such as those in relation to the environment, personal hygiene and oral care, dietary needs, communication, mobility, activities, sexuality and mental health needs were detailed within care plans.

Our observations showed people were provided with care and support in line with their care plans. We saw one person's care plan stated, 'Talk to [name] about what we are going to do, as in, 'Now we're going to help you…have a wash.' Reassure if [name] becomes anxious.' We observed staff followed this plan during our inspection. Another person's plan indicated staff should ensure the person was wearing their glasses. We observed the person to be wearing their glasses and when a member of staff observed the person had removed their glasses, the person was respectfully asked if they would like assistance to put their glasses on.

We reviewed the care record of a person who had been living at the home for less than two weeks. Their care record contained relevant information pertaining to the individual, including a photograph and details regarding the person's likes and dislikes and level of support required. This enabled staff to provide appropriate care and support to the person.

We spoke with people living at the home, including two people who showed us their private rooms had been arranged in a way to suit their preferred living arrangements. This demonstrated the registered manager was responsive to people's needs and developed personalised care and living arrangements for people.

Care plans contained information to assist staff to effectively distract people when this was necessary. For example, one person's care plan stated, 'Try to distract [Name] by asking if they would like to go for a walk or come and listen to music as [Name] likes music and dancing.' The staff we asked told us they accessed people's care plans regularly and were aware of the content. A member of staff described the distraction techniques they used and we observed staff engaging positively with people using appropriate techniques.

Daily records, which documented the care and support people had been offered, consisted of tick sheets and individually written entries each day. Records showed people had received support in relation to oral care, personal hygiene, skin care and nail care for example. Where people had declined or refused care and support, this was also recorded. This meant records were kept of the care and support offered and provided

to people.

The registered manager told us people were involved in devising their care plans and we saw evidence of this. The home had a system, whereby each person living at the home would be 'resident of the day' once a month and the person's needs were reviewed. Records showed people, and their relatives where appropriate, had been asked for their views and had contributed towards evaluating their care through this process, although this was not formally recorded as a review. Areas such as risks, needs, meal planning, housekeeping, activities and any maintenance issues were discussed and action taken. We looked at records for the month of May for the 'resident of the day.' These showed discussions had taken place regarding care plans and we saw evidence, where a relative was unable to attend on that day, they were contacted by telephone so they could contribute. This showed people were involved in their care planning.

The registered provider employed a person who was dedicated to coordinating activities within the home. People were offered a range of social activities in-house or in the community. Activities included dancing, bingo, dominoes, arts and crafts, armchair exercises and games to stimulate reminiscence. We asked the member of staff who was responsible for planning activities how they ensured activities were person centred. We were told, "Looking at the person and not dementia." The activities coordinator demonstrated a sound understanding of person centred care. We observed two members of staff playing with a balloon and passing this to people. People were smiling and laughing and enjoying the activity. In addition, the home held open days and engaged with the local community.

People confirmed to us they could make their own choices. One person told us, "I like to get up really early. I always have. They know that so help me get up when I want. Oh yes, I can do what I want." Another person told us, "I stay in my room all the time by choice. They have lots of activities but I'm not into all that. I like to stay in my room".

The registered provider had a policy for managing complaints. Records showed, since our last inspection, one complaint had been made by a person. We saw the registered manager followed the procedure and the person was satisfied with the outcome. Staff were knowledgeable and clear of the actions they would take if a complaint was raised. This demonstrated complaints were managed appropriately.

We looked at handover records which showed appropriate information was shared between staff, for example information in relation to people's mobility, diet, food and fluid intake, medical history and other relevant information. This enabled continuity of care when staff changed.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager in post, who had been registered with the Care Quality Commission (CQC) to manage the home since March 2016.

Comments from people in relation to the registered manager were positive. One person told us, "The manager is marvellous. She doesn't miss anything and she never looks down on anybody. She's very friendly."

Some comments from the most recent questionnaires sent to people and their relatives included, 'Consistency of team members has been very good and there hasn't been a high staff turnover within the home,' and, 'The staff are fabulous.'

A member of staff told us, "Management are very supportive." Another staff member said, "If I had any concerns, I wouldn't be afraid to voice those concerns."

The registered manager spoke highly of the registered provider and told us they felt supported. We were told, "I have a lot of support from the area manager and operations. They're a really good support." The registered manager said, in relation to the staff working at Aden View, "We have brilliant staff, who work so hard."

Staff we spoke with felt there was an open culture at Aden View. We were told by a staff member, "I'm able to admit any mistakes. We always work as a team. We have regular staff meetings."

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

The registered manager engaged with people, relatives and staff, through meetings and quality assurance questionnaires for example. Questionnaires were sent to people and their responses were sent to the support office, which were then analysed. Summarised responses and any actions required were shared with the registered manager, in order for action to be taken where necessary.

Staff told us they had regular meetings and records showed meetings were held with different groups of staff, including night staff. Records from meetings showed staff were reminded of the need to ensure people's choices and needs were met and staff were thanked for their hard work. A staff member said, "The manager gets us all talking, sharing different ideas. They are very beneficial." Meetings are an important part of a manager's responsibility to ensure information is disseminated to staff appropriately and to come to informed views about the service.

Records showed the last residents' meeting was held during April 2017. Items such as laundry, residents' views in relation to staff, quality of meals, activities and the management of the home were discussed. Positive comments were recorded such as, 'We discussed other activities but residents were happy with the

current programme,' and, 'Residents very pleased with the management and feel if they have any concerns they would feel comfortable and confident reporting them.'

The registered manager told us regular compliance visits from the registered provider took place. These resulted in action plans and the registered manager told us they received feedback following these visits. The registered provider held regular quality meetings. Monthly quality and risk meetings took place which considered the quality of service provision in line with the CQC's key lines of enquiry.

Monthly audit quality reports relating to people's dependency, weight, pressure ulcers, infections and any medication errors, accidents or incidents and hospital admissions were submitted to the registered provider. These were discussed at quality meetings and actions were taken to address any areas of risk or concerns. The compliance review undertaken by the registered provider's internal team highlighted the need to improve Mental Capacity Act 2005 associated work. The registered provider had developed an action plan to address this work, which was ongoing at the time of the inspection.

Monthly medication audits took place and these considered storage temperature checks, reconciliation of medicines, whether medicines had been recorded appropriately and whether medicines trollies were clean. Regular mattress audits took place to ensure suitability of mattresses.

We saw the outcome of an activities audit from April 2017 stated, 'To chase up a new Vicar/Priest for in-house prayers.' We saw this had been undertaken and the registered manager was communicating with local religious leaders. This demonstrated, where activities audits identified issues, these resulted in actions.

Records showed the registered manager regularly undertook a 'walk-about' within the home. Areas such as staffing levels, resident falls, documentation, activities, pressure equipment settings and call bell response times were monitored. Records showed daily flash meetings took place, during which staffing, resident concerns, catering, maintenance, housekeeping and activities were discussed. This showed the registered manager was proactive in monitoring the quality of care.

Up to date policies and procedure were in place, for example in relation to safeguarding, whistleblowing, medicines management, complaints and infection control. This helped to ensure current, up to date, guidelines were being followed.

We saw a notice advertising a care home open day, which indicated, 'All are welcome.' The registered manager had arranged for children from a local school to attend a 'Teddy bears' picnic' at the home. This showed the registered manager engaged with the local community.

Up to date records were kept which reflected the care and support people had been provided. For example, food and fluid charts were recorded and up to date where this was identified as necessary and records showed appropriate support was provided for people who required assistance to change position regularly. This showed contemporaneous records were kept as required.

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 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always provided with the consent of the relevant person and staff did not always act in accordance with the requirements of the Mental Capacity Act 2005.