Mauricare Limited

Aston Manor

Inspection report

Moorlands Road
Dewsbury
West Yorkshire
WF13 2LF

Tel: 01924439321

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19 April 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Aston Manor on 10, 13 and 19 April 2017. The first day of inspection was unannounced. This meant the home did not know we were coming.

Aston Manor is a care home registered to provide nursing and residential care for up to 32 people. It consists of one building with two floors, although the upper floor has a split level. All bedrooms are single with ensuite facilities.

On the ground floors there is a communal lounge and separate dining room. On the upper floor there is a communal lounge with dining area. Both floors also have shared bathrooms, toilets and shower rooms. The home has an enclosed garden area with seating.

At the time of this inspection there were 24 people living at the home; one person was in hospital.

Aston Manor was last inspected in July 2016. At that time it was rated as 'Requires Improvement' overall. It was deemed to be 'Requires Improvement' in the domains of Safe, Effective, Responsive and Well-led, and 'Good' in the domain of Caring. A warning notice for a breach of regulation relating to good governance from the previous inspection was re-issued. We asked the registered provider to send us an action plan to tell us how they were going to tackle breaches of regulation relating to safe care and treatment, safeguarding service users, receiving and acting on complaints and staffing. At this inspection we found on-going and multiple breaches of the regulations in relation to safe care and treatment, staffing, safeguarding service users and good governance and further breaches in relation to consent and dignity. We are currently considering our options in relation to enforcement and will update the section at the back of this report once any enforcement action has concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Not all incidents of abuse involving people living at Aston Manor had been reported to the local authority safeguarding team and to CQC, as is required.

One person was using mobility equipment they had not been assessed for. Care staff were assisting another person to move using equipment they had not been trained to use and which the person had not been risk assessed for thereby placing them at risk of falls and injury.

Risks to people, such as skin integrity, choking, bedrail use, and the support required to move safely to bathe or shower, had not been assessed.

People were supported to take their medicines in a person-centred way, however, we found concerns with the way medicines were stored and their administration recorded.

Most parts of the home were clean, but some were not. We observed poor infection control practice during the inspection. The temperature of water in shared bathrooms and toilets had not been tested to make sure it was at a safe level.

Feedback about staffing levels from people, their relatives and care staff at Aston Manor was mixed. Rotas showed day and night shifts were regularly understaffed according to the levels required based on the home's dependency tool.

Staff had not received the training they needed to support people effectively. A care worker new to health and social care had not been enrolled on the Care Certificate or equivalent training.

People's care records showed some decisions had been made for them in their best interests when an assessment of their capacity to make these decisions for themselves had not been made. This was a finding at the last inspection in July 2016.

One person admitted to the home in 2012 who lacked capacity to consent to their living arrangements did not have a Deprivation of Liberty Safeguards authorisation in place.

People's nutritional documentation did not always contain a complete and accurate account of the care and support they received. During mealtimes we observed people in the dining area had a better dining experience and received more support than those served their meal in the lounge area, who lacked support to eat and drink.

The majority of interactions we observed between care workers and people at the home were positive. We also witnessed interactions which were less positive, when people's dignity had not been maintained or promoted.

The quality of care plans in place at Aston Manor varied. Some care plans were individualised and contained person-centred detail, whereas others we saw were either generic or missing altogether. People told us they had not been involved in designing or reviewing their care plans; we saw no evidence in people's care plans as to how they had taken part in the care planning process.

Concerns raised at the previous two inspections relating to the registered provider and manager's oversight of the quality and safety of the service remained. We found issues which had not been identified by audit and multiple breaches of regulation were repeated.

Recruitment records showed most checks had been made to ensure staff suitable to work with vulnerable people had been employed. Gaps in two care workers' employment history and the reason one care worker's last employment contract had been terminated had not been documented, as is required by the regulations.

People's access to meaningful activities was limited. We recommended the service source nationally available guidance on activities for people living with dementia and use it to update their activities provision.

Some aspects of the home had been adapted to better meet the needs of people living with dementia. We recommended aspects, such as the contrast in carpeting and between walls and handrails, were improved.

Of the people and relatives we spoke with, only one relative had raised minor concerns about the service. They said these had been acted upon. Records showed all official complaints were now recorded, investigated and responded to appropriately. We recommended the complaints policy be displayed where people living at the home could access it.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Not all incidents of abuse between people at Aston Manor had been reported to the local authority safeguarding team or to CQC.

People were mobilising or being supported to move by staff using equipment they had not been assessed for.

Some risks to people had not been assessed or managed properly. We found concerns around the documentation of medicines administration.

Parts of the home and some equipment used to support people were not clean.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received the training and supervision they needed to support people effectively. These were issues identified at the last inspection.

The home was not compliant with the Mental Capacity Act 2005. This was also the case at the last inspection.

We observed differences in the dining experience and level of support people received to eat and drink.

Is the service caring?

Requires Improvement

The service was not always caring.

Most interactions between care staff and people we observed were positive, but some were not.

People were not involved in designing and reviewing their care plans. They had access to advocates when they needed help to make decisions.

Staff had not received training in end of life care but could describe the most important aspects. The level of detail in people's end of life care plans varied.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The quality of people's care plans was mixed. Some contained person-centred detail and others were generic.

Daily records did not always evidence people were supported according to their care plans. People's access to meaningful activity was limited.

None of the people or relatives we spoke with had made a formal complaint. The system of receiving and responding to complaints had improved.

Is the service well-led?

Inadequate

The service was not well-led.

Breaches of regulation identified at the last inspection had not been resolved. The registered provider and manager's oversight of quality and safety was poor.

Records showed management held regular meetings with people and relatives, and with staff at the home. Relatives had been given surveys, but people who used the service had not.

People told us the home was well-managed; half of the relatives we spoke with agreed.

Aston Manor

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.

This inspection took place on 10, 13 and 19 April 2017. The first day was unannounced. The inspection team consisted of two adult social care inspectors and one 'expert by experience' on the first day of inspection, and one adult social care inspector on the second and third day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this inspection had been a carer for an older person living with dementia.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the 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 the inspection.

As part of the inspection we reviewed the information we held about the service and requested feedback from other stakeholders. These included Healthwatch Kirklees, the local authority safeguarding team, the local authority infection prevention and control team, and the Clinical Commissioning Group. After the inspection we spoke with two other healthcare professionals who visited the home regularly. Feedback was mixed; concerns were shared about staffing levels, the quality of care plans, evidence of staff training and record-keeping, whereas comments about staff were positive.

During the inspection we spoke with four people who used the service, six people's relatives, five members of care staff (including nurses), the registered manager, and a cook.

We spent time observing care in the communal lounges and dining rooms and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us.

As part of the inspection we looked at three people's care files in detail and selected care plans from 12

other people's care files. We also reviewed three staff members' recruitment and supervision documents, staff training records, six people's medicines administration records, accident and incident records, and various policies and procedures related to the running of the service.

Inadequate

Is the service safe?

Our findings

All the people we spoke with told us they felt safe at Aston Manor. One person told us, "These girls (care workers) are magnificent, kind and friendly. They do their best." Relatives also felt their family members who used the service were safe. One relative commented, "I think [my relative] is safe here. They work very hard."

At the last inspection in July 2016 we identified a breach of the regulation relating to safeguarding people, as a safeguarding incident between two people living at the home had not been reported to the local authority safeguarding team. At this inspection we reviewed safeguarding records to check incidents had been reported appropriately and promptly. We also reconciled the records of safeguarding incidents with statutory notifications made to the Care Quality Commission (CQC), as registered managers and providers have a legal duty to inform CQC of any actual or suspected abuse suffered by a person using their service.

We checked nine incidents recorded at the home with the local authority. One incident had been logged with the out of hours safeguarding team who asked staff at the home to call back the next day during working hours, but this had not been done. Another incident had not been reported to them; the other seven had. Eight of the nine incidents had not been notified to CQC as is required. This meant the local authority safeguarding team and CQC had not been informed of all incidents between people at the home and could not therefore take appropriate action.

Failure to provide information about safeguarding concerns to the local authority safeguarding team and to CQC was a continuous breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in July 2016 we identified a breach of the regulation relating to safe care and treatment as people were supported to move using shared equipment and equipment they had not been assessed for. At this inspection we noted two unlabelled zimmer frames in a corridor when we arrived on the first day. We asked two care staff whose they were and neither knew. One said, "They should have people's names on. Otherwise they might be peoples who are deceased." Later the same morning we observed one person mobilising with an unlabelled zimmer frame. Zimmer frames are adjusted to an individual's specifications, for example, their height. When we asked a care worker they checked the person's room for their labelled zimmer frame but could not locate it. This meant people were still using mobility equipment they had not been assessed for and were therefore at risk of falls.

At the last inspection two handling belts were in use at the home. Staff were using them to support people to move, although people had not been assessed properly for their safe use. At this inspection records showed only one person was being supported to move with a handling belt. Two care workers we spoke with said they had used the belt to support the person. One said they had received training in the past for this but could not remember when; the other had received moving and handling training in 2017 since starting work at the home but this had not included the use of handling belts. Another member of care staff told us staff no longer used the handling belt as the person's mobility had improved. When we reviewed the person's care records, there was no risk assessment in place for the use of a handling belt and this was not

included in their mobility care plan as a method of support they required. This meant the person was placed at risk of falls because they were being supported with equipment they had not been assessed for and by staff who lacked the appropriate training.

During this inspection we observed five examples of unsafe moving and handling of people by care staff. Two manoeuvres involved care staff lifting people by their underarm areas, so-called 'drag-lifting'; we reported our concerns to the local safeguarding team. Three manoeuvres involved care staff partially taking people's weight by supporting them by their underarm areas. Supporting people to move in this way can be very painful for the person and can injure care workers. This meant people were placed at risk by unsafe moving and handling procedures. We raised this with the registered manager. They spoke with the staff involved and organised further moving and handling training for care staff to take place shortly after the inspection.

Concerns with moving and handling demonstrated a continuous breach of Regulation 12 (1) and (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because care and treatment was not always provided in a safe way.

We found cleaning products and alcohol hand gel was stored in unlocked cupboards in a communal kitchen and lounge area on the first floor of the home. This meant people were at risk of accessing harmful substances.

Records at the home showed most of the appropriate checks had been undertaken on the equipment, facilities and utilities in use at Aston Manor. An exception to this was checks on water temperatures in shared bathrooms and toilets. Records for this could not be produced as no member of staff had been delegated the responsibility and the registered manager had not checked. Health and Safety Executive (HSE) guidance states a vulnerable person's risk of injury and death is increased when hot water temperatures exceed 44°C. Cold water temperature checks are also required to ensure the risk of Legionella is minimised. This meant water temperatures were not monitored and people were thereby placed at risk of scalding and Legionella.

These examples evidenced a breach of Regulation 12 (1) and (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as insufficient measures had been taken to keep people safe.

At this inspection we reviewed how the home managed risk to people. Care records showed people had been assessed for their risk of developing pressure ulcers, weight loss, falls and developing infections. However, we identified two people with swallowing problems who had no choking risk assessments in place. One of these people had bedrails fitted to their bed but there was no risk assessment in place to evaluate whether this was a safe option for the person. None of the people at the home had risk assessments or care plans which informed staff how to support them safely to bathe or shower, and care plans for hoisting lacked detail as to how equipment should be used. This meant not all risks to people had been assessed thereby placing them at risk of harm.

We reviewed the care records of three people identified as being at risk of developing pressure ulcers. One person's care plan said they needed two to three hourly support to change position in order to help reduce their risk of pressure ulcers. A second person's care plans said they needed three to four hourly support to reposition and the third person's plan said they needed 'regular' pressure relief, but what this meant was not defined. We checked paper and electronic documentation for these people and found no records of positional changes were kept by care staff, although two care workers we spoke with said this did happen. This meant the home could not evidence how they helped reduce people's risk of pressure ulcers.

One of the three people who needed support to change position had two pressure ulcers at the time of this inspection. At the morning handover meeting on the second day of this inspection we heard the night nurse tell the nurse coming on duty this person's pressure ulcers had worsened and needed to be reviewed by a specialist nurse. Over eight hours later we asked the registered manager if a referral had been made for this person; it had not, so the registered manager did it straightaway. We also noted the person did not have a wound care plan in place for their pressure ulcers. After the inspection we were told the person had been reviewed by a specialist nurse who determined the ulcer was caused by their position when seated upright. They provided additional cushioning to help reduce the risk to the person's skin integrity.

Issues with skin integrity risk assessment and management demonstrated a breach of Regulation 12 (1) and (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because care and treatment was not always provided in a safe way.

We observed a medicines round during the inspection and noted medicines administration was person-centred. The nurse spoke calmly and respectfully to people as they supported them to take their medicines and did not rush people. All the people we spoke with about their medicines were happy with the support they received. This meant people received their medicines in a caring and respectful way.

Most people's medicines were supplied by the home's pharmacy in blister packs, but some were in boxes or bottles. We saw the nurse checked people's medicine administration records (MARs) before administrating the medicines and then signed them afterwards. If people refused their medicines, this was noted. Not all people prescribed medicines 'when required', in other words, to be taken as and when they needed them, had protocols in place to describe when and how often they could be given by staff. Protocols are important as they contain the person-centred detail care workers such as agency nurses who may not know people well, need to ensure people get the medicines they need.

When we checked six people's MARs to see if medicines administration was recorded correctly we found there were issues. Some people's printed MARs from the pharmacy had been amended. For example, MARs for 'when required' medicines had been changed so they would be given or applied at set times. Decisions to change MARs must only be made by the prescriber; we could find no documentation to support the changes that had been made. We also found MARs which had been fully handwritten; some had not been signed by the nurse writing them, and others had not been countersigned by another member of staff. This is good practice to ensure instructions are correct. We noted a laxative medicine on one person's MAR had been signed as 'not required' for the following two days by a nurse and a handwritten note in the medicines file said it was to be withheld for two days as the person had suffered loose stools that day. When we asked about this we were told care workers had informed the administrator and they had instructed the nurse administering medicines to withhold the medicine. This is poor practice as a decision should be made each time a medicine is due to be administered as to whether it is required. This meant some people were not getting their medicines as prescribed.

The application of people's topical creams was recorded by the nurse administering medicines. One nurse told us they applied medicated cream, such as pain-killers and steroids, and the care workers told them when they had applied other creams such as moisturisers and barrier creams. They then recorded this on the MAR with a 'C'. This meant there was no audit trail of which member of staff had actually applied the cream. Another nurse said they thought care workers recorded the application of creams in people's daily notes. As there were no missing signatures in people's MARs this suggested some nurses were signing MARs when they were not sure people's moisturising and barrier creams had been applied. We brought this to the attention of the registered manager. She spoke with the home's pharmacy and arranged for topical creams MAR charts to be devised so the care workers applying creams could sign them in future.

During the inspection we noted prescribed items were not always stored safely or used by the person they were prescribed for. For example, we found a topical cream prescribed for one person in another person's bathroom. One person had a box on the floor in their bathroom which contained a topical steroid cream which had passed its expiry date seven months earlier. Some people's food supplements were stored on a shelving unit in the dining area where other people could access them.

Throughout the inspection we saw tubs of drinks thickeners left unattended in communal areas where people could access them. National guidance was produced following the death by asphyxiation of a person who accidentally ingested a drinks thickener, which states all thickening agents must be stored safely to reduce risk to people. When making drinks for people who needed a prescribed thickening agent to make it safer to swallow, we observed one care worker used the same tub for two people. When asked how they knew how much to add, the care worker said the instructions were on the tub. This would be correct for one of the people; the care worker told us they knew how much the other person needed because it was in their care plan. This meant thickening agents prescribed for individuals were used to thicken the drinks of others. This meant prescribed items were not always stored or used safely and people were placed at risk.

Stock medicines were safely and securely stored in a clinic room at the home. However, on the first day of inspection we noted both medicines trolleys were stored in a communal corridor area during the day and were not secured to a wall, as is good practice. This was rectified by the second day of inspection. The temperature of the clinic room was monitored and we saw non-refrigerated medicines were stored at the correct temperature. The temperature of the drug fridge was also monitored; however, we saw it had frequently exceeded the 8°C upper limit in March 2017. When we informed the registered manager she was surprised and stated this had not been brought to her attention by staff monitoring the fridge temperature. She ordered a replacement fridge the same day. This meant some people's medicines had not been stored correctly at the home.

We checked the storage and recording of controlled drugs such as strong pain-killers and counted some medicines to see if they tallied with stock recorded in the controlled drugs book. This was all done correctly.

Issues with medicines were a breach of Regulation 12 (1) and (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because care and treatment was not always provided in a safe way.

Most people and their relatives told us they thought the home was clean. One person thought the home's cleanliness varied and one relative told us the home was not clean.

As part of the inspection we looked around the home in people's rooms and bathrooms (with their permission), in the kitchen, in communal areas and shared bathrooms and toilets. Most areas seemed clean and we saw domestic staff cleaning each day of the inspection. However, we identified areas that were not clean and observed some poor infection control practice. We found some soft toys and dolls in the activity room were soiled and a fabric footstool in the main lounge area downstairs was heavily stained. In the morning of the first day of inspection we noted one bathroom had been used but not cleaned afterwards; the underside of the bath seat was soiled, as was the toilet, and underneath the bath there was a thick layer of dirt, including a soiled cleansing wipe which was stuck firmly to the floor. In one person's room we noted the underside of their bed had a thick layer of dirt and there was a layer of debris and crumbs between their bedsheet and mattress. After the domestic worker had finished for the day we returned to check both rooms and found they were the same. Cleaning records for the upper floor had not been completed for the two days prior to the inspection. We showed the rooms to the registered manager. She cleaned them immediately herself and said she would speak to the domestic workers and make regular checks in future.

Some of the people living with dementia at Aston Manor were supported by care staff with their continence. On three occasions on the first day of this inspection we saw soiled incontinence pads which had been discarded on the floor by people were removed by care staff but the floor was not cleaned afterwards. On the third day of inspection we checked the home's three shared wheelchairs and noted they all smelled very strongly of urine and one had heavily stained footplates. We brought this to the attention of a member of staff who agreed they would not want to sit in either chair. However, when we checked the chairs again over five hours later they had not been cleaned. This meant people were placed at risk of infection by poor cleaning practices.

Most care staff clothing we saw was clean. However, when we arrived on the first day of inspection we were greeted by a member of staff in a heavily marked uniform top which had a recent food stain on the back. When asked about it, the member of staff stated they had been asking for a new uniform for three or four years. This meant people were at risk of infections because staff uniforms were not always clean.

Concerns around cleanliness of the home and infection control evidenced a breach of Regulation 12 (1) and (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as insufficient measures had been taken to prevent the potential spread of infection.

At the last inspection in July 2016 we identified a breach of regulation relating to staffing as there were not sufficient members of care staff deployed to meet people's needs. At this inspection we analysed the home's dependency tool used to calculate staffing levels and checked rotas to see if shifts in the preceding four weeks had been fully staffed. We also spoke with people, their relatives and members of care staff on duty.

Two people told us there were always enough staff on duty, whereas two others said it varied. One person said, "The staff have very little time at all, but they are a dedicated lot who seem to support each other." Another person told us there was, "Not necessarily enough staff on at night, but if you need them you press your bell and they come", and a third said, "I think it's improved, I don't think there was (enough staff)." A relative we asked if they thought there were enough staff during the day responded, "Mostly, yes, but they do seem a little understaffed at times." Two relatives told us there were not enough staff at night and at weekends; one said, "There is fewer staff on duty on Sundays."

Care staff feedback about staffing levels was also mixed. Comments included, "Sometimes we can be short-staffed and sometimes it's OK", "Sometimes (there are enough staff), not always", "Shifts I've been on have always been alright", and, "We really need to work as a team to help each other. It's very difficult to meet their (the people's) needs." Healthcare professionals who visited the home during the day told us that whilst the home was busy, they had no concerns about staffing levels.

The registered manager showed us how staffing levels were calculated by evaluating the needs of people at the home. Each day shift had eight care workers and one nurse rostered. Each night shift one nurse was rostered with three care workers. Rotas showed less than half of day shifts in the four weeks prior to this inspection had been were fully staffed. Of these, three shifts had one nurse and six care workers and one had one nurse and five care workers. Over a third of night shifts, ten in total, had been staffed by a nurse and two care workers in the four weeks prior to this inspection. At least five people needed the assistance of two staff to move safely and the home had three long corridors of bedrooms and several communal rooms through which several people moved independently. This meant when one person who needed two to one support at night was being assisted, there was only one other member of staff for the other people at the home. In addition to supporting people, night care staff also had cleaning and laundry duties. One member of night staff listed their tasks each night shift and told us, "It's difficult." The registered manager acknowledged there were times when night shifts had three staff members in total; she said the home was trying to recruit

more staff to ensure there were always four staff members on at night.

We arrived early on each day of this inspection and made observations of staffing levels and response times to call buzzers until early evening. We noted during times of high demand, such as getting up time in the morning and mealtimes, care staff were stretched. This meant people did not always receive the support they needed, for example, with eating and drinking. For two days of the inspection there was no activities coordinator on duty. On both of these days we observed people received very little stimulation, most sitting in the lounge with either the TV or music CDs on. We noted six people chose to walk up and down corridors and outside in the garden during the day; most of this time they were unaccompanied and had little interaction with care staff. Feedback from people, their relatives and staff, plus our observations and analysis of staff rotas showed there were insufficient staff deployed to meet people's needs.

Concerns around staffing levels demonstrated a continuous a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as insufficient staff were deployed to meet people's needs

We inspected the recruitment records of three members of care staff employed at the home since the last inspection. This included original application forms, references from previous employers, copies of photographic identification, proof of address and a Disclosure and Barring Service (DBS) check. The DBS helps services make safer recruitment decisions. We noted two staff members had gaps in their employment history and one staff member's previous employment had been terminated, but there were no records to show this had been investigated. After the inspection the registered manager provided reasoning to explain these issues but they had not been documented at the time the staff were considered for employment. This meant recruitment processes at the home were not fully robust.

Inadequate

Is the service effective?

Our findings

People told us they thought staff at the home were well trained. One person said staff were well trained because, "They always come and talk to me, ask me what I want and see what I am doing for the day." Four relatives thought care staff had the skills they needed to support people; one commented, "There is a noticeboard for staff training, they keep up to date with things." One was not sure if staff were well trained and a fifth told us, "I think a lot of the staff are new."

At the last inspection in July 2016 we found a breach of the regulation relating to staffing as the home's training matrix evidenced not all staff had received the training essential for their role. This was a continuous breach from the inspection before that in November 2015.

At this inspection we found concerns remained. For example, of the 42 staff listed on the training matrix, eight had not had received moving and handling training, 15 had not received infection control training, 24 had no food hygiene training recorded, 17 had not received fire safety training and 25 staff members had still not had training on the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). As at the last inspection, we found staff knowledge of MCA and DoLS was limited. Records also showed of the 42 staff 13 had not done any safeguarding training and two others had training more than three years prior to this inspection. This was an issue identified at the last inspection, when 11 members of staff had not completed safeguarding training. In response to our concerns the registered manager arranged training sessions for staff on fire safety, health and safety, dementia awareness and moving and handling. This was also part of the action plan following the last inspection, however, the training matrix showed staff were still not up to date with these courses. This meant staff at the home still did not have the training they needed to meet people's needs effectively.

This was a continuous breach of Regulation 18 (1) and (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we identified staff supervisions were generic and centred around themes chosen by the registered manager; these were often in response to problems at the home. At this inspection we found supervision records were still photocopied sheets of generic concerns discussed with the care worker; they were the same for different care workers. According to the registered provider's supervision policy, each care workers' supervision should include a review of the individual's practice, and an assessment of their training and development needs. In the records we saw there was no information to show care workers' personal and professional development or individual training needs had been discussed at meetings. This meant care staff were not be receiving the support they needed to provide effective care to people at the home.

A newly recruited care worker told us their induction period had included shadowing more experienced members of staff, and training. Records showed another care worker employed one month earlier with no previous experience in a health and social care setting had not been enrolled on the Care Certificate. The Care Certificate is an introduction to the caring profession and sets out a standard set of skills, knowledge and behaviours that care workers follow in order to provide high quality, compassionate care. Completion of

the Care Certificate involves learning theory and the testing of competence. Homes are expected to either implement the Care Certificate or provide an in-house induction which includes all aspects of the Care Certificate. During the inspection the registered manager provided a copy of an induction document they intended to use with this care worker, however, it was out of date and referred to the regulations in place prior to April 2015. This meant care staff new to health and social care were not receiving an induction which included the Care Certificate or equivalent.

This was a further breach of Regulation 18 (1) and (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The 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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards or DoLS. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Records showed the registered manager had applied for DoLS for people when they had been found to lack capacity to consent to live at Aston Manor. We saw people's care files included DoLS care plans when authorisations had been granted by the supervisory body. One person admitted to the home in 2012 who lacked capacity to consent to living there did not have a DoLS authorisation in place or application for one made. The registered manager could give no reason why this had not been done. This meant the person was being deprived of their liberty without legal authorisation.

This was a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in July 2016 we found people's care files did not include decision-specific mental capacity assessments and best interest decisions for aspects such as the home's CCTV system and the administration of medicines covertly. At this inspection we found nothing had changed, in that there were no decision-specific MCA assessments in place for any aspect of people's care and treatment. For example, one person had bedrails in place; their care file showed the person's spouse had been consulted about the decision, but there was no decision-specific MCA assessment to show the person lacked capacity to consent to or refuse the use of bedrails. The care files of people receiving essential medicines covertly because they would otherwise refuse them contained letters of permission from their GPs and consent from their relatives. One nurse explained this procedure to us and was not aware decisions to give medicines covertly must include an initial MCA assessment of the person and best interest decision if they were deemed to lack capacity. Other decisions which had been made for people in this way included the use of CCTV and the locking of people's bedroom doors when they were not in their rooms. The registered manager told us MCA assessments and best interest decisions were done, "Verbally as conversations", and were not recorded separately or in detail. This meant the home was still not following the correct process for assessing people's capacity prior to making decisions on their behalf.

This demonstrated a breach of Regulation 11 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us the food and drinks served at Aston Manor were good; they told us there was plenty of choice and snacks and drinks were available throughout the day.

The most recent food hygiene inspection at the home in May 2016 had given the service five stars, which meant standards of food hygiene were very good. We spoke with the cook during the inspection. They could explain how foods were modified for people with special requirements, such as texture for safer swallowing or low sugar for diabetes. The cook could also describe the meals each person needed and understood their individual needs, dislikes and preferences well.

We observed two meals during the inspection and one of our inspection team ate a meal with people using the service. Tables in the dining room were set with cutlery and condiments. The first floor lounge and dining room was not in use on the first day of this inspection. At lunchtime we noted some people were asked to move to the ground floor dining room for their meal, whilst other people remained in the lounge. We saw this was because the dining room was full. People in the dining room were asked for their choice of two main course options, whereas not everyone in the lounge was given a choice. People were also asked if they wanted a pudding but not told what this was. We saw one person was given one meal option even though they said they did not like it; they were not offered the other choice. The person told us they had asked a care worker for soup instead of the two meal choices available; however, we saw they brought back ham sandwiches telling the person all soup was homemade and so they could not have any. When we discussed this with the registered manager she was surprised as tins of soup were always available in the kitchen stores.

We observed people were not routinely offered a choice of drinks. On the first day of inspection we saw some people were asked for their choice of drinks and others were just provided with a drink; this happened at lunchtime and during the afternoon. On the second day of inspection we saw one care worker approach people in the lounge with two glasses of different juice to ask them their preference; this was an example of good practice.

The people served lunch in the lounge had their meals and drinks placed on low side tables, which were not easy to reach or eat from. As they were out of eye-line for a person seated upright in a chair, we saw four people often stopped eating if they were not prompted. During lunch, one person in the lounge area was supported to eat by a member of staff and others popped in and out occasionally, but we saw they did not prompt people to eat. Mealtimes are an opportunity for people to gather and socialise, and people living with dementia are more likely to enjoy eating when surrounded by others who are also eating. This meant the people in the lounge during the lunch meal were not supported properly to eat and drink, or to take part in a communal mealtime experience.

The home kept records of the food and fluids consumed by people at risk of weight loss. However, we noted they lacked the detail required to make them meaningful because the amount of food the person was served was not recorded and at times the amount consumed was not recorded either. Without recording how much food was served to the person it cannot be established how much they ate. On the first day of inspection we checked people's food and fluid records for the day just before 5pm and found they were blank. A care worker told us they had not written the records yet but had the information in their head. This meant a contemporaneous record of the food and fluids people consumed was not kept by care workers.

People's care files and the monthly weight loss audit evidenced people's GPs and the dietician were informed when they had experienced weight loss. Most people at risk of weight loss had care plans in place which described issues they had with eating and drinking and the measures in place to promote weight gain. However, we identified two people who had lost a considerable amount of weight over the six months

preceding this inspection. One of these people had no eating and drinking care plan in place. Staff at the home, including care workers, the cook and the registered manager, could all describe this person's likes, dislikes and issues with eating, and the relevant healthcare professionals had been involved with their care. We saw the person had gained weight the month prior to this inspection. However, this meant care staff, including agency workers, accessing the person's care plans would have no information as to how to support this person's nutritional intake effectively. The second person's nutrition care plan stated they should be weighed weekly, although they could at times refuse this; records showed they had been weighed once in 2017 at the time of this inspection. Both people had been seen by dieticians and their GPs had been updated about their condition; a monthly audit of people's weight evidenced the actions taken to address any concerns around weight loss.

This meant actions to manage people's nutritional risk and risk of weight loss had not always been recorded. This was a breach of Regulation 17 (1) and (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us they had access to wider healthcare when they needed it. One relative said, "My relative was very ill and every few days they called the doctor in." People's records showed they had been seen by a range of healthcare professionals, including opticians, tissue viability nurses, speech and language therapists and dieticians. One healthcare professional we consulted about the home after this inspection told us, "I've never had any concerns about the place. I feel my advice is followed", and a second said, "It's positive how they work with us." This meant people were supported to meet their wider healthcare needs.

Adaptations had been put in place at Aston Manor to make it easier for people living with dementia to navigate around the home. We saw picture signage for bathrooms, toilets and other communal areas. Pictures of historical events and murals were displayed on walls. We did see some aspects which were less dementia friendly. Upstairs we noted walls, doors and grab rails were all painted very similar pale colours, which meant they would not stand out for people living with dementia with sight problems.

On the second day of inspection we observed two care workers attempting to assist a person into the lounge. As the flooring in the corridor and lounge areas contrasted strongly, the person was unsure of their footing and was attempting to step over what they thought was a barrier or step. Contrasting flooring can be difficult to perceive for people living with dementia. We did, however, see contrasting flooring used with good effect at the home, where it was very clear where the corridor met the top of a set of stairs. This meant although some modifications had been made to the home, further adaptation could increase people's ability to navigate and mobilise.

We recommend the service uses nationally available good practice on dementia-friendly design and adaptation to make improvements to the home.

Requires Improvement

Is the service caring?

Our findings

The people we spoke with at Aston Manor told us the staff were kind and caring, and their relatives agreed. Comments included, "Staff speak to me in a normal voice, they don't shout and bawl. It's how they approach you, they say 'thank you' to me", "I find they are very good at respecting my choices", "Staff are very friendly, accessible and competent", "The girls do an amazing job, they are interested in the family as well and get to know you", and, "They come and talk to me, ask how things are going, treat me as normal." One relative also told us, "Staff don't treat them (the people) like they are ill, they treat them like normal, treat them with respect and dignity."

During the inspection we observed some good interactions between staff and people. On the first day of inspection we saw a care worker approach a person sitting in the lounge with others who had been incontinent. The care worker gently informed the person they had accidently spilled their tea and suggested they go together to the toilet to change the person's clothing. This was a good example of helping to preserve a person's dignity. We also saw staff responding promptly and politely to people's requests for help and support.

A person living at the home had a birthday during the inspection. We saw the person was presented with a birthday cake and staff encouraged other people to join in singing 'happy birthday' to them.

The quality of interactions between staff and people who needed full support to eat at mealtimes varied. Some care workers used this as an opportunity to engage the person in conversation, whereas as others sat quietly next to the person and presented more food as each mouthful was swallowed.

On the morning of the first day of inspection a care worker turned off the TV in the lounge and put on a music CD without consulting the people in the lounge. This same CD was then played several times during the day. On the second day of inspection we observed a care worker sitting in the lounge with people watching Jeremy Kyle. We asked the care worker if the people liked Jeremy Kyle; they told us the people usually had music on instead and put on a music CD without asking the people in the lounge. That morning the care worker changed the CD on two more occasions, again without consulting people in the room. This meant the care staff did not always give people choices around entertainment in the lounge.

Some interactions between staff and people were not positive. For example, one person who had been supported by staff to a toilet after being incontinent came back to the lounge area in the same wet clothing and was provided with their lunch meal. Another person who had spilled a lot of moist food down their trousers was observed mobilising away from their meal by a member of staff who did not offer to support the person to change their clothing. A third person wearing a skirt was supported by care workers into a wheelchair and taken down a corridor. Due to the person's seating position, other people could clearly see up the person's skirt as their dignity had not been maintained by staff. When we approached one member of staff who was sitting with a person to ask if we could have a conversation in private, the member of staff responded by saying, "[The person's] got no capacity and has been agitated this morning. If I leave [they'll] get upset." This was said in front of the person. This meant people were not always treated with dignity and

respect by staff at the home.

These examples constituted a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's dignity was not always respected by staff.

We asked people if they had been involved in designing and reviewing their care plans; they said they had not. Feedback from relatives about their involvement was mixed; three said they were and received regular updates, one said they were not, one told us they had been when their relative had been admitted but not since, and one was not sure. The registered manager told us care staff took a laptop computer and sat with people while they updated their care plans to obtain their views, but we could find no evidence of this in people's care files. This meant people's involvement in designing their care plans could not be evidenced. After the inspection the registered manager told us they were going to write to people's relatives and invite them to care planning meetings with their family member in order to update their care plans. We will check this at the next inspection.

People's families had been asked to complete life histories for their relatives and we saw some good dementia and communication care plans where this information had been used to make them person-centred. Some families had not provided this information so it had not been possible to do this for their relatives.

People told us they were supported to remain as independent as they could be by staff at the home. One person said, "They ask if I need help then let me get on with it", and another person told us, "When they take me to the toilet they settle me down and then leave me until I call them."

People had access to independent advice in the form of advocacy services. The registered manager could describe the correct process for referrals to advocates and gave examples of people living at Aston Manor who used advocates to support their decision-making. We saw information about advocacy services was displayed in the home, although this was in the entrance foyer where people could not access it.

We asked the registered manager how they ensured people's equality and diversity needs were met. She listed several people at the home who saw a priest regularly and could explain the cultural practices of people from other religions, although there was no one using the service at the time of this inspection with these needs. She told us, "There's a small family room they could use for praying."

One person using the service had English as a second language. Their care records evidenced efforts between the care staff, a healthcare professional and the person's family to promote communication. The healthcare professional had advised the person's mood may be affected by their inability to understand English as their dementia progressed. The person had not responded to picture cards or reacted positively to CDs of traditional music from their birth country. This meant the home had tried to promote communication with a person who had English as a second language.

People's DNACPR or 'do not attempt cardiopulmonary resuscitation' forms, if they had them, were located in a file in the main office where they could be accessed quickly if needed. DNACPR decisions are made by healthcare professionals and guide care workers as to whether or not to attempt cardiopulmonary resuscitation if a person's heart stops. The DNACPR forms we saw had people's correct name and address details on as is required to make them valid.

Care staff at Aston Manor supported people with end of life care if it was their wish to remain at the home. The home's training matrix showed end of life care training was not provided to staff, so we asked care

workers what they thought was important when supporting people as they approached the end of their life. Comments included, "It's about making the resident comfy and meeting their needs. We find out from family if they've expressed interests in the past", "Their wishes are important. We make sure they're pain-free and in the surroundings they prefer", "Mouth care and pressure care are important", and, "We make sure they're comfortable. We do regular checks."

The quality of people's end of life care plans was mixed, with some containing person-centred detail, and others basic information or funeral arrangements. One person's care file did not contain an end of life care plan and another's advance care plan was blank. This can be because people and relatives do not wish to discuss end of life care; when this happens, attempts to obtain information should be recorded. Three relatives told us the home had spoken to them about their family members' end of life wishes, two relatives said they had not, and one relative could not remember the subject being raised with them. This meant the home did not routinely document people's end of life wishes.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with told us they received support from care staff when they needed it. One person said, "They always get me to the lift when I need it and if I want they come up with me."

Care records at Aston Manor were a combination of electronic and paper. People's risk assessments and care plans were recorded on an electronic system, as were some of their daily records. Other records, such as food and fluid balance charts, hourly records and behavioural charts were kept on paper.

People's electronic care records included care plans for a range of aspects, such as eating and drinking, moving around, washing and dressing, mental capacity and continence. We saw they had been reviewed on a regular basis. The level of detail in people's care plans varied. Some contained person-centred detail specific to that person; for example, one person's eating and drinking care plan gave detailed information about the support they required with diabetes, and a second person had a very detailed care plan around the challenging behaviours they experienced. A third person's eating and drinking care plan said they often liked to walk around and eat at the same time; we saw this during the inspection. Other care plans, however, contained generic information which was replicated in other people's care plans, for example, information around people's capacity to consent to CCTV at the home and the locking of their bedroom doors when they were not in their rooms.

Some people lacked care plans for aspects of their wellbeing they were receiving support with or would in the future. As evidenced previously in this report, one person who had lost weight did not have an eating and drinking care plan, and another person did not have an end of life care plan. One person with a history of seizures and another with a diagnosis of epilepsy did not have care plans in place to guide staff in the event of their having a seizure. Another person did not have a washing and dressing care plan, even though their night care plan stated they needed assistance with all their personal care needs. Daily records showed one person had refused a bath or shower for the month prior to the start of this inspection; there was nothing in their care plan about their tendency to refuse personal care or what to do when this happened. We spoke to staff to find out if they could describe what care and support people needed. We found staff could explain the care needs of individuals, such as nutritional support, health conditions, continence, behaviours that may challenge others and pressure area care.

We asked three care workers how they accessed people's care plans to find out what support people needed from them. Two care workers told us people's care plans were kept in paper folders in the care staff office, and a third said they were in the paper folders and on the electronic system. When we pointed out people's care plans were only available on the electronic system two care workers seemed surprised, and one said, "I know, I can see that looks bad." This meant some care workers did not know where people's care plans were located and had therefore not read them, We fed this back to the registered manager. After the inspection she started a review of people's care plans which involved the care staff to ensure they understood people's assessed needs.

As evidenced earlier in this report, we found people's food and fluid charts were not always updated after

each meal, and the amount of food served was not recorded. This meant the information recorded may not be accurate. We also found the support people received to reposition in bed to reduce their risk of pressure ulcers was not recorded. Care workers recorded other interventions on the electronic care system; we saw there were separate entries for oral care, baths and showers, activities and continence care. The records we sampled showed people had been assisted with aspects such as bathing and showering, continence, and eating and drinking. However, we did note some electronic records relating to the activities people took part in were generic and replicated in other people's daily records. This meant people's daily records did not contain a complete and contemporaneous record of the support they had received.

Concerns with record-keeping and the lack of detail in care plans was a breach of Regulation 17 (1) and (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as an accurate, complete and contemporaneous record was not kept for each person.

An orientation board was located on the wall of the main downstairs corridor. These are large dementia-friendly information boards which usually include details about the day, date, time and weather. When we arrived on the first day of inspection the orientation board had a date which was three days earlier, the clock had stopped at 2.30am or pm, and the weather was shown as drizzly, even though it was fine. Later that morning the date was changed to that day's date, but the time and weather were still wrong. By the third day of inspection we noted the time was still wrong and the weather still drizzly, even though it was fine each of the days we were there. This meant orientation information for people living with dementia was not correct and could therefore create confusion.

Feedback from people and their relatives about activities at the home was mixed. One person said, "There is always something going on"; two other people said there were not many activities available and one person was not sure. Four relatives told us they thought there were enough activities. One said, "They do plenty of days out, for families as well", whereas two relatives said there were not, one commenting, "Definitely not. There is not much stimulation."

On the first day of inspection we noted a large activities board in the main ground floor corridor, with spaces for each day of the week. It was blank, and remained blank throughout the inspection. On the first and third days of inspection the activities coordinator employed by the home to work five days a week was not on duty. We were told this was because they had worked at the weekend. The service was also trying to recruit a second activities coordinator.

On the days we spent at the home we noted most people spent their time sitting in the lounge with the TV or music on, whilst some people mobilised around the home independently. At times care workers were seen to talk to individuals or engage one or two people by throwing balls or playing games, but most of the time there was very little going on. Doors to the enclosed garden area at the home were unlocked during the day, which allowed people who wanted to go outside the opportunity to do so at will, and we did see people doing this. Overall, feedback from people and our observations showed people's access to meaningful activities was limited.

We recommend the service reviews their provision of activities for people living with dementia in line with nationally available good practice, such as guidelines from the National Institute of Clinical Excellence (NICE), which highlight the importance of activities to people living with dementia.

None of the people we spoke with had ever made a complaint about the service. Of the six relatives we spoke with only one had raised concerns about the home. They told us, "I complained quite a lot but they did fix everything."

On the first day of inspection we noted thank you cards from relatives were displayed on a noticeboard in the home's entrance foyer, but they were not dated so we could not tell how long they had been there. By the second day of inspection the cards had been moved to a display folder in the entrance foyer. The entrance foyer also contained a request for concerns, complaints and compliments, presumably from people's relatives and other visitors, as people could not access this area. There was no complaints policy displayed where people living in the home could access it.

We recommend the service make available information on the process for making complaints or raising concerns in an area of the home where people can access it.

At the last inspection in July 2016 we identified a breach of regulation as the registered manager did not have a system in place for the documentation, investigation and response to complaints. At this inspection we found a system was in place to record, investigate and respond to complaints. We reviewed the records of complaints and concerns received by the home since the last inspection in July 2016. Three complaints had been received verbally. We saw each complaint had been documented, investigated and the complainant responded to appropriately. The registered manager told us, "I have an open door policy for residents and families." This meant the complaints system had improved at the home.

Inadequate

Is the service well-led?

Our findings

People we spoke with told us the home was well managed, although only one person knew who the registered manager was. One person said the home was well managed because, "They fetch you what you want and the meals are decent." Another told us, "It is generally well managed, yes, but they could do with more staff and the manager could get to know patients better." A third person commented, "It's well run. Staff are very friendly and help you with your problems."

Three people's relatives thought the home was well managed, one said it was not and another said it varied. Comments included, "It does not seem professional, it's very run down and needs an overhaul", "I think they do the best they can", and, "It's all about communication which is very good. They have family days and involve the family, such as at Christmas."

Most feedback from staff about the registered manager was good. Comments included, "She's always pleasant and polite", "Any problems I've had she's always been there", and, "She's OK, she's very helpful. She's approachable", although one member of staff commented, "She does seem to avoid confrontation."

After the last inspection in July 2016 we re-issued a warning notice for a breach of the regulation relating to good governance, because concerns around the registered provider and manager's oversight of safety and quality of the home raised at the previous inspection in November 2015 had not been adequately resolved. At this inspection we checked to see if improvements had been made.

The accidents and incidents system in place at the home involved the recording of incidents on paper in an accidents and incidents file, and on the electronic system in individual people's records. The registered manager audited accidents and incidents in the paper file each month, although she told us she just checked to see appropriate action was taken in each case and did not analyse the records for trends. We found several incidents on the electronic system which were not included in the paper records. This meant the registered provider and manager lacked oversight of all the accidents and incidents which had occurred at the home. They also did not perform trend analysis to try and identify measures to reduce accidents and incidents in future.

Records showed various aspects of the home were audited on a monthly basis. These included the mealtime experience, medicines, infection control and cleanliness, people's weight, care plans, and various areas of health and safety. Most audits were in the form of tick lists although some had corresponding action plans. Concerns raised previously in this report evidenced problems with the effectiveness of audit at the home. For example, a medicines audit in March 2017 found the fridge temperature was regularly monitored and in range, handwritten changes to medicines administration records had been signed by a GP or second nurse, and medicines trolleys were locked to a wall when not in use. We observed this was not the case during this inspection.

Records for a 'manager's daily audit' and 'random walkaround sheet' were tick lists which checked aspects such as the storage of cleaning products, the cleanliness of toilets and bathrooms, and cleanliness of

wheelchairs. As stated earlier in this report, during this inspection we found wheelchairs smelled strongly of urine, one bathroom was not clean, and cleaning products were stored in unlocked cupboards in a communal area. This showed these daily audits were not effective.

The monthly care plan audit consisted of a sheet which listed the person's name and room number, and had tick boxes for 'assessments', 'care plans', weight and 'Waterlow'. Waterlow is a risk assessment to evaluate a person's risk of developing pressure ulcers. How the person's assessments or care plans had been audited was not recorded, and there was no action plan attached to show what updates or improvements, if any, had been made. The registered manager told us, "I check they're all updated and relevant to that person at that time." As evidenced earlier in this report, we found issues with the quality and consistency of care plans which evidenced the lack of effective audit by the registered provider and manager.

Other aspects which demonstrated the registered provider and manager's lack of oversight was the home's lack of compliance with the Mental Capacity Act 2005 and the lack of comprehensive training provision and effective supervision for staff, both of which were highlighted at the last inspection and in the warning notice served afterwards.

Records showed representatives from the registered provider had visited the home for audit purposes three times in the five months prior to this inspection; although the registered manager told us they visited most weeks. Records of these audits were brief and showed representatives of the registered provider had solicited feedback from people and staff, checked the building and the provision of activities, and looked at records of any complaints made. However, provider checks had not focused on areas of concern identified at the last inspection, to ensure they had been resolved. For example, their audit had not included the home's response to and reporting of safeguarding incidents, staff training, the effectiveness of monitoring undertaken by the registered manager or the quality and relevance of people's care plans. Concerns raised at this inspection evidenced the registered provider also lacked oversight of quality and safety at Aston Manor and both the registered provider and manager had failed to make improvements in line with the warning notice we reissued after the last inspection.

The registered provider and manager lacked oversight of quality and safety at the service. This evidenced a continuous breach of Regulation 17 (1) and (2) (a) (b) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Part of a registered manager's or registered provider's responsibility under their registration with CQC is to have regard to, read, and consider guidance in relation to the regulated activities they provide, as it will assist them to understand what they need to do to meet the regulations. One of these regulations relates to the registered manager's/registered provider's responsibility to notify us of certain events or information. By not notifying us of incidents such as these, we are unable to assess if the appropriate action has been taken and the relevant people alerted. At this inspection we found notifications for serious injuries, authorisations for Deprivation of Liberty Safeguards and deaths had been made. Some notifications for actual or suspected abuse involving people at the home had been made, but as discussed earlier in this report, some had been missed. We raised this with the registered manager and she told us the reporting system would be reviewed and improved. Since this inspection, notifications for abuse involving people have been made in accordance with the regulations.

Registered providers have a legal duty under the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015 to display the ratings of CQC inspections prominently in both their care home and on their websites. We saw ratings from the last inspection were clearly displayed on the registered

provider's website. At the home we found information about the last CQC inspection was located in amongst other documents in the home's entrance foyer. On the second day we found they had been clearly displayed on the wall of the entrance foyer, as is required by the regulations.

We asked people about the atmosphere and culture of the home. Two people described it as, "Alright", with one adding it was, "Relaxed and friendly." Another person said the atmosphere was, "Very pleasant because of the attitude of the staff", and a fourth person told us, "Good staff. Most of the time they make sure you get what you need. Easy to make friends here."

In the staff room at the home various posters from the registered manager and registered provider were displayed. We noted most had a negative tone. For example, one stated that due to an incident at night management were commencing unannounced checks. Another stated it was 'apparent staff were abusing the breaks system' so measures were being taken. A third poster about sickness and absence concluded with 'the home is run for the benefit of the residents, not the staff', and a fourth stated staff with hospital appointments must bring letters to evidence their required absence. This suggested there was a negative culture amongst the care staff team. We asked the registered manager about the tone of these communications. She agreed they might seem negative but felt she was responding to real issues which had occurred at the home.

Records showed staff meetings were held regularly at the home. Some were general staff meetings for all care staff and others were meetings for nursing staff. Various items had been discussed and a representative of the registered provider regularly attended. Minutes showed feedback about inspections carried out by CQC and other organisations was given to staff at these meetings. Care workers told us they felt able to raise issues if they wanted to and had been asked for their views via a staff survey. This meant there was regular communication between management at staff at the home.

There was a relatives' noticeboard on a ground floor corridor which displayed information about forthcoming events, the date of the next quarterly residents' and relatives' meeting, and a request for ideas for suitable activities for people. A list of planned refurbishments and redecoration at the home was also shown; we saw this included consultation with families prior to painting people's rooms in order to personalise them. A notice also asked relatives to complete feedback surveys, which were available in the entrance foyer. We asked the registered manager if people at the home were also surveyed for feedback. She told us they were not, adding, "It's my own mistake because they have got the right to say if they like the home", but then went on to emphasise that people could always feedback at residents' and relatives' meetings. However, people may not wish to provide feedback in front of others and prefer to complete a survey instead.

A residents' and relatives' meeting was held during this inspection, however, meeting minutes were not yet available for us to inspect. A member of staff told us attendees had discussed the upcoming refurbishments as well as this inspection and a recent inspection by another organisation. The registered manager told us from April 2017 they would be available one Saturday each month to speak to people's relatives; this was so relatives who worked during the week could still see her. This meant people and their relatives were given opportunities to feedback about the home and speak with management.