Mauricare Limited

Aston Manor

Inspection report

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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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We inspected Aston Manor on 30 and 31 August and 8 September 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. At the time of this inspection there were 24 people living at the home.

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

Aston Manor was last inspected in April 2017. At that time we identified multiple breaches of regulation. As a result, the home was rated as 'Inadequate' overall, as it was deemed to be 'Inadequate' in the key questions of Safe, Effective and Well-led, and 'Requires Improvement' in the key questions of Caring and Responsive. This inspection found some improvement had been made at the home but it was not sufficient to change the overall rating from the last inspection. The home is therefore still inadequate and remains 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.

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.

Feedback from people and their relatives about safety at the home was mixed. People were seen using

labelled walking frames, an improvement from the last inspection, but risk assessments and care plans had not been updated for people supported to transfer by staff using handling belts.

Most aspects of the building and its facilities, utilities and equipment were safe. However, personal emergency evacuation plans had not been updated for several months and a risk assessment of the water system in July 2017 concluded people were at risk of Legionella and effective action had not yet been taken.

People's moving and handling risk assessments and care plans lacked the detail staff would need to support them safely to mobilise, and to bathe and shower. One person with swallowing problems had no choking risk assessment in place. Care plans to manage risk to people's skin integrity were not clear. These were all issues raised at the last inspection.

Most medicines were managed and administered safely. However, medicine administration records for people's topical creams were not always completed; some care plans for 'when required' medicines were missing or lacked person-centred detail.

Staffing levels had improved since the last inspection. We observed people's personal care and nutrition/hydration needs were met; however, people's social interaction with staff was limited.

Staff had undergone some training since the last inspection; however, there were still gaps in the training matrix for courses such as the Mental Capacity Act, first aid and food hygiene. A care worker new to health and social care at the last inspection who had not been enrolled on the Care Certificate had been enrolled since, but had only completed a small part of it.

About half of the staff had received one supervision since the last inspection; however, records showed this had not included discussion around their training needs or personal and professional development, in accordance with the provider's policy.

The registered provider and registered manager were still not compliant with the Mental Capacity Act 2005. People had not been assessed for their capacity to make specific decisions relating to their care and treatment. This was a finding at the previous two inspections.

Feedback about the food and drinks served at the home was positive. We observed people were not always given a choice about the food and drinks they received and the support to eat provided by staff was not always person-centred. The detail of food and fluid records had improved, however, on the first day of this inspection, records for breakfast, lunch and snacks had still not been completed by 2.45pm.

Care plans for people who had lost weight did not always include information about the action taken to manage their nutritional risk. This was a finding at the last inspection in April 2017.

People had access to a range of healthcare professionals to help support and maintain their wider health needs. Relatives told us they were kept up to date about their family member's wellbeing.

Most interactions between staff and people at Aston Manor were respectful, but some were not. The registered manager had deployed a 'dignity champion' to challenge poor practice after concerns were raised at the last inspection, but there was still more work to do.

At the last inspection we found no evidence people had been involved in developing and reviewing their care plans. At this inspection we could find no evidence this had changed in the care files we sampled.

Information about people was not always stored securely.

People's care plans and daily records were not always an accurate and contemporaneous record of their care needs or of the support they received from staff.

People who experienced behaviours that may challenge others did not always receive person-centred support in accordance with their care plans. Some behaviour care plans we sampled lacked detail about triggers for behaviours and suggested de-escalation techniques.

One complaint had been managed by the registered manager since the last inspection. There were no records to show how it had been investigated or responded to.

People's access to meaningful activity was limited. This was a concern raised at the last inspection.

Although some improvement had been made to the audit process at Aston Manor, the registered manager and provider still lacked oversight of safety and quality at the home.

An action plan provided in June 2017 by a consultancy contracted by the provider had failed to result in significant improvement at the home as we identified new and continuous breaches of regulation.

Relatives had been asked to complete a survey about the service but people who lived at the home had not. There had been no residents' and relatives' meetings since the time of the last inspection in April 2017.

As at the last inspection, information about advocacy, the complaints procedure and the home's CQC inspection ratings was located in the entrance lobby to the building where people could not access it.

When asked, care staff at the home could not describe what good person-centred dementia care should involve.

We found breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. You can see what action we have 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?

Inadequate

The service was not safe.

Not all people and their relatives thought the service was safe. The reporting of safeguarding incidents had improved.

Some risk assessments and care plans to manage people's risk contained contradictory information, were missing or lacked detail.

Most medicines were managed safely; some medicines records were missing, incomplete or lacked detail.

Staffing levels had increased since the last inspection. We saw people's personal care and nutritional needs were met in a timely way, although social interaction with staff was limited.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received the training, supervision and appraisal they needed to provide safe and effective care.

The registered provider and registered manager lacked understanding about the Mental Capacity Act 2005.

Feedback about the food and drinks was positive, although people did not always receive a choice, or person-centred support to eat and drink.

People had access to healthcare professionals to meet their wider health needs. The service had made changes to make the home more 'dementia-friendly.'

Is the service caring?

Requires Improvement

The service was not always caring.

Most interactions between staff and people were positive, but some were not. The registered manager had deployed a 'dignity champion' to challenge poor practice.

People had not been involved in developing and reviewing their care plans. This was a finding at the last inspection.

The level of detail in most end of life care plans we sampled was poor. This was a concern at the last inspection.

Is the service responsive?

Inadequate

People's care plans were not always an accurate reflection of their care and support needs.

People who experienced behaviours which may challenge others did not always receive support in accordance with their care plans.

People's access to meaningful activities was still limited.

There was no evidence to show how a complaint received since the last inspection had been investigated and resolved.

Is the service well-led?

Inadequate

The service was not well-led.

We identified new and continuous breaches of regulation which evidenced an overall lack of improvement at the home.

Surveys had been sent to relatives since the last inspection but not to people who lived at Aston Manor, so they had no opportunity to provide feedback.

Care workers could not explain the principles of good dementia care; all but one response we received were task-focused.

Staff meetings had not been held frequently, but minutes showed the registered manager had offered support to staff and voiced her appreciation of them.

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 30 and 31 August and 8 September 2017. The first day of inspection was unannounced. The inspection team consisted of two adult social care inspectors and one 'expert by experience' on the first day of inspection, two adult social care inspectors on the second day, and one adult social care inspector on the 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 provider completed a Provider Information Return (PIR) in June 2016 but had not updated it since then. 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.

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.

During the inspection we spoke with three people who used the service, seven people's relatives, seven members of care staff (including nurses and the dignity champion), the registered manager, the nominated individual, the head of care, the activities coordinator, a domestic assistant, a kitchen assistant and a cook. The registered manager was not present on the first and second day of inspection.

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 15 other people's care files. We also inspected four staff members' recruitment and supervision documents,

staff training records, five people's oral medicines administration records and eight people's topical 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

One person told us they did not always feel safe at Aston Manor. As we spoke with them another person was experiencing behaviours that may challenge others in the lounge area, and had been for nearly two hours. The person we spoke with said they did not feel safe when other people were distressed in this way. One relative told us they felt their family member was safe; they said, "[My relative] has a crash mat by [their] bed"; this was in case they fell out of bed. A second relative responded, "Oh yes (my relative is safe)." However, a third relative told us their family member who used the service had been physically assaulted by other people at the home. They said, "When [my relative] gets in the way of others they hit [them]."

At the last inspection in April 2017 we identified a continuous breach of the regulation relating to safe care and treatment, as a person was seen mobilising with an unlabelled zimmer frame, so staff could not be sure it had been adjusted to suit their specifications. We observed unsafe moving and handling manoeuvres, and handling belts had been used by staff without appropriate risk assessments and care plans. At this inspection all the moving and handling manoeuvres we saw were safe, except for one where a hoist sling dropped a short distance whilst being lowered as a clip on the hoist arm had not been adjusted properly. The person was not harmed but may have received a shock. The care workers hoisting the person acknowledged the error, and we saw them using the same equipment safely at other times during the inspection.

Throughout the inspection we observed two people who used zimmer frames mobilising with frames labelled with their names, so this aspect had improved. However, when we checked the records for two people staff told us they supported to transfer with handling belts, we found one person's file contained no risk assessment for this and no instructions on which belt to use or how it should be applied. The other person's moving and handling risk assessment and care plan stated they were hoisted and included no information about the use of handling belts, even though we observed staff using one to support the person during the inspection. This meant people were still at risk of falls because they were being supported with equipment they had not been assessed properly for.

This was a continuous breach of Regulation 12 (1) and (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in April 2017 we identified a breach of the regulation relating to safe care and treatment as harmful substances had been stored in unlocked cupboards in a communal kitchen and lounge area. At this inspection we found all such products were stored safely. At the last inspection we also found checks on water temperatures in shared bathrooms and toilets had not been done. 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. At this inspection we found temperature checks had been undertaken on water outlets at the home, including communal bathrooms and toilets. Hot water temperatures were within the safe range; however, the temperature of cold water had regularly been over 20°C, the temperature below which Legionella is dormant. HSE guidance states there is a reasonably foreseeable risk of Legionella if the water

temperature in all or some part of the system may be between 20–45°C. It recommends cold water be maintained, where possible, below 20°C.

After the inspection the registered provider submitted a Legionella risk assessment completed by an external contractor in July 2017 and records for monthly water temperature testing since the last inspection. The risk assessment concluded, 'The risk of the occurrence Legionella bacteria in your water systems appears to be out of control', and, 'It is very likely that the Legionella bacteria will occur in your water systems.' This was because hot water was not stored at a high enough temperature and cold water temperatures were not low enough to reduce Legionella risk. It was recommended urgent action was taken in the next one to three months, however, cold water temperatures for August and September 2017 showed 20 rooms still exceeded 20°C, so action was yet to be taken to resolve the issue. This meant people at Aston Manor were at risk of Legionella.

This was a continuous 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 found most aspects of the home's facilities, utilities and equipment had been inspected for safety as required. This included fire extinguishers, hoists for moving and handling people, and gas and electrical appliances. However, we noted there were only six hoist slings listed on the safety testing certificate in April 2017 and when we asked how many were in use in September 2017, we were told there were 10 or 13. After the inspection the registered manager clarified that the additional slings had been purchased since the April 2017 inspection for people who had either been admitted since then or whose needs had changed. There was no list kept of the home's slings and when they were last tested; the head of care said they would make a list of the home's slings to keep better track of them and their testing in future.

People's electronic care records included a personal emergency evacuation plan (PEEP); PEEPs contain person-centred information for those helping people to evacuate in emergency situations. There was a paper folder in the manager's office which we were told would be given to emergency services if an evacuation was needed. We found PEEPs in this file had not been updated for several months. Four people listed were no longer using the service, one person recently admitted to the home did not have a PEEP, and the PEEP of another person who needed a hoist stated they could walk with the encouragement of one care worker. This meant people would be at risk in emergency situations as information about their needs was not always up to date.

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.

At the last inspection in April 2017 we identified a breach of the regulation relating to safe care and treatment as people did not always have risk assessments in place for the care and support they received from staff, or for specific health conditions. This included a person with bedrails and two people at risk of choking. In addition, people's risk assessments and care plans lacked detail as to how to support them to bathe and shower safely, and risk assessments and care plans for use of the hoist lacked detail as to what equipment to use and how to apply it.

At this inspection we found one person was using bedrails and a risk assessment was in place. One of the two people who had been at risk of choking was no longer using the service. The other person's eating and drinking care plan contained information regarding how the person's risk of choking was managed with a modified diet, but there was no choking risk assessment. People's moving and handling risk assessments and care plans still lacked the information staff needed to help people move safely. For example, one

person's moving and handling care plan stated they needed to be hoisted, but there was no information about which hoist to use or what type or size of sling. Only one moving and handling care plan we sampled contained information about the hoist to be used, the type and size of sling, and which loops must be attached for safe hoisting. None of the seven moving and handling risk assessments and care plans we reviewed contained information on how to support people to bathe or shower safely. This meant people remained at risk as appropriate risk management systems were still not in place.

At the last inspection in April 2017 we reviewed the care records of three people identified as being at risk of developing pressure ulcers. We found information in their care plans about the support they needed to reposition was contradictory or vague, and records to evidence people were supported to change position were not kept. At this inspection we reviewed two of the three people's records again; the third person was no longer using the service. We found information was still contradictory and when we asked four care workers about the repositioning needs of both people they gave us different answers. Repositioning charts evidenced both people were supported to change position when in bed, but not when seated in a chair or wheelchair. Both people slept on air mattresses to reduce their pressure ulcer risk, and we were told they were set according to the person's weight, although this was not stated in their care plans. When we checked, both air mattresses were on the same firm setting, even though one person weighed over 13kg more than the other person. Staff told us one of the people had a pressure ulcer and was having bed rest during the day so we checked their records. An entry on 24 August 2017 stated the person had the early stages of a pressure ulcer and their skin integrity risk had increased; however, their skin integrity care plan had not been updated with this information. This meant measures in place to reduce skin integrity risk had not improved.

During the inspection we were present when a member of staff noticed a person putting something to their mouth. The nurse took action to retrieve the object and it was identified as a 3cm long cap off a piece of equipment used to prick people's fingers to take blood samples. The cap had not been disposed of safely thereby placing the person at risk of choking.

Issues with risk assessment and management demonstrated a continuous breach of Regulation 12 (1) and (2) (a) (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.

At the last inspection in April 2017 we identified a breach of the regulation relating to safe care and treatment as medicines were not always managed safely. Some people's medicine administration charts had been amended by staff at the home without consulting the prescriber, and not all medicines prescribed for people 'when required' had care plans in place to guide staff as to how and when to administer them. In addition, it was not possible to determine which staff had applied people's prescribed creams, medicines were not always stored safely, and the medicines fridge had been malfunctioning but staff had failed to notify the registered manager.

At this inspection we found most medicines had been given as prescribed. We reconciled six medicines, including three controlled drugs, with recorded stock levels and all six tallied correctly. A system for ordering, booking in and returning medicines was in place. Medicines were stored safely. We observed a medicines round and saw the nurse spoke with people respectfully and explained what their medicines were and why they needed to take them. When people refused their medicines the nurse was patient and returned later to try again.

We identified some issues with medicines records at Aston Manor. Two 'when required' medicines had no accompanying care plans to advise staff when and how to give the medicines. One person's 'when required'

medicine care plan for Diazepam said it was for 'agitation', and contained no more person-centred detail. Care plans for 'when required' medicines are important when people cannot verbalise their need for a medicine and may be supported by staff who are not familiar with them, for example, agency care workers. In addition, nurses did not record on the back of MARs why 'when required' medicines had been administered so it was not clear what they had been administered for. For example, one person had been administered 'when required' Paracetamol three times a day for over two weeks. The reasons why had not been recorded on their MAR and the person had not been referred to their GP.

At the last inspection in April 2017 nurses were recording 'C' on MARs to indicate care workers had applied most of people's creams. At this inspection we found topical MARs were now in place for care workers to sign. We sampled eight people's topical MARs and found gaps in recording in all eight. For example, one person was prescribed an itch relief cream twice a day; we found there were 14 missing signatures on the person's MAR since the record was started. We also noted gaps in records for a medicated cream to be applied by nursing staff; it should have been applied four times a day but there were more than 30 gaps in their MAR, with no explanation given as to why the cream had not been applied.

Concerns with medicines demonstrated a continuous breach of Regulation 12 (1) and (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us they thought the home was clean most of the time. One relative said, "Yes, they do the best they can", and a second commented, "Most of the time they keep up to it." We received positive feedback from healthcare professionals who visited the home and had noted improvements in infection control procedures.

At the last inspection in April 2017 we identified a breach of the regulation relating to safe care and treatment as some areas of the home were not clean. We also found shared wheelchairs at the home smelled strongly of urine, and one member of staff wore a uniform that was not clean. At this inspection we found the home was clean and tidy; pockets of odour were noticeable when people were getting up or had received personal care, but these dissipated afterwards. Wheelchairs had been cleaned and did not smell, and care staff had been issued with new uniforms. This meant the breach of regulation had been resolved.

At the last inspection in April 2017 we identified a breach of regulation relating to staffing as there were insufficient staff deployed to meet people's needs. At this inspection feedback from relatives about staffing levels was mixed. Comments included, "Sometimes weekends can be a problem. But I think they have improved that. It seems to be getting better", "At the moment they are good, but not in the past", "Definitely got better", "Not enough staff and a lot of stand-ins (agency staff)", and, "I would like to see more staff. It gets worse on an evening." Responses from the relatives' survey carried out in June 2017 included, "Staff seem run off their feet, more permanent staff please", and, "The care of staff is good considering the lack of staff on duty and what they have to cover."

Feedback from staff was more positive. One member of care staff told us, "Sometimes we are OK. If we are short-staffed we struggle", a second care worker told us, "Staffing is OK when no-one calls in sick", and a third said staffing was, "Much better – more staff now." A fourth member of care staff said, "Staffing levels have got better."

Rotas showed most shifts were staffed according to the registered provider's dependency tool. Agency staff were used when regular staff were on holiday and shifts could not be filled. We saw the dependency tool had been adjusted following a recent admission. Night staffing levels had increased since the last inspection. One member of night staff told us, "Having three staff (three care workers plus a nurse) has made a massive

difference." The rota showed the number of care workers and nurses was the same for each day of the week, including weekends, although the registered manager and head of care worked mainly on week days. A 'dignity champion' worked four days a week, including weekends, and was in addition to the care staff; their role was to ensure people's needs were met and their dignity respected and promoted.

At this inspection we observed staff deployment was better during mealtimes as people received the support they needed and staff were attentive. A kitchen assistant supported people to eat in the dining area until 10.30am which meant care staff could focus on supporting people to get up. We noted people were assisted with continence care when they needed it, and call buzzers were answered quickly. However, between meals we observed people walking up and down corridors with little interaction from staff and people sat in communal areas with limited or no meaningful activity with staff. Our observations showed staffing deployment at mealtimes had improved; however, at other times people's social interaction with staff and access to meaningful activity was limited because care staff were busy.

At the last inspection in April 2017 we identified a continuous breach of the regulation relating to safeguarding, as incidents between people living at the home had not been reported to the local authority safeguarding team and to the Care Quality Commission (CQC), as required by registered managers and providers. At this inspection we reviewed nine safeguarding records to check incidents had been reported appropriately and promptly. We also contacted the local authority safeguarding team to check they had been made aware of safeguarding incidents. Of the nine incidents we checked, all had been reported to the local authority safeguarding team but one had not been reported to CQC. As discussed earlier in this report, during the inspection we witnessed an incident involving a person who was placed at risk of choking on a piece of equipment which had not been disposed of correctly. This was also not reported to CQC as an incidence of neglect, despite our advising it should be. This meant there had been an improvement in the reporting of safeguarding incidents, although the system did not work every time.

At the last inspection we found the recruitment process at the home was not fully robust as gaps in applicants' employment history had not been explored. At this inspection we found no new members of staff had been appointed since April 2017, but the application form used by the home had been updated to request an explanation of any gaps in employment, so this was an improvement.

Inadequate

Is the service effective?

Our findings

People told us they thought staff at the home were well trained and knew how to support them. Relatives agreed. One relative told us, "Compared with what they had before, they seem to have a lot more equipment; makes life easier", and a second said, "They seem to know what they're doing."

At the last two inspections, in April 2017 and July 2016, we identified a breach of the regulation relating to staffing as the training matrix evidenced not all staff had attended training in areas relevant to the people they supported. This was a continuous breach from the two previous inspections.

At this inspection we found gaps in staff training records persisted. For example, of the 42 staff listed on the training matrix 11 had not completed infection control training, 17 had not attended first aid training, 33 had still not completed food hygiene training and 27 staff members had not had training on nutrition or the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). As at the last two inspections, we found staff knowledge of MCA and DoLS was still limited.

We asked to see evidence the competence of nurses to administer medicines had been assessed on a regular basis. The registered manager told us a clinical lead had been appointed since the last inspection and their role was to support and supervise the nursing staff. However, they had since gone on long term absence and no medicines competency assessments had been completed. This meant staff at the home had still not received the training and support 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 in April 2017 we identified staff supervisions were generic and consisted of photocopied sheets of concerns which 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 of their training and development needs. We sampled four care workers' supervision records from August 2017 we found no information to show care workers' personal and professional development or individual training needs had been discussed at meetings. As at the last inspection, staff did not receive an annual appraisal of their performance. This meant care staff were still not receiving the support they needed to provide effective care.

At the last inspection records showed an employee had recently commenced employment at the home with no previous experience in health and social care and had not been enrolled on the Care Certificate. The Care Certificate is an introduction to the caring profession; it sets out a standard set of skills, knowledge and behaviours care workers need in order to provide high quality, compassionate care. Completing the Care Certificate involves learning theory and competency testing of practice. Homes are expected to either implement the Care Certificate or provide an in-house induction which includes all aspects of the Care Certificate. As there had been no new recruits at the home since the last inspection, at this inspection we checked the personnel file of the same care worker to see if they had completed the Care Certificate. A Care

Certificate self-assessment workbook was in their file but only one of the 15 sections had been completed. This meant staff new to care still did not complete the Care Certificate, or an equivalent introduction to care.

This was a continuous 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.

At the last inspection in April 2017 we identified a breach of the regulation relating to safeguarding as one person who lacked capacity to consent to living at Aston Manor, and who had been there since 2012, had no DoLS authorisation in place. Shortly after the inspection we were notified an application had been made for them. At this inspection we found all the people who needed to have a DoLS either had an authorisation or an application for one had been made. This meant the breach of regulation had been resolved.

At the last two inspections, in April 2017 and July 2016, we found people's care files did not include decision-specific mental capacity assessments and best interest decisions for aspects of their care and treatment, such as covert medicine administration, bedrails and the use of CCTV. At this inspection we found very little progress had been made, and what had been done evidenced a continued lack of understanding around the MCA on the part of the registered manager. For example, in June 2017 rails had been fitted to one person's bed at the request of their relative; there was no assessment made of the person's capacity to consent to this. The person's mental capacity care plan read, '[Name] does not have the ability to make big decisions about [their] care and safety due to cognitive deficit and dementia.' A second person's electronic record contained a statement about enhanced observations; it stated that due to the person's 'lack of understanding' a letter had been sent to the person's family to ask for their permission. Exactly the same statement was seen in another female resident's communication care plan, although it used the possessive pronoun 'his' throughout, evidencing it had been copied from someone else's records and was not person-centred. A third person's mental capacity care plan consisted of a record of a conversation with the person where they were asked their name, if they had a daughter, and if they were OK. Because their responses did not correspond to the questions the care plan concluded, 'This clearly indicates [the person] lacks capacity.' A fourth person receiving their medicines covertly still had no MCA assessment or best interest decision in place. This demonstrated the registered provider and registered manager's repeated failure to become compliant with the Mental Capacity Act 2005.

Non-compliance with the Mental Capacity Act 2005 demonstrated a continuous breach of Regulation 11 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection three members of staff told us one person was physically restrained during personal care because they often became distressed and aggressive. This involved two care workers holding the person's hands while another care worker provided the personal care. When we checked the person's care records there was no information or guidance for staff on using physical restraint for this person. Also during

the inspection we found one person walking alone in the short corridor area on the first floor between two locked doors, indicating the person had been placed there by staff. When we asked about this, we were told the person was escorted to their room on this corridor when they became physically aggressive in order to 'calm down.' The person had come out of their room and closed their door which had locked behind them; there was no seating available in the corridor and no access to a drink or a toilet. The person's behavioural support care plan made no reference to secluding the person to help them calm down.

The practice of restraint and seclusion without risk assessments or care plans in place demonstrated a breach of Regulation 13 (4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Feedback about the food and drinks served at the home from people and their relatives was positive. One person told us about the meal, "They're alright. You get plenty", and a second person said, "It's always fish on a Friday. The pudding today was brilliant."

During this inspection we observed three mealtimes and one member of the inspection team ate a meal with people who used the service. People were either supported to eat in the dining area on the ground floor or were assisted by staff in lounge areas. At the last inspection we saw people did not always receive the support they needed to eat and drink; at this inspection we saw this had improved. A kitchen assistant helped people to eat and drink at breakfast time and other care workers also supported people as they got up. People ate at dining tables in the ground floor dining room; however, people dining in the upstairs communal area, which included a dining table, stayed in lounge seating and were given meals on small tables. A care worker we spoke with could not explain why the dining table was not used.

Throughout the inspection we heard care staff offering people the choice of various drinks, meal items and snacks, but this was not the case every time. Two options were available for each meal; however, we saw people were not always asked what they wanted to eat, or told by staff what it was they were about to eat before food was proffered. For example, a care worker we observed helping a person to eat said to them, 'I've got you some more juice [name] and some dessert" and then proceeded to present the pudding to the person on a spoon. When we asked if the pudding was the person's choice, the care worker told us the person did not make choices, however, "[Name's] a good eater so we always give [them] the main pudding rather than yoghurt." We also observed one pudding choice being taken on a tray to the upstairs lounge. Once there they were uncovered and custard was added without asking people if they wanted it, or if they preferred another option. The puddings then sat going cold with one person offered one, without being told what it was, 15 minutes later. We asked one person if they always got a choice at mealtimes and they said they did not; they told us, "You get what they're dishing out. I'm happy with what I get." This meant people were not always given a choice at mealtimes and we saw food, which was meant to be served hot, was allowed to go cold.

People did not always receive the support they needed to eat their meals independently. During a lunchtime meal we observed one person eating with their hands; their eating and drinking care plan stated they preferred finger foods to make eating independently easier. We saw they were served a normal meal which they tried to eat with their fingers; a member of staff we spoke with was not aware of the requirement for finger foods in the person's care plan. A second person ate their food with one hand, which meant they pushed food around and off the plate. When we asked if plate guards might help the person to eat staff agreed and said the home did have some; however, they were not brought for the person, and we saw they were not in use the following day. Plate guards form a rim around part of a plate to prevent food from falling off and can be used as a barrier to push food against when scooping with a fork or spoon. This meant people were not always supported to eat meals independently.

At the last inspection we identified a breach of the regulation relating to good governance as records of action taken to manage people's weight loss, including people's daily food and fluid charts, were poor. At this inspection records showed action had been taken to address people's weight loss most of the time and people had eating and drinking care plans in place. We also found the level of detail recorded on people's food and fluid charts had improved such that it was now possible to determine how much people had eaten. However, on the first day of inspection we noted some people's food and fluid charts had not been completed for breakfast, lunch and snacks by 2.45pm that afternoon. We fed this back to the head of care that day and noted records were kept in a timely way on subsequent days of inspection. Another concern was the lack of records in the kitchen relating to people's food and drink needs and preferences. Despite this, kitchen staff were able to describe people's needs in terms of food consistency, but they were unable to list all people at the home who had recently lost weight. This meant there had been some improvement in terms of food and fluid recording; however, there was work to do to ensure improvement continued and was sustained.

At this inspection we sampled the eating and drinking care plans of three people who had lost weight recently. One person's care plan was dated August 2017 but contained an entry dated March 2017 stating the person was severely underweight with a body mass index (BMI) of 16 and the results of blood tests were awaited. Records for August 2017 showed the person's BMI had reduced further to 14.4 but there was no information in their care plan to say what action, if any, had been taken. The second person's care plan was dated June 2017; it stated they were losing weight and the GP must be contacted, and staff should aim to weigh the person weekly. BMI is calculated from a person's weight and height and can indicate whether a person is a healthy weight. The person's weight records showed they had not been weighed for eight weeks prior to this inspection and no reason for this was given. Weight records showed the third person had lost 11.2kg since April 2017; their eating and drinking care plan dated August 2017 stated the person had been refusing tea and supper meals on occasion, but made no reference to their large weight loss. As at the last inspection, when we spoke with the registered manager she could explain what action had been taken to address each person's weight loss. This meant actions taken to manage people's nutritional risk and risk of weight loss were still not always recorded in their care plans.

This was a continuous 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 care staff made appropriate referrals to other healthcare professionals when they needed it, and people's relatives said they were kept up to date about changes in their family member's health. One relative said, "With regard to referrals, yes they keep me informed." During the inspection we observed relatives asking a nurse for updates about their family members who used the service on two occasions. Both times the nurse took time to speak to the relatives and could provide up to date information which evidenced their knowledge of each person's health and wellbeing. People's records evidenced they had seen various healthcare professionals, including GPs, members of the falls team, speech and language therapists, and dieticians. This meant people had access to external healthcare professionals in order to meet their wider health needs.

At the last inspection in April 2017 we found that whilst some adaptations had been made to the design of the building to make it more suited to people living with dementia, further adaptation could have increased people's ability to navigate and mobilise safely. We recommended the registered manager accessed nationally available good practice on dementia-friendly design and adaptation to make improvements to the home. At this inspection we noted a handrail that had previously been the same colour as the wall had been painted a contrasting colour to stand out more. In addition, signs had been added to tables in the dining room informing people what meal they were about to have. The registered manager told us in

addition to these changes she had displayed reminiscence information outside the ground floor lounge area, replaced the orientation board so the clock worked, and purchased a large clock with hands to go in the ground floor lounge area. A consultant contracted by the registered provider to advise on improvements at the home had also suggested that pictures on walls be lowered so people could see them more clearly; the registered manager said she intended to action this advice. This meant changes had been made to the environment in accordance with good practice in dementia care.

Requires Improvement

Is the service caring?

Our findings

People appeared relaxed and happy with staff at the home. When we asked relatives if they thought the staff were kind and caring one told us, "Yes, they are caring", a second relative said, "Yes, nearly all of them", and a third relative told us, "They seem to be caring." Responses from the relatives' survey carried out in June 2017 included, "Staff always pleasant and approachable", and, "The staff at Aston Manor have given my [relative] the best care possible. The staff have also been supportive to me and my other relatives." A third relative described the quality of care as variable, stating, "As there are different staff from day to day the quality of care varies and some staff are very professional but others are not." We also asked an external healthcare professional if staff at the home were caring. They replied, "Absolutely. They do a very difficult job."

At the last inspection in April 2017 we identified a breach of the regulation relating to dignity as some of the interactions we observed between staff and people were not caring. At this inspection we observed staff were caring and knew people well as individuals; they were responsive to people's needs, but at times did not respect their dignity. For example, we observed three people being supported to eat at lunchtime. We noted interaction between each staff member and the person they were supporting was limited, whereas staff chatted amongst themselves about their social plans and about another service user who was unwell. During an observation in the ground floor lounge we saw two care workers entered the room to support a person to the lounge upstairs. Another staff member told them the person was watching a film on TV, however, the person was still escorted upstairs and no explanation why was given to the person by staff. Other interactions we observed were friendly and staff showed kindness to people they supported. This meant not all interactions between staff and people were respectful.

Since the last inspection found people's dignity was not always respected, the home had deployed a 'dignity champion' in addition to the care workers on duty. They worked four days a week; their role was to highlight poor practice by other staff members and to ensure people were cared for and had their needs met. The dignity champion told us, "If I see something I challenge it. If it goes on I tell the manager." The registered manager told us, "I feel [the dignity champion's] role has been productive for the home because [they] do challenge people (staff)." This meant the home had tried to address the issues with staff respect for people's dignity but there was more work to do.

At the last inspection we could find no evidence people had been involved in developing or reviewing their care plans and feedback from their relatives was mixed. After the inspection the registered manager told us she would write to people's relatives to arrange meetings to review and discuss the care people received. At this inspection one person told us they had not seen their care plan, and relatives said care plans were kept on the computer. None of the people or relatives reported being invited to a care planning meeting and we saw no evidence of this in the care plans we sampled. This meant people were still not involved in designing and reviewing their own care plans.

During the inspection we observed information about people was not always stored securely as the door to the manager's office was left standing open at times when there were no staff present. This meant people,

their relatives or visitors could access information if they chose to. A room used by care workers to store information about people was locked by a bolt at the top of the door; this meant people with capacity to use the bolt, relatives and visitors could access the information in this room if they wanted to. This meant people's information was not always stored securely as is required.

At the last inspection we found the registered manager was knowledgeable about the referrals process for advocacy services and could provide examples of people at Aston Manor who had used advocates. At that time we saw information about advocacy services was displayed in the entrance foyer where people could not access it due to a locked door. At this inspection we noted this had not changed. This meant people had been referred for support with decision-making by staff but information about advocacy was still located in a part of the home they could not access.

As at the last inspection, the registered manager could list people at the home who saw a priest when they visited on a monthly basis. She could also explain the cultural practices of people from other religions, although there was no one using the service at the time of this inspection with such needs.

At the last inspection we found the quality and level of detail in people's end of life care plans was mixed. Some such care plans contained person-centred detail whereas others had only basic information or funeral arrangements and two we saw were blank. At this inspection two relatives told us they had discussed their family member's future wishes with care staff, one of whom said they had signed a form. Another relative said they had not been approached about this aspect of care for their family member.

As part of this inspection we sampled six people's end of life or future wishes care plans. One of the six care plans included brief details of a relative's request for the person to remain at Aston Manor, for contact to be made with them at any time and details of the person's funeral arrangements. Of the other five, two people had no end of life or future wishes care plans, and the other three stated the person had a DNACPR in place, but no other details. DNACPR means 'do not administer cardiopulmonary resuscitation'; such 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. This meant action had not been taken to ensure people's end of life wishes had been recorded.

Inadequate

Is the service responsive?

Our findings

People we spoke with who lived at Aston Manor told us they had never made a complaint about the service. One relative said they had made complaints about the care their family member received; when we asked whether they had been resolved the relative told us changes would be made a for a while but then the service would, "Revert back to old ways." A second relative said of making a complaint, "You can go to the office, they will listen to you."

At the last inspection in April 2017 we found complaints had been investigated and responded to appropriately. After the inspection we recommended the registered manager make available information on the complaints process in an area of the home where people can access it; this was because information about complaints was displayed in the home's foyer which people could not enter. At this inspection records showed one complaint had been received since the end of the last inspection. Records showed a discussion had been held with the complainant in July 2017 and a commitment was made to investigate the concerns and respond within seven days. A brief handwritten record of an outcome meeting held with the complainant dated six days later was recorded, but there was no information as to how the complaint had been investigated, what the outcome was or what measures had been put in place to prevent similar problems in future. We also saw one relative's response to a survey in June 2017 where they had rated various aspects of meal provision, the laundry, and their family member's room décor as 'not acceptable.' This had not been treated as a complaint by the registered manager. Two other complaints had been received about the care provided at the home since the last inspection, but these were investigated and resolved by another registered manager for the provider. At this inspection we saw the complaints procedure was still displayed in the home's foyer and not in a part of the home where people could see it. The registered manager said she had displayed it on the 'relatives' noticeboard' in a corridor, but people had taken it down and moved it; she said she would make another copy and put it back on this noticeboard. This meant the complaints procedure was not always robust and people did not have access to information on how to complain.

This was a breach of Regulation 16 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we identified a breach of the regulation relating to good governance as people's care plans did not always constitute a complete and accurate record of their care and treatment. At this inspection we found the same issues. For example, one person who we saw was assisted to eat by staff had an eating and drinking care plan which stated they could eat independently. Another person's eating and drinking care plan made no reference to the assistance they required to eat and drink, whereas we observed they needed full assistance. A third person who had sustained a wound in a fall in August 2017 had no wound care plan in place to advise staff which dressings to use or how often they needed changing. A fourth person's mobility care plan included the use of another person's name throughout. A fifth person's medicines care plan stated they were given their medicines covertly; when we asked a nurse about this they told us this was not the case, and the person took their medicines when they were administered. This meant people's care plans did not always reflect their current needs.

At the last inspection care workers told us they did not read people's care plans. At this inspection we asked five members of care staff if they had read people's care plans, all five told us they had not. Reasons given for this included a lack of computer skills and no opportunity due to being too busy supporting people. Care staff were still not aware of the content of people's care plans despite this being raised as a concern at the last inspection which meant the care people received was not always appropriate to their needs.

At the last inspection we found some daily records on the computer system had been copied so they appeared on different people's records with the same wording. At this inspection we identified similar concerns. For example, on 17 August 2017 three people's activity records contained the same generic information about enjoying their surroundings, listening to music and watching TV. The same three people had the entry 'person-centred interactions' as a record of their activities for between six and eight days in August 2017. What 'person-centred interactions' were was not defined. Other daily records on the computer system evidenced people received support with their continence, as well as to wash, dress, and to eat and drink; such records were person-centred and individualised. This meant people's daily records did not always contain a complete and contemporaneous record of the support they had received.

We reviewed the records of a person admitted to Aston Manor since the last inspection in April 2017. The person experienced behaviours which may challenge others and was receiving one-to-one support from a care worker during the day while they settled into the home. We found the person had no behaviours care plan to guide staff around their triggers for behaviours or distraction techniques to help them calm down. The person also lacked a mental capacity care plan. This meant care workers did not have the information they needed to support the person's complex behaviours.

Further concerns with record-keeping and the lack of detail in care plans was a continuous breach of Regulation 17 (1) and (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we identified concerns around the support people received when they experienced behaviours that may challenge others and the records kept about such behaviours. On the first day of inspection one person was extremely distressed in a communal area for nearly two hours. During this time care workers sat and spoke with the person for short periods which appeared to calm the person, but when they left the person, they became very distressed once again. In the person's behaviours care plan it stated they were best supported on a one-to-one basis in their own room when experiencing distress, as this helped them to calm down. This meant the person did not receive person-centred care according to their care plan.

The care plans of two other people who experienced behaviours that may challenge others we sampled lacked detail as to the triggers for their behaviours or the distraction techniques care workers could use to try and de-escalate incidents. We noted one person who had been involved in eight incidents of physical aggression toward staff and other people using the service in the four months prior to this inspection had only been placed on an ABC chart a week before this inspection. ABC, or antecedent behaviour consequence charts, can be used to understand the triggers for behaviours and help identify successful distraction techniques so future episodes are minimised. This meant information about the person's incidents of aggression towards others had not always been collected. The person who experienced extreme distress for nearly two hours on the first day of our inspection was not on ABC charts, so there had been no attempt made to understand and reduce their distress. We asked the registered manager how information relating to incidents of behaviours that may challenge had been used to try and reduce future incidences; she said there was no such analysis of information gathered. This meant the service failed to ensure people who experienced behaviours which may challenge others received person-centred care.

This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in April 2017 we recommended the service reviewed their provision of activities for people living with dementia in line with nationally available good practice, as our observations showed people's access to meaningful activity was limited. At this inspection we found nothing had changed. An activity coordinator was in post at Aston Manor, although they also worked shifts as a care worker. The rota showed the activity coordinator had worked the majority of shifts over the eight weeks prior to this inspection as a care worker, working between zero and three activity coordinator shifts per week during this time. The activity records for three people for August 2017 evidenced the lack of provision of meaningful activities. All three records showed people had either listened to music, watched TV, had visits from friends and family, or received 'person-centred interactions.' Doors were open so people could go outside independently if they were able and we saw several people walked around the corridors and in the garden for much of the day. No trips out of the home had been arranged over the summer for people, although a boat trip for people's relatives had taken place in August 2017. The cook, who arranged some of the trips, told us two trips had been organised for September 2017, after this inspection.

The registered manager said she was trying to recruit another activities coordinator but had not been successful. She also told us no action had been taken regarding our recommendation to review the home's activities provision to make them more dementia-friendly. We noted that aside from being a care worker at the home, the activities coordinator had received no relevant training for their activities role. This meant people's access to meaningful activity had not improved since the last inspection.

This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Relatives told us the home was well-managed, although one said it was, "Most of the time." Relatives also said they felt able to raise concerns with the registered manager if they needed to. One relative commented, "Yes, you can always go to the office", and a second relative said of the manager, "She's alright. She's usually there in the office. I can ring up and talk to her."

Feedback from staff about the registered manager was mainly positive. Comments included, "She's lovely. You can go to her with problems", "She is very helpful", and, "If I said anything I'm confident it would be dealt with"; although one member of staff told us they did not think the registered manager had, "The skills to do the job."

At the last inspection in April 2017 we identified a continuous breach of the regulation relating to good governance as the registered manager and provider lacked oversight of the safety and quality of the service. At this inspection we found some improvements had been made but concerns remained.

The audit of accidents at the home had been improved. A paper file included information on each fall or other accident at the home; these were then analysed for trends by the registered manager on a monthly basis. Measures taken to address any concerns raised, such as referrals to the falls team, were recorded to evidence what action had been taken. The audit of medicines had also improved; a series of daily, weekly and monthly audits had been introduced. We saw these included a range of checks and had picked up the same issues with medicines records we identified at this inspection. This meant the process of audit had improved but it did not always lead to sustained improvement.

In comparison, the audit of incidents between people at the home was no better. Incidents were listed in a 'safeguarding' file and measures taken to deal with each incident were recorded, but there was no analysis of incidents to identify any trends or patterns. As stated earlier in this report, information about incidents involving people experiencing behaviours which may challenge others was also not analysed to try and minimise future occurrences. The audit of care plans, whose quality was noted to be variable and at times poor at the last inspection, had not changed. The audit sheet consisted of a tick list of each part of people's care files. There was no prompt to evaluate whether people's care plans and risk assessments were up to date, and we found at this inspection that in some cases they were not. This meant the quality of audit for some aspects of the home's safety and quality had not improved.

The registered manager also audited people's weight on a monthly basis and recorded the actions taken when people had lost a significant amount of weight over the previous month. We noted there was no longer term analysis of weight trends which would highlight people who were losing weight more slowly. The registered manager said she did not do this, but could see the need for it and would add this to the audit after the inspection.

The head of care and registered manager undertook various daily and weekly checks and walk-arounds on weekdays to ensure the home was clean and safe. Domestic assistants recorded work they had completed

on cleaning sheets; one told us, "My cleaning is spot checked. They tell me if things are not as they should be." The registered manager compiled a weekly report for the provider; this included information about complaints, safeguarding incidents, any equipment which had broken, visits from other healthcare professionals and details of any meetings, supervision or appraisals held.

At the last inspection we saw records of provider visits undertaken by the nominated individual, who was a director of the registered provider's company, were brief. They evidenced the nominated individual sought feedback from people and staff, checked the building, and assessed the provision of activities for people. The audit did not include any review of documentation, such as care plans, medicines records or audits completed by the registered manager. At this inspection we saw the scope of audit had not changed; records showed the nominated individual had completed one audit of the home since April 2017. Care staff at the home told us the nominated individual and another director from the provider's company made visits to the home on a weekly basis, but there were no records kept of changes or improvements they had made. The nominated individual told us they did not review care or audit records at the home, and acknowledged that, "Quality assurance has been lacking." To address this, after the last inspection the provider had contracted an external consultancy to help support them with quality improvement. Consultants had visited the home and compiled an action plan which was given to the registered manager at the end of June 2017. The consultants were due back to review progress with the action plan at the time of this inspection; the nominated individual said of the registered manager, "We've given her the space to do the work." Our observations at this inspection showed little improvement had been made by the provider and registered manager as numerous new and continuous breaches of regulation were identified.

As at the last two inspections, other aspects which evidenced the registered provider and registered manager's lack of oversight was their continued lack of compliance with the Mental Capacity Act 2005, the continued lack of staff access to a comprehensive training programme, and a continued lack of effective supervision and appraisal for staff.

This was a continuous breach of Regulation 17 (1) and (2) (a) (b) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we noted relatives were asked to complete feedback surveys but people who lived at Aston Manor were not. The registered manager told us she would ensure people were included in the next survey; she also said she would make herself available to see relatives at the home who did not visit on weekdays on one Saturday every month. At this inspection records showed people's relatives had been sent surveys in June 2017; feedback was largely positive although a number of suggestions for improvement had been made. The nominated individual told us the survey results had yet to be analysed but they planned to display the results along with 'You said, We did' information to explain how the feedback was used. Once again, people who lived at the home had not been included in the survey. The registered manager had attended the home on Saturdays to see relatives, but the most recent residents' and relatives' meeting had been held during the last inspection in April 2017, so people had been given no opportunity to feedback about their care since then. This meant the registered manager failed to ensure people had the same opportunities to feedback about the home as their relatives.

At the last inspection we found staff culture was not always positive and messages from managers displayed in the staff room had a negative tone. At the inspection we saw most notices had been removed from the staff room. Minutes of staff meetings showed praise and appreciation had been conveyed to staff by the registered manager and head of care. For example, the minutes of a staff meeting in May 2017 concluded the registered manager and head of care were there to 'Support in any way they can.' However, staff meetings had not been held regularly since the last inspection. Records showed there had been one care

staff meeting, one maintenance staff meeting, two kitchen staff meetings, and one domestic staff meeting. There had also been one meeting held after the last inspection to discuss issues of concern. This meant the tone of communication with staff had improved, although staff meetings were not held frequently.

Registered managers and providers have a responsibility under their registration with CQC to notify us of certain events or information. Notifiable events include serious injuries, authorisations for Deprivation of Liberty Safeguards, deaths, and safeguarding incidents. As stated earlier in this report two incidences of abuse were not reported to CQC as is required, but all others we checked had been, and they had been reported to the local safeguarding team. This meant the registered provider and registered manager's compliance with reporting had improved but there was more work to do to make sure all notifiable events were reported.

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. Ratings from the last inspection were shown on the registered provider's website, however, those in the home were displayed in the foyer, which was not accessible to people who lived there. In addition, the ratings had been badly colour-printed so it was not immediately obvious what the ratings were. This meant people at the home could not view the ratings from the last report and information that was displayed for relatives and visitors was not clear.

Aston Manor's website describes the home as, 'Offering specialist care for those with more advanced dementia symptoms and challenging behaviour.' We asked care staff to describe what good dementia care involved. Comments included, "Understanding and patience. Good communication between staff", "Looking at the person as a person. Making sure they are fed, clothes are clean; keep them safe", "Good hygiene, well fed. Sit and talk to them, hold their hand", "It's person-centred care. We take each individually, consider their likes and dislikes. We try to make them feel at home", and, "Ensuring people are clean, receive continence care, are comfortable and in a safe environment." Care workers' knowledge was therefore variable and mainly task-focused, centred around the activities of daily living. Good dementia care involves understanding the person and their history, promoting dignity and independence, providing people with opportunities to take part in meaningful activity, and above all, involves a person-centred approach. This meant most care staff we spoke with lacked knowledge of the fundamental principles of good dementia care.