Mr Carl Denis

The Aylsham Manor

Inspection report

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Date of inspection visit:
04 October 2021

Date of publication:
29 November 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Aylsham Manor is a residential care home providing personal care and support for up to 30 people aged 65 years and over, some of whom were living with dementia. At the time of the inspection, the service was full, with one room kept empty for respite care. The service consisted of an extended main house with bedrooms across two floors, and communal facilities, with accessible outside space .

People's experience of using this service and what we found
People's care needs continued to not be fully risk assessed or mitigation put in place to manage risks, for example in relation to falls, and aspects of the care environment. When people experienced falls and potentially hit their head, monitoring for signs of head injury were not being recorded to show completion. People were not being supported to maintain healthy weights, as recognised risk assessment tools were not in use.

People were not being protected from the risk of harm, as reporting measures were not being followed by the provider to ensure that referrals were made following incidents and accidents to the local authority safeguarding team; in line with their own policies. People living with dementia were not protected from accessing risk items, such as prescribed creams and teeth cleaning tablets, as the keys to the lockable cabinets were being left in the locks.

People continued not to be protected from the risk of catching infections such as COVID-19, as the provider was not following current government guidance to keep people safe. A person assessed as requiring a specialist diet, was not receiving food in the correct consistencies to mitigate their risks of choking.

The governance systems and processes in place did not ensure that people's safety was consistently maintained. People were supported to have choice and control of their lives; however, the policies and systems in the service did not ensure staff supported them in the least restrictive way possible and in their best interests. Whilst we found concerns in relation to the safe storage of topical medicines, we found other areas of medicines management had improved. We have made a recommendation regarding areas of improvement for pre-employment risk assessments.

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

Rating at last inspection (and update)
The last rating for this service was Inadequate with breaches of the regulations, (published 21 July 2021). A Warning Notice was served on 16 June 2021 in relation to the breach of regulation 12 for (safe care and treatment), with the timescales for the provider to be compliant by the 16 July 2021. At this inspection enough improvement had not been made and the provider was still in breach of regulation 12 and had not met all the requirements of the warning notice.

At the last inspection, the provider was also found to be in breach of regulations for, staffing, consent, good governance and fit and proper persons employed, which resulted in the provider sending us an improvement plan, and regular updates. We also met with the provider after the last inspection.

At this inspection, whilst some improvements had been made, the provider remained in breach of regulations for safe care and treatment, consent, protecting people from risk of harm or abuse, staff training and supervision and good governance.

This service has been in Special Measures since 21 July 2021. During this inspection the provider demonstrated that sufficient improvements had not been made. The service remains rated as inadequate overall. Therefore, this service remains in Special Measures.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

We initially undertook a targeted inspection to check whether the Warning Notice we previously served in relation to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met.; We inspected and found there was a concern with the provision of safe care, and the decision was made to widened the scope of the inspection to become a focused inspection which included the key questions of the key questions of safe, effective and well-led.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has remained rated inadequate. This is based on the findings at this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Aylsham Manor on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service.

This will usually lead to cancellation of their registration or to varying the conditions 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 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.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

The Aylsham Manor

Detailed findings

Background to this inspection

The inspection
This was initially a targeted inspection to check whether the provider had met the requirements of the Warning Notice in relation to Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Having reviewed all information and inspection findings from the site visit, the decision was made to widen the inspection to a focused. We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
Two inspectors and one medicines inspector.

Service and service type
The Aylsham Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The provider had registered with the Care Quality Commission. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with the provider and members of the management and staff team, including two senior members of care staff and members of the kitchen staff. We observed the provision of care and support in communal areas and part of the medicine round. We reviewed a range of records. This included four people's care records and 20 medication records. We looked at staff files in relation to COVID-19 risk management. A variety of records relating to the management of the service, including policies and procedures were reviewed. Formal feedback was given to the provider at the end of the site visit.

After the inspection
We made referrals to the local authority safeguarding team, due to concerns and poorly managed risks identified during the inspection visit. We liaised with the provider to source additional information.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At the last inspection, the provider had failed to ensure risks to people had the condition of the care environment were fully assessed and mitigated. This resulted in a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, sufficient improvement had not been made and the provider remained in breach of regulation 12.
- The quality of care records remained poor. Improvements to the level of detail and information contained in care records, including risk assessment and measures of mitigation had not been made since the last inspection.
- People were not being protected from harm. Documentation did not show that staff monitored people following falls for possible head injuries. Staff were also not recognising where people were showing changes in their usual routines, and that this could be a sign of a head injury.
- Risks within the care environment were poorly assessed. The provider had put risk assessments in place, but these were generic and not reflective of people's individual needs.
- Risk items were not being stored safely. Staff left keys in the medicine cabinets, which the provider was aware of. This gave people, including those living with dementia access to risk items such as teeth cleaning tablets and prescribed medicines.
- There was no audit of window restrictors. The provider had only installed a window restrictor when the risk was identified as an outcome of the last inspection. There were still windows without restrictors on, and there were no risk assessments in place to detail how to keep people safe.

Risks relating to the health and welfare of people, and the safety of the care environment continued to not be fully assessed and managed. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
At the last inspection, the provider had failed to prevent the risk of the spread of infection, including COVID-19. This resulted in a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, sufficient improvement had not been made and the provider remained in breach of regulation 12.
- We were not assured that the provider was preventing visitors from catching and spreading infections, specifically COVID-19. We found visitors to be entering the building without staff confirming their test results

or checking their temperature first.
● We were not assured that the provider was admitting people safely to the service. One person had returned to the service three days prior to the inspection. The provider was not testing them daily, had not cohorted staff or introduced any additional safety measures, in line with current COVID-19 government guidelines.
● We were not assured that the provider was meeting shielding and social distancing rules. Changes had not been made to the layout of seating in communal lounges and dining rooms to support social distancing.
● We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed. The provider demonstrated a lack of recognition of their own accountability to follow government COVID-19 guidance to prevent the spread of infection, in relation to arrangements for visitors and readmissions of people from hospital.
● We were not assured that the provider's infection prevention and control policy was up to date. The provider was unable to give inspectors a copy of their policy. Risk assessments for people and staff had not been dated and were not updated following changes in circumstances such as testing positive for COVID-19.
● We were not assured that the provider was using PPE effectively and safely. Kitchen staff continued to not wear their face masks in line with government guidance or their own individual risk assessments.
● We were not assured the provider was facilitating visits for people living in the home in accordance with the current guidance. Arrangements in place were found not to be followed by all visitors, and not enforced by the provider.

There continued to be insufficient measures in place to prevent the risk of the spread of infection. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At the last inspection, risks relating to the fitness and safety of staff employed at the service remained an area of concern. This was a continued breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, sufficient improvement had been made and the provider was no longer in breach of regulation 19.
● The provider was recording checks made in relation to gaps in employment. This safety measure was now in place to ensure the provider was satisfied of a staff member's suitability and levels of experience.
● Safety checks were in place to ensure staff were suitable to work at the service. References and checks were in place prior to a new staff member beginning employment.
● The provider was looking into risks identified through pre-employment checks before commencing employment. However, this process would benefit from the use of recognised risk assessment forms and completion in a legible format.

We would recommend the use of recognised risk assessment forms, to ensure all relevant checks are recorded and risk mitigation in place, as part of the pre-employment process.

Using medicines safely
At the last inspection, the provider had unsafe medicine management practices in place. This resulted in a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, sufficient improvement had been made and the provider was no longer in breach of

regulation 12 in relation to medicines management.

● People received their medicines as prescribed. All staff authorised to give people their medicines had been assessed as competent and we observed that staff followed safe procedures when giving people their medicines.

● Improvement had been made to guidance for staff. Information for staff to help them to give people their medicines consistently and appropriately was in place. This included for medicines prescribed on a when required basis (PRN).

● Staff demonstrated greater knowledge and understanding. Staff had benefited from additional training and support from the local medicines optimisation team to improve standards of medicines management.

● Some concerns around the recording of medicine sensitivities were identified. However, we were assured that staff took immediate action to resolve this once brought to their attention.

Systems and processes to safeguard people from the risk of abuse

● Policies and procedures were not followed to keep people safe. The provider was not adhering to the local safeguarding guidance on reporting of falls, particularly where people had experienced injuries.

● The provider did not recognise their own accountability in relation to the reporting of safeguarding incidents and concerns to the local authority, to maintain people's safety.

● Findings from this inspection visit resulted in referrals being made to the local authority safeguarding team, to ensure risks to people were recognised and addressed.

The provider was unable to demonstrate action taken to maintain people's safety and protection from harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● The provider had not learnt and reflected on feedback provided after the last two inspection visits. Whilst some improvements had been made, there was a lack of recognition as to the seriousness of risks identified, and why these needed to be addressed as a matter of priority.

● The provider was not acting on feedback given. Following the last inspection visit, the provider had received support from the local authority, and infection, prevention and control team, yet had not used their feedback as a learning opportunity to make the required levels of improvement at the service.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (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 had the appropriate legal authority and were being met.

At the last inspection, the provider continued not to work in line with the MCA and DoLS, which resulted in decisions not being made in line with legislation and legal frameworks. This was a continued breach of regulation 11. (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, sufficient improvement had not been made and the provider remained in breach of regulation 11.
- The provider was unable to demonstrate that the conditions attached to people's DoLS had been followed and did not provide any additional supporting evidence when this was repeatedly requested.
- People's care records continued to contain statements about their capacity and ability to make decisions, but this was not supported by an assessment of their capacity.
- The provider continued to make joint decisions with people's relatives, who did not have the legal powers to make those decisions.
- Where people were assessed to lack capacity, best interest decisions had not been completed to ensure that the least restrictive options had been explored.

The provider continued not to work in line with the MCA and DoLS frameworks, which resulted in decisions not being made in line with legislation and legal frameworks. This was a continued breach of regulation 11. (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At the last inspection, risks relating to staff training, competency and supervision were identified. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, whilst some improvement had been made, the provider remained in breach of regulation 18.

- There continued to be low levels of staff supervision, including for those staff in their induction period, and no performance appraisals had been completed.
- There remained some gaps in staff training. When this was discussed with the provider, consideration of performance management or disciplinary action if this was not addressed by the individual staff member had not been considered.
- Staff had not completed up to date training in the use of the defibrillator in place at the service or in relation to the management of behaviour which may challenge, which was a shortfall identified at the last two inspections.

Risks relating to staff training, supervision and appraisals were identified. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff uniforms were on order. This was an area of concern raised by people living at the service during the last inspection. The provider was in the process of addressing this.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support

- People's choking risks were not well managed. One person had recently been discharged from hospital with specialist guidance to follow in relation to their food consistencies. Staff were not adhering to the guidance and had not contacted the speech and language therapists for advice about how to keep the person safe.
- Staff were not keeping contemporaneous records of people's food and fluid intake.
- Fluid records where people required use of thickener were poor. These records did not clearly show if thickener had or had not been given and did not record the amounts of fluid consumed.
- People's care records did not identify risks in relation to choking, or specialist diets in all relevant sections. This did not ensure staff were aware of people's needs and risks, particularly if staff were new in post.
- Guidance from healthcare professionals was not always sourced by the provider.
- Staff were not using a recognised screening tool to monitor people's weights and any associated risks or changes.
- The provider continued to work closely with the GP practice and other health and social care professionals. However, had not reviewed changes in people's needs for example in relation to choking risks and medicine administration.
- The service supported people to attend medical appointments, taking them in vehicles rather than using transport to reduce the risk of the spread of infection.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Based on inspection findings, staff continued not to be implementing government guidelines into practice, to ensure care was delivered consistently and in line with expected standards; particularly in relation to the management of COVID-19 and MCA.

● People's own values, beliefs and preferences were respected by staff, and reflected in people's care records.

Adapting service, design, decoration to meet people's needs

● There continued to be a lack of signage throughout the service, particularly to support people living with dementia to maintain their levels of independence.

● People decorated their bedrooms with their own furniture and personal effects. This made each person's bedroom feel homely and in line with their personal tastes.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has now remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

At the last two inspections, the provider continued to have poor governance arrangements in place to drive improvement at the service. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, sufficient improvement had not been made and the provider remained in breach of regulation 17.

- The provider's auditing systems remained poor. Practices were not in line with the basic standards expected to demonstrate the safe provision of regulated activities. The provider did not have sufficient oversight and was not acting on risks where identified.
- The provider had received support from the local authority and infection prevention and control team. However, continued not to implement guidance into practice. This resulted in poor recording, auditing and quality checks as well as a lack of implementation of training and supervision.
- Change within the service only happened where the provider was guided for example by CQC to make changes, not as a result of findings from their own audits and safety checks in place.
- Minimal change had been made to the content of people's care records. The quality of records remained poor, with a lack of records to demonstrate the completion of the provider's own quality audits.
- The provider continued to demonstrate a lack of understanding of their own regulatory responsibilities and had not acted on the findings at the last inspection to drive improvement. For example, the service continued not to have a COVID-19 policy in place and concerns around infection prevention and control remained.
- The provider continued to not be completing detailed post incident and accident analysis, with a lack of assessment for themes and trends to prevent the risk of reoccurrence.
- Concerns regarding the provider's understanding of their regulatory responsibility to meet the requirements of duty of candour remained.
- The provider continued to be unable to demonstrate that they recognised their own legal responsibilities and accountability as a registered provider. The repeated breaches of regulation, and ongoing poor rating

further supported this.
● Key documents such as risk assessments were not being signed off by the provider. Many audits and documents such as staff risk assessments were undated, and not being reviewed.
● There continued to be examples of where we would expect to see onward referrals being made for specialist guidance and advice and this was not in place. The provider lacked understanding in relation to their responsibilities regarding referrals to keep people safe.

The provider continued to lack understanding and recognition of their own regulatory responsibilities and accountability and have poor governance arrangements in place to drive improvements and standards at the service. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider told inspectors that they plan to change their care records from paper to electronic records, as they recognised that handwritten care plans were no longer able to keep up with changes in people's need to keep staff fully up to date.

● Changes had been put in place to seek feedback from people and relatives. However, at the time of the inspection, not all responses had been received, so the provider was not in a position to provide full feedback on outcomes.
● Examples of positive feedback received by the service in relation to end of life care provision were shared with inspectors.