Mauricare Limited

Aston Manor

Inspection report

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Date of inspection visit:
14 July 2016
21 July 2016

Date of publication:
19 September 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Aston Manor took place on 14 and 21 July 2016 and was unannounced. The previous inspection, which had taken place during November 2015, had found the service was in breach of specific regulations. We had issued warning notices to the registered provider and registered manager which meant they were required to take immediate action with regard to assessing and mitigating risks, detecting and preventing the spread of infection and assessing, monitoring and improving service provision. We had issued requirement notices and received action plans from the registered manager and registered provider to show how they would address other breaches we found with regard to providing person centred care, treating people with dignity and respect, staffing and meeting nutritional needs.

This inspection found improvements had been made in each of these areas. However, there were continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to safe care and treatment, good governance and staffing. New breaches of the regulations were found in relation to safeguarding and the management of complaints.

Aston Manor is a nursing home, registered to provide care for up to a maximum of 32 older people. The home has two floors and provides care and support for people with nursing and residential needs, including people who are living with dementia. There were 27 people living at the home at the time of this inspection.

The service had a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager and staff were aware of relevant procedures to help keep people safe and were aware of signs that may indicated someone was at risk of abuse of harm. However, on the day of the inspection, we identified a safeguarding concern that had not been reported and investigated. Not all staff had received up to date safeguarding training.

Risks to people had been assessed and risk reduction measures had been considered.

People were weighed regularly and appropriate referrals were made to healthcare professionals regarding diet and nutrition when necessary. People received appropriate support in order have their nutrition and hydration needs met.

Some moving and handling equipment was used for people whom had not been specifically assessed for the equipment.

The number of staff identified as being required were not always deployed. There was an instance of a nurse working a 24 hour shift.

Medicines were administered safely by staff who had received appropriate training to do so.

Improved practices were observed in relation to cleaning and the prevention and control of risks associated with spread of infection.

Staff had received induction to prepare them for their role, which included shadowing more experienced members of staff. Staff received regular supervision and told us they felt supported in their roles. However, not all staff training was up to date.

Where people lacked capacity and were deprived of their liberty, the registered manager had made appropriate applications to the supervisory body in order for this to be authorised. However, the registered manager did not always act in accordance with the Mental Capacity Act 2005. Decision specific mental capacity assessments had not always been completed when decisions were made in people's best interests.

People were given choices throughout the day and we saw staff sought consent from people prior to providing care and support.

People's rooms were clean and personalised. Pictorial signage was used throughout the home, to assist people to navigate around the home.

People told us and we observed staff were caring. People's privacy and dignity were respected.

Care plans were person centred and contained information to enable staff to provide care and support to people. Appropriate information was shared between staff to enable continuity of care.

Records of complaints were disorganised and complaints were not managed and responded to effectively.

The registered manager was visible throughout the home and knew people's needs. Relatives and staff told us the registered manager was approachable.

The registered manager undertook regular audits in order to improve provision of service.

You can see what action we told the registered 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?

Requires Improvement

The service was not always safe.

Staff showed an understanding of safeguarding reporting procedures but the registered manager had not reported and investigated a safeguarding incident.

The number of staff identified as being required were not always deployed.

Risks to people were assessed and measures were put into place to reduce risks.

Medication was administered safely by staff who were appropriately trained to do so.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received induction and on-going supervision and support.

Staff and the registered manager did not always act in accordance with the Mental Capacity Act 2005.

People received appropriate support in order to have their nutrition and hydration needs met.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were caring.

We observed positive interactions between staff and people who lived at Aston Manor.

Staff respected people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People and their relatives had been involved in developing care plans, which were reviewed regularly.

People's rooms were personalised to their own tastes and contained items of sentimental value.

People engaged in a variety of activities.

Complaints were not always managed well.

Is the service well-led?

Requires Improvement

The service was not always well led.

Relatives and staff told us they felt the registered manager was approachable and the registered manager knew people and their needs.

The registered manager completed regular audits which resulted in some improvements to the service, however, further development was required in this area.

Policies and procedures related to out of date regulations.

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.

The inspection of Aston Manor took place on 14 and 21 July 2016 and was unannounced. The inspection team consisted of two adult social care inspectors on each day.

Prior to the inspection we reviewed the information we held about the home. This included information from the local authority and the clinical commissioning group as well as information we received through statutory notifications.

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

We used a number of different methods to help us to understand the experiences of people who lived at the home, including speaking with people, making observations and inspecting records. We spoke with three people who lived at the home, four relatives of people who lived at the home, five care staff, a member of domestic staff, a nurse, the head of care and the registered manager.

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

Requires Improvement

Is the service safe?

Our findings

A person we asked told us they felt safe and said, "I like living here."

A family member said, "It feels as safe as anywhere can be." Another family member said, "Safe? Yeah."

A further family member, however, had a different view. This family member told us they felt their relative was unsafe. They told us they had asked the registered provider to install CCTV in the quiet, small lounge area because they felt this would provide a sense of safety. However, they felt they were being, "Brushed off." We asked the head of care about this who told us the registered provider was arranging to have enhanced observations in this area, which means images are relayed to a monitor in the registered manager's office but are not recorded.

One family member said staffing levels were, "Okay." Another said, "Yes, there are enough staff."

The door to the home was secure on arrival and a member of staff granted the inspection team access and checked our identity. This helped to keep people safe, as unauthorised access to the home was prevented.

Staff and the registered manager were clear about safeguarding reporting procedures and were able to outline different types of abuse and give examples of potential signs to look for, which may indicate if someone was at risk of harm or being abused. The registered manager told us they would report unexplained bruising, altercations and any other allegations of abuse. A member of staff told us they would report any suspected abuse to the registered manager and said, "If not acted on I would phone safeguarding team or CQC."

Records showed, however, only 28 out of 39 members of staff on the training matrix had completed up to date safeguarding training. We asked the head of care if this was an accurate reflection of the training staff had received and were told this was the case. The registered manager contacted us following the inspection to confirm that additional safeguarding training had been sourced and arranged for staff who required this.

Prior to the inspection, we received some information of concern, alerting us to the fact a person had a bruised eye. During our inspection we did see a person with a bruised eye. We asked the registered manager about this and were told the unidentified bruising had been reported to safeguarding. The registered manager told us the person tended to rub their knuckle in their eye and the registered manager considered this may be the cause. We could not see this information in the person's care plan. When we asked family, they were not aware of the person rubbing their eye with their knuckle. We contacted the local authority safeguarding team, following our inspection, who confirmed the bruising had been reported to safeguarding the day following the inspection. This meant the bruising had not been reported immediately to safeguarding and only following the inspection was the bruising reported. It is important to have robust safeguarding reporting procedures so people are protected from abuse and improper treatment. This demonstrated a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because systems and processes were not established and operated effectively in line with

safeguarding reporting procedures.

The previous inspection found some people were walking around without appropriate footwear. We checked during this inspection and found everyone who we observed was wearing shoes and slippers that appeared to fit the person. Staff offered assistance to people moving around the home, where this was required.

Records showed people had been weighed monthly and their weights had been entered onto their care records. We saw evidence people had been referred to the nurse and to their GP where concerns had been raised. Frequency of weighing was then increased to weekly and weight was monitored. We saw records of this. The previous inspection found the weighing scales not to be accurate. We saw records of scales being recalibrated and serviced.

The previous inspection found people were using equipment that was not specifically for them. We asked the registered manager what actions they had taken since the last inspection to address this and we were told all equipment had been labelled for individuals. However, we checked and found equipment such as zimmer frames and wheelchairs were not labelled. Furthermore, we saw two handling belts that were being used to assist people to move. One was labelled with the name of a person. We asked a member of staff who the person was and we were told, "I've worked here five years and I've never heard of that name." We asked who the belts were for and were told by the member of staff, "Anyone that needs them. We keep them here so we can just grab one if we need it." The two handling belts were very different and people should be assessed for a specific type of belt. This could put people at risk of being assisted to move inappropriately. Furthermore, this would increase the risk of the spread of infection. We shared this with the nurse and head of care. Following the inspection, the registered manager confirmed staff knowledge regarding moving and handling was being assessed and competencies checked. However, the above demonstrated a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because care and treatment was not always provided in a safe way in terms of moving and handling people.

The previous inspection found risk assessments were scant, not relevant and contained inaccurate information. We found improvements at this inspection. We saw risks had been assessed and risk reduction measures had been considered to reduce the risks associated with falling for example. Consideration had been given to the use of bed rails and we saw a person had been assessed for the use of bed rails but other risk reduction measures had been used because the use of bed rails posed a greater risk to this particular person. Risk assessments had also been completed in relation to evacuating the building in an emergency, behaviour risk assessments, nutritional risk assessments and infection control for example.

Records showed safety checks took place in relation to the building and the environment. For example, window restrictors were checked monthly and we saw these were repaired when necessary. The nurse call system was checked monthly. Portable appliance testing had been recently completed. We saw lifting and moving and handling equipment had been recently serviced and certified as safe to use. Corridors were free from clutter. This helped to ensure the premises were kept safe.

We asked staff what they would do in an emergency, such as if they found a person collapsed on the floor. Some staff could not describe the actions they would take. Two staff members said the nurse would deal with this. We asked a member of staff if they would start to resuscitate someone before the nurse was present and they said, "I don't know." This demonstrated some staff were unsure of what actions to take in an emergency. We shared our findings with the head of care, who told us the first aid training staff received was, "Only basic."

We spoke with the registered manager, following the inspection, who advised they had approached an external training company to provide more effective training. The registered manager confirmed staff had been booked onto additional first aid training. Furthermore, staff had been addressed by the nurse during a staff meeting and handovers and reminded regarding recovery position and actions to take in an emergency.

The previous inspection found a lack of accident and incident recording and analysis. During this inspection we found accidents and incidents were logged and recorded with a summary of each month, which enabled trends to be analysed. We could see evidence of actions taken such as a crash mat and sensor mat being used to reduce the risk of injury to a person.

The registered manager told us they used a dependency tool to help determine staff numbers. This took into account people's needs in relation to continence, mobility, personal care, eating and drinking for example. The registered manager told us they felt there were enough staff to meet people's needs and, if necessary, the registered manager would be able to recruit additional staff. The head of care also told us they felt staffing numbers were sufficient.

The registered manager told us staffing levels were one nurse and eight carers, one of which was head of care, as well as three laundry and domestic staff, a handyman, a cook, a dining assistant, an administrator and an activities coordinator, as well as the registered manager to provide care and support for 27 people. We observed people's needs being met during the inspection. One person was provided one to one care by the home. Overnight the registered manager informed us there were three carers and a nurse on duty.

However, this number of staff were not always deployed. For example, during the week prior to the inspection rotas showed that, for three days of that week, there were six carers and a nurse working on the early day shift and on one day the rota showed only five carers and a nurse worked the late day shift. Rotas showed that one staff member on each of these days, who had been allocated duties, were absent due to sickness. A member of staff told us, in relation to staffing levels, "It varies. There should be seven or eight but it has gone down to five. It's difficult. Frustrating. It's not all the time. It's when there's sickness and no agency staff."

We had received some information of concern prior to our inspection, alleging that a staff member had worked a 24 hour shift. We asked the registered manager about this during the inspection and were told this was not the case. However, during the inspection a member of staff told us a nurse had worked a 24 hour shift. We inspected rotas which showed a nurse had worked an early, late and night shift, which equated to 24 hours. We contacted the registered manager and asked them if this meant the nurse had worked a 24 hours shift. The registered manager told us, "Yes, in that instance the nurse would have had to stay on the premises."

We saw night staff varied. The rota showed sometimes there were two carers and a nurse and sometimes there were three carers and a nurse. We asked the head of care to explain this. The head of care told us the dependency tool used to help determine staff numbers indicated that two carers and a nurse were required at night and said, "We have too many night staff so we allocate to make up people's hours." We clarified what the head of care was saying and asked if the staff numbers changed depending on staff and were told, "Yes. We only need two carers but sometimes we have three." The nurse we spoke with, however, told us, "There used to be three staff on nights but now we have four because the numbers have increased."

Following the inspection, we spoke with the registered manager who confirmed two additional nurses had been recruited. The registered manager had obtained Disclosure and Barring Service checks and was

awaiting reference checks to be completed, prior to the nurses commencing induction. This showed measures had been taken to address the shortfall in nurses, resulting in the nursing staff working long hours. Furthermore, the registered manager advised they were in the process of consulting staff regarding shift patterns. The registered manager considered that shortening shifts may reduce staff sickness levels and be a more effective way of working. The registered manager had spoken to some staff and the issue would be raised at the next staff meeting. The registered manager explained they felt this would offer a more flexible way of working for staff and this would also allow for an overlap of shifts over a lunchtime period.

Although steps were being taken to address the issues regarding staffing numbers, the above examples meant sufficient numbers of staff were not deployed to ensure people's care and treatment needs were met effectively. This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We sampled four staff files and found safe recruitment practices had been followed to ensure staff were safe to work with vulnerable people. For example, the registered manager ensured that references had been obtained and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups of people.

We saw, where there were concerns regarding staff, these were not fully addressed. For example, the probationary review for a member of staff stated some other staff felt they, 'Came across as being quite rude when giving handover.' The review stated, 'Another review to be completed in four weeks.' However, we could not see evidence of this having taken place. We asked the head of care whether a follow up review had taken place and were told if a further review had taken place the record of this would be in the file, but there was no evidence in the file. Furthermore, there was no evidence of supervision having taken place with the member of staff, since the review on 11 April 2016.

On a list of training in relation to medication, we saw 'refused' written next to a staff member's name. We asked the head of care what this meant and were told the staff member had refused to attend the training because they felt they should be, "On the floor." We asked whether any action had been taken or how this had been addressed. The head of care advised, "No. They'll probably do it next time". Although this person was not responsible for administering medicines, these examples showed a lack of action when staff conduct fell below that which was required.

Medicines were administered in an efficient and caring manner by a nurse and a carer who had been trained to do so. The medicine trolley was locked between each administration of medicine, which reduced the risk of unauthorised access to medicines. Medicines were popped into pots, without the member of staff touching the medicine which was good practice and helped to reduce the risk of the spread of infection.

Some people required their blood pressure to be checked prior to medicines being administered. The nurse did this where necessary and this was recorded clearly on the medication administration record (MAR). Stock levels were checked after each administration. The stock levels of medicines remaining reconciled with the records.

Creams that were opened included a date of opening. This helped to ensure only medicines that were in date were being used.

The previous inspection found significant concerns regarding cleanliness and infection control. We found improvements in this area during this inspection. A family member told us they felt the home had good

infection control and was well cleaned.

On both days of the inspection, the inspection team found offensive odours within the home, upon arrival. However, these did seem to reduce as each day progressed and as the domestic staff cleaned the home. Beds were stripped down to the mattress and we observed these to be clean. A member of domestic staff told us, and records showed, mattresses were cleaned every day.

Records of cleaning showed quarterly showerhead descaling had taken place, mop heads were cleaned daily and there were daily tick sheets that cleaning staff had completed to show they had cleaned different areas within the home. We saw supplies of personal protective equipment were available for staff to use and anti-bacterial hand gel dispensers were placed in the corridors. Records showed these were checked regularly and we found these to contain gel.

Requires Improvement

Is the service effective?

Our findings

A family member told us, "It's a brilliant home. As good as you can get." Another said, "[Name of relative] eats and says it's nice."

When we asked whether people felt staff were skilled, a family member told us they felt as though staff knew what they were doing. This family member said, "It tends to be the same people now. I rarely see agency."

We were told, "The food is nice. There is plenty of food." A family member said, "[Name] has a really good appetite and they really enjoy it."

The previous inspection found the registered manager had no process in place for monitoring staff ability. The registered manager advised there was now a training matrix in place, linked to a computer system, to enable staff training to be better monitored and organised. The registered manager advised new staff received an induction and this was documented through a check list. We saw evidence of this and the new staff we spoke with told us they felt they had received a thorough induction. The head of care was a point of contact for new staff.

The newer members of staff we spoke with told us they had the opportunity to shadow more experienced staff before they were expected to perform their caring role. A member of staff said, "I've had quite a bit of training. Moving and handling, dementia and safeguarding." This meant that staff had received essential training and information, prior to commencing their role.

We viewed the training matrix and saw there were some gaps in training. For example, records showed, out of the 39 staff listed on the matrix, 29 had completed moving and handling training, 22 had completed first aid training, 19 had completed fire safety training and 28 had completed safeguarding training. We asked the head of care if the matrix was a true reflection of the training staff had undertaken and were told, "Yes." This showed not all staff had received training essential to their role.

We could not find evidence to show staff had received Mental Capacity Act (MCA) or Deprivation of Liberty Safeguarding (DoLS) training as MCA or DoLS were not included on the training matrix. We asked three care staff whether they had received training in MCA and DoLS and they told us they had not. We found staff lacked awareness of the principles of the MCA and DoLS.

We spoke with the registered manager following the inspection, who advised they had approached an external training company to provide more effective training. The registered manager provided confirmation training had been booked in relation to essential areas such as first aid, fire safety, infection control, MCA and DoLS and equality and diversity. However, the above demonstrated a further breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because some staff had not received appropriate support and training to enable them to carry out the duties they were employed to perform.

Staff received regular supervision. The head of care carried out staff supervision with care staff. This revolved around a particular 'theme' chosen by the registered manager, such as staff sickness levels for example. We looked at minutes of staff supervision and found these were generic and the same items were included in each staff members' record. We found themes such as staff sickness, time keeping, staff being mindful how they spoke to families, staff being reminded to follow instructions of a senior person in charge. However, records of supervision did not show staff were given the opportunity to reflect on their own practice and discuss their own training and support needs. This is an important aspect of one to one supervision.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The registered manager had considered and assessed that some people who lived at the home lacked capacity and were being deprived of their liberty. The registered manager had therefore applied to the local authority in order to seek authorisation, in accordance with the principles of the MCA and associated Deprivation of Liberty Safeguards.

The registered manager had an understanding of the MCA. However, although reference was made in people's care plans as to whether people had capacity, there was a lack of decision specific mental capacity assessments. The home made use of enhanced observations, which is CCTV that does not record but allows the registered manager to view communal areas from the office monitor. Some people were not able to give consent to this, due to lacking capacity. The registered manager had made a decision, in conjunction with people's family members, that to use this type of observation would be in the person's best interest and this was recorded. However, although decisions had been made in some people's best interest, we could not find decision specific mental capacity assessments to demonstrate people lacked capacity in order to make this particular decision for themselves. A person was administered medicines covertly. Although the person's GP had been consulted regarding the safety of this, there was no decision specific mental capacity assessment to demonstrate the person lacked capacity to make decisions about their medicines. We highlighted the lack of decision specific mental capacity assessments to the head of care who agreed this would be addressed.

Throughout the inspection, we observed staff seeking consent from people. For example, when a person had food on their chin following a meal, the carer asked the person if they could wipe their chin for them.

We observed a mealtime experience. Staff respectfully asked people whether they wished to wear an apron to protect their clothes. People's choices were respected. One person was very clear they did not wish to wear an apron and the staff member was respectful of this and left the apron with the person, advising they could simply place it over their knee if they wished. The person appeared happy with this.

Some people did not want to eat the food that was offered, even though they had made their own choice of what they would like to eat. Staff were accommodating and people were offered different foods and meals. People who had changed their minds did not have to wait an excessive period of time to be served their

alternative, so they were still able to eat their meal with their peers.

Staff gave people appropriate support to eat their meals, using respectful reassurance in order to encourage people to eat more.

Mealtimes had a calm, pleasant atmosphere. One person required a lot of staff attention and we observed staff managed this well by assuring the person they would assist them but also ensuring other people received the support they required.

The previous inspection found everyone was given plastic cups, regardless of their circumstances or level of need. At this inspection we observed people were given drinks in a variety of different style cups, according to their need.

Food and drink was available in between meal times. We saw people being asked if they would like drinks throughout the days of the inspection. One person asked for a banana. A member of staff accommodated the request and assisted the person to peel their banana.

During mealtime, in the upstairs lounge, we saw one person was becoming agitated and confused and the person was continually moving into standing position. Staff were attentive to the person, offering reassurance and encouragement to stay and eat their meal.

We observed staff providing support to people who needed assistance to eat. Staff did this in a respectful way, reminding the person what they were eating and engaging in soft conversation. People appeared at ease with staff.

Staff observed one person had not eaten their lunch. Staff were observant to this and proactive in asking whether the person would like to try something different. The person asked for a sandwich and this was provided.

For people who chose to remain in the lounge areas, meals were served to each individual already plated, with a cover and staff ensured people had everything they needed within reach. This demonstrated people received support in order to meet their nutritional and hydration needs.

Attempts had been made to make the environment homely, with paintings on walls and photographs on display. Bedrooms were personalised and we saw sentimental items displayed. Patio doors opened from a small lounge into an outside space. The outside area was a pleasant space with a well maintained garden and seating area.

People living with dementia can experience difficulty with orientation. Pictorial and word signage was used to assist people to navigate around the home. Displaying information such as the date, day and time can be beneficial in reducing anxiety. We saw an orientation board on display, showing the correct information in relation to the date and time.

People had access to health care. We saw referrals had been made to different health professionals such as GP, district nurse and chiropodist for example.

Good

Is the service caring?

Our findings

One person told us, in relation to staff, "They are helpful." Another said, "I like them. They are nice, but I put them right."

A family member told us, in relation to the behaviour of their relative, "Staff are aware it's the illness, not [Name of relative]." They added, "It's friendly. The food's nice and I have no issues with clothes and laundry."

Another family member told us they liked the care staff and said they go, "Above and beyond." Another said, "Staff are lovely."

Another relative told us, "I'm very happy with the care here, yes."

A staff member told us, "I love it here. It's challenging but I love it." Another member of staff said, "I love this job. There's always room for improvement but I love it. Giving people quality of life."

We asked a member of staff how people's privacy and dignity was maintained. We were told, "If people want to be alone they can be. We maintain checks on people. If we use the hoist, we always cover legs."

A member of staff told us, "The residents. You love them all. They all have their own personalities. They are lovely. That's what we're here for."

During the inspection, a staff member was hit in the face by a person. This happened suddenly, with no warning. We observed the staff member showed no retaliation and acted with compassion and kindness towards the person, diverting the person's attention and offering reassurance.

We observed care staff using appropriate touch and reassuring words to people throughout the inspection.

A member of staff observed a person's dignity was being compromised because the person's clothing had 'ridden up'. The carer spoke with the person discreetly whilst assisting the person to readjust their clothing.

Staff were friendly towards people, whilst maintaining a level of professionalism. A person asked a staff member if they wanted some of their dessert. The staff member said, "No thanks, I'm watching my figure." The person found this amusing and they laughed together. At other times, staff were professional and discreet and spoke quietly in people's ears, so as to maintain people's dignity.

A member of domestic staff told us they would knock on people's doors and ask permission to enter the person's room. If permission was refused, the staff member said they would leave and, "Try again later." We observed staff to knock on people's doors before entering their rooms.

We saw a member of staff was supporting a person to the outside garden area. The member of staff asked

another person, as they were passing, whether they wanted to join them. It was clear this person was very pleased to have been asked and the staff member showed patience and respect towards both people as they were supported to go into the garden area.

We observed a person's trouser braces to come undone, leaving the person's dignity potentially being compromised. Staff were quick to notice this and a member of staff assisted the person in respectful and discreet manner. This helped to maintain the person's dignity.

Although information regarding DNACPR (do not attempt cardio pulmonary resuscitation) orders was included in staff handovers, some staff we spoke with were not aware which people this was relevant to. This could mean people's wishes and decisions, regarding whether someone should be resuscitated, were not respected. We shared this with the head of care and, following the inspection, the registered manager told us staff had been reminded of the importance and relevance of this information.

Requires Improvement

Is the service responsive?

Our findings

A family member told us they felt the registered manager was trying to improve the home by catering more for individual needs and making care more person-centred.

Another family member told us, "Any concerns are dealt with straight away and they respond quickly."

Each person had a care plan and these were held electronically. Assessments were in place in relation to behaviour, infection control, personal hygiene and dressing, communication, medical history and wellbeing, emergency evacuation, falls risk and nutrition for example. The registered manager told us care plans were reviewed monthly or more frequently if required and we saw evidence of this.

Care plans were in place and contained details regarding the level of assistance each person required, such as in relation to washing and dressing, medication and communication for example. The records we sampled contained up to date plans. Information such as whether the person had a preference of a male or female carer was included.

A family member told us they had been involved in the care planning for their relative. Furthermore, this family member said family meetings were held every quarter, so they felt involved with the care and home in general.

Due to care plans being held electronically, this meant in order to read the plans staff needed to go into an office. When we asked if staff had the opportunity to read care planes, a member of staff we spoke with told us they had the opportunity to read people's care plans. However, another member of staff shook their head and said, "No, not really." We asked how staff were made aware of people's needs, if they did not read care plans and we were told information was passed on from more experienced members of staff and in handovers. This meant there was a risk people's care was not provided in line with their assessed need and care plan.

A member of staff was able to tell us about a person who preferred to eat their food in quieter areas. We observed this person was having their lunch in a quiet lounge within the home. This showed the member of staff was aware of this person's preferences.

On the second day of our inspection, two members of staff told us the upstairs lounge was sometimes open and sometimes closed to residents, dependent on staff numbers. We were told, "Sometimes we open the upstairs lounge. Depends on the senior. They will tell us. Sometimes it's all week. If that happens then staff split between two floors. But sometimes there's not enough [staff]. Sometimes it's less and there's only six members of staff." Another member of staff told us, "The lounge upstairs opens depending on staffing levels." We asked another member of staff if the upstairs lounge was sometimes closed due to staffing levels and they confirmed this. However, on the first day of our inspection, a member of staff had told us about a person who preferred the upstairs lounge because it was, "Quieter." This meant the person was not always able to access their preferred lounge, depending on staffing numbers.

People's rooms were clean and tidy. We saw people had access to their own toiletries. Photos and items of sentimental value were on display in people's bedrooms which helped to create a homely, personalised environment. One person had painted their own bathroom in a colour of their choosing. This showed people were able to personalise their environment.

Daily notes were written for each person. These were person-centred and included information relating to the person's health, mood and key activities. This helped to ensure appropriate information was shared between staff.

The home employed an activities coordinator. A board displayed upcoming activities, such as a sensory morning, sing-a-long, darts and cards, a walk in the park, morning in the garden, craft work and media and books. We saw a summer fair was being advertised. A family member told us the activities coordinator, "Does a lot of work regarding life history. Chats about likes and dislikes." Having a dedicated activities coordinator meant care staff at the home were able to continue to provide care whilst people participated in activities.

We asked to see how complaints were managed and were given a folder containing complaints. It was difficult to determine exactly what actions had been taken because the information was not organised well. There was a lack of oversight of complaints and no analysis. There were loose sheets in the folder that appeared to not be in a particular order. One said, 'see attached,' but there was nothing attached. One complainant had stated, 'We still notice a smell of urine on seats.' Written on the back of the complaints form was, 'Discussed with [Name of staff] who are responsible for cleaning and infection control.' However we could not evidence the complainant had been responded to. Other recent complaints included a person being dressed in ripped trousers, a person being wet, a broken bin in a person's room and a broken ornament. We could not see any written responses to any complaints, although some recorded that staff had spoken with family and family were happy with the response. This demonstrated a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered manager did not establish and operate an effective system for identifying, receiving, recording, handling and responding to complaints.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager in post, who had been registered with the Care Quality Commission to manage the home since October 2014.

A family member told us they felt the registered manager and staff were very approachable. They told us, "Information is always passed on." Another said, "If I have any concerns I approach the manager. They listen."

Another family member said, "The manager knows people well. [Name] talks to people and helps at lunchtime.

A member of staff we spoke with told us they felt supported by the registered manager and head of care.

We found the registered manager to be more visible throughout the home during this inspection than the previous inspection. The registered manager worked at the home full time. We saw the registered manager clearly knew people who lived at the home and we observed good, caring interactions.

The registered manager was a dementia friend and dementia champion. A Dementia Friends Champion is someone who encourages others to make a positive difference to people living with dementia. The registered manager told us they felt people appeared happier at the home than they had previously. The head of care felt there had been an improvement in the home in the last ten months.

An enhanced observation system, consisting of cameras in communal areas which linked to a monitor in the registered manager's office was in use. The registered manager felt this gave them a better oversight of the home.

The registered manager told us their aim was to, "Bring the home back to a good standard." The registered manager saw staff were key to this vision and said they wanted stable, happy staff who wanted to work in the home.

The head of care told us the registered provider visited the home once a week and knew people who lived at the home and staff. The head of care advised new resources had recently been provided for the home, such as new chairs, new flooring and funding for an activities coordinator.

A member of staff told us they felt the registered manager was, "A good, supportive manager." However, this staff member felt the registered provider was not willing to invest the necessary resources to improve the home and they felt this restricted the registered manager.

Staff meetings were held monthly and we saw minutes from some staff meetings. Items discussed included staff sickness, staff being reminded not to discuss service users with families or ex-colleagues, enhanced observations being used in communal areas and staff deployment.

We saw minutes from family meetings held. Items discussed included activities, staffing levels and the most recent CQC report.

We looked at some questionnaires that had been completed by family members. One had ticked 'poor' in relation to rooms, facilities and activities. The person had written, "We feel there are areas that can be improved upon." However, we could not see evidence this had been followed up or actioned in any way. This showed a lack of action being taken in response to feedback.

The previous inspection found a lack of auditing. We found improvements at this inspection. The registered manager completed a 'daily walk-around audit' of the home and looked at areas such as the dining room, lounges, medication room, kitchen and reception areas and this was documented. The previous inspection found these had not been completed daily. We saw these had resulted in actions being taken. For example, records for 6 June 2016 showed, 'Asked domestic to clean the carpet due to strong odour. Cleaned straight away.' Another record stated, 'Library found uncleaned. Spoke to night carers.' This showed the registered manager was taking action to improve the quality of service provision and cleanliness.

Regular meal time audits took place. We saw this resulted in actions, for example, we saw one audit documented on 27 June 2016, 'Reminded staff to ensure all meal choices are displayed on the board and that it's big enough to people to see at a distance.' This showed the registered manager was using audits as a way to improve the service.

An infection control audit took place monthly, by the supervisor for domestic and laundry. We saw records of this and action was taken and recorded when necessary.

A monthly care plan audit took place. Records showed four aspects of the plan were audited. These were, 'care plan,' 'assessment,' 'weight' and 'waterlow' (indication of risk of skin sores). Audit records showed that, during February, the weight and waterlow information in a care plane was incomplete. The registered manager had taken action to rectify this. This showed the auditing of care plans resulted in improved practice and recording of information.

A medication audit took place monthly. This involved auditing supply of medicines, medication administration records, storage and safe administration for example. The audit indicated 'some' medicines were given covertly. We saw advice and consent had been sought from the person's GP and family. However, we could see no evidence that a mental capacity assessment had been completed in relation to the person's capacity to understand and make decisions about medication. This showed, although medication audits took place, they did not always highlight areas for development.

We saw some 'master copies' of forms to be completed when water temperature checks were undertaken. However, we could not find any completed forms to confirm checks had taken place. We asked the head of care who was unable to confirm or locate evidence that checks took place. We also saw blank forms in relation to bed rail checks. The head of care told us that carers would check bed rails regularly but was not able to provide evidence of this. This demonstrated a lack of oversight in relation to health and safety checks.

We looked at policies and procedures. These had been recently updated during the month of the inspection. However, they related to out of date regulations. This meant the registered manager was not developing policies in line with current legislation and regulations.

Although there had been improvements in auditing since the last inspection, there was a continued lack of

management oversight because the registered manager had failed to recognise and take action, through systems and processes, for example that some health and safety checks were not being completed and recorded, safeguarding reporting procedures had not being followed, staff were using shared equipment for people, staff were not always acting in accordance with the Mental Capacity Act and complaints were not organised and managed effectively. This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for service users because some moving and handling equipment was used for people who had not been specifically assessed for that equipment. 12(1), 12(2)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not established and operated effectively in line with safeguarding procedures. 13(1), 13(2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered manager did not establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons. 16(2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed to meet people's identified needs. 18(1).

Staff did not receive appropriate training to enable them to carry out the duties they were employed to perform. 18(2)(a).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager and registered provider did not have efficient systems to assess, monitor and improve the quality of service. 17(2)(a). The registered manager and registered provider did not sufficiently assess and mitigate risks relating to health, safety and welfare of service users and others. 17(2)(b). The registered manager and registered provider did not seek and act on feedback from relevant persons for the purposes of continually evaluating and improving services. 17(2)(e).

The enforcement action we took:

Warning notice re-issued to the registered manager and registered provider.