Mauricare Limited

Aston Manor

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
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 26 and 29 March 2018.

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. The home was placed in Special Measures on 6 July 2017. We also took enforcement action to cancel the registration of the registered manager and vary a condition of the provider's registration.

We kept Aston Manor under review and inspected the service again in August 2017. We identified continuing breaches of regulation. As a result, the homes overall rating remained unchanged; 'Inadequate', as it was deemed to be 'Inadequate' in the key questions of Safe, Effective, Responsive and Well-led, and 'Requires Improvement' in the key question of Caring. The home remained in Special Measures. We therefore, took further action in line with our enforcement procedures to prevent the registered manager and registered provider from operating this service.

The inspection on 26 and 29 March 2018 was to see if any improvements had been made to the quality of care people received. During this inspection, we identified the service was breaching regulations related to person centred care, dignity, staffing and governance.

Aston Manor is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Aston Manor is registered to provide nursing and residential care for up to 32 people, at the time of this inspection there were 24 people living at the home. The home provides communal areas to the ground and first floor as well as single en-suite bedrooms..

The service had a registered manager in place. 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.

Risks to people were assessed although further work was needed to ensure they provided sufficient detail and were updated to ensure they were reflective of peoples current support needs. Accidents and incidents were recorded and analysed but the system in use did not enable the registered manager to easily identify patterns occurring over a period of months.

There was a system in place to ensure the premises and equipment were safe to use. Previous concerns regarding cold water temperatures and personal emergency evacuation plans had been addressed. Staff had received fire training but had not practised a simulated fire drill or been trained in how to use evacuation sledges.

There were no concerns raised regarding staffing levels at the home. There was no system in place to regularly check the professional qualifications of nursing staff employed at Aston Manor and personnel records did not always evidence the rationale for gaps in candidates employment history.

People's medicines were stored and administered safely; improvements had been made to the management of creams. Where medicines were prescribed 'when required' all but one of the medicines we reviewed contained a protocol to reduce the risk of unsafe or inconsistent administration.
Relatives told us they felt their family member was safe and staff were clear about the types of abuse and their responsibilities in reporting any concerns.

New employees received induction when they commenced work at Aston Manor. Training involved both e-learning and face to face training. The training matrix evidenced not all staff had completed all the required training and records of staff supervision were inconsistent although most staff had recently received an appraisal of their performance.

People were supported to eat and drink although; people were not always supported to make their own choices. We noted staff were more likely to ask people when they were able to respond verbally to the options available to them. People were weighed at regular intervals and the registered manager monitored this, although the system in place did not enable them to easily identify people who may have gradual weight loss.

Information was shared between staff at handovers and we saw people received input from other health care professionals as needed.

People were not always supported to have maximum choice and control of their lives, we found records in peoples care plans did not evidence a robust and person centred approach to meeting the requirements of the Mental Capacity Act 2005. Staff knowledge and understanding of the MCA was limited.

Relatives told us staff were caring. The interactions we saw between people and staff were predominantly caring and kind although we also saw examples which showed further work was required to ensure this approach was truly embedded.

Staff were aware of how to maintain people's privacy and dignity and we saw examples of this during the inspection. Staff were respectful people's individuality. Support to access advocacy services was readily available.

The registered manager had taken steps to involve relatives in the review of their family members care plan but work was still needed to enable people who lived at the home to be part of this process, where possible.

Relatives told us people were not provided with sufficient activity to keep them engaged. The head of care whose role involved organising activities had not received training specific to providing meaningful engagement for people living with dementia. The head of care was due to go on a period of extended leave but at the time of the inspection no alternative arrangements had been made to provide activities for people.

People had a number of person centred care plans in place, although we identified one person's care plan was not reflective of their current support needs. Support for people when they experienced behaviours that may challenge others and the records kept about such behaviours had improved since the last inspection.

Where people had communication difficulties information was not provided in an alternative format. Feedback from relatives and staff regarding the management of the home was positive.

Regular audits were completed at the home but these had failed to provide an in-depth assessment of the quality of the service provided. The registered provider visited the home on a regular basis and completed a monthly report however, not all aspects of the audit were completed and they had failed to identify or address issues raised in this and other CQC inspections.

Regular staff meetings were held and action had been taken since the last inspection to implement meetings for relatives but there was still no system to gain feedback from people who lived at the home. Feedback surveys were available for relatives to complete but this was ad hoc and there was no evidence to suggest feedback had been reviewed or followed up. Although a recent complaint had been addressed by the registered manager.

This service had been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us improvements have been made and are no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures. However, we found a continuing breach of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014; you can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk assessments were in place but further work was still required to ensure they were reflective of people's current needs.

Recruitment and personnel records did not always include all relevant information.

There was a system in place to ensure safeguarding concerns were responded to.

Checks were made to ensure the premises and equipment were safe.

Is the service effective?

Requires Improvement

The service was not always effective.

We were unable to clearly evidence the training staff had received. Records of staffs' supervision where irregular.

People were supported to eat and drink although people were not always enabled to make their own choices.

Decision specific capacity assessments were in place but the assessment process was generic and not person specific.

People had access to healthcare.

Is the service caring?

Requires Improvement

Not all aspects of the service were caring.

Staff interactions with people were predominantly caring but further work was needed to ensure this was fully embedded.

We saw examples of staff maintaining people's privacy, dignity and confidentiality.

People's relatives had been invited to a review of their family

members care plan.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not provided with access to regular meaningful activities.

Care plans were person centred and provided direction for staff where people may exhibit behaviours that may challenge others.

Information about how to complaint was available but no change had been made to the format to make it accessible to people who lived at the home.

Is the service well-led?

Requires Improvement

The service was not always well led.

Feedback about the registered manager was positive.

The system of governance was not sufficiently robust.

Regular meetings were held with staff and meetings with relatives had commenced. But there was no evidence feedback was gained from people who lived at the home.

Aston Manor

Detailed findings

Background to this inspection

This inspection commenced on 26 March 2018 and was unannounced. The inspection team consisted of an inspection manager, two adult social care inspectors, an assistant inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this occasion had experience of working in health and social care. One inspector also visited the home again on 29 March 2018, this visit was also unannounced.

Prior to the inspection we reviewed all the information we had about the service including statutory notifications and other intelligence. We also contacted the local authority commissioning and contracts department, safeguarding, infection control, the fire and police service, the Clinical Commissioning Group, and Healthwatch to assist us in planning the inspection. We reviewed all the information we had been provided with from third parties to fully inform our approach to inspecting this service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was used to help inform our inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time in the lounge and dining room areas observing the care and support people received. This included completing a Short Observational Framework for Inspection (SOFI); this is a way of observing care to help us understand the experience of people who could not speak with us. We spoke with two people who were living in the home and four visiting relatives. We also spoke with the registered manager, head of care, a senior care staff member, four care staff and a member of the catering team and housekeeping team. We reviewed four staff recruitment files, we looked at two people's care records in detail and a further seven care plans for specific information. We looked at five people's medication administration records and a variety of documents which related to the management and governance of the home.

Requires Improvement

Is the service safe?

Our findings

Relatives we spoke with felt their family member was safe. Relatives told us; "I don't see anything that is unsafe. Staff respond quickly, they are there in a heartbeat if there is a problem or the buzzers go off", "They know where [person] is and check up on [person]" and "Safe, yes things have got better. [Person] hasn't had falls for a bit as they are now in the small lounge where [person] is safe, they keep a good eye on [name of person]."

Where we asked staff about safeguarding people from the risk of harm or abuse, staff were clear about the types of abuse and their responsibilities in reporting any concerns. One staff member said, "If I had a safeguarding concern I would report straight to [name of registered manager]." The registered manager told us they were the safeguarding lead for the home and it was their responsibility to ensure all relevant concerns were reported to the local authority safeguarding team and CQC. This demonstrated there was a system in place to ensure concerns were responded to appropriately.

At the previous two inspections in April and August 2017 we found information and records relating to people at risk of developing pressure ulcers were inconsistent and contradictory. At this inspection we found improvements had been made. For example, an assessment of people's risk of pressure ulcers was in each of the care files we looked at. Each assessment had been reviewed and updated on a monthly basis. This helped to identify people whose risk was greater and enable risk reducing measures to be implemented.

One care file recorded the person was to sit on a pressure relieving cushion during the day; we saw staff had sat them on their pressure cushion on both days of the inspection. Two people were nursed on pressure reducing mattresses when they were in bed. It is important these mattresses are set correctly to ensure they are effective. We saw information relating to the setting was recorded in the care file; although, we had to ask the registered manager to find this information as it was not easily located. The information was also kept in the person's bedroom. We checked both mattresses and found the setting matched the instructions in the care plan.

At the last inspection in August 2017 we found people were being supported with equipment they had not been properly assessed for and where moving and handling risk assessments were in place, they lacked sufficient detail to reduce the risk of harm to people and staff. At this inspection although we recognised improvements had been made, further work was still required to ensure they were an accurate reflection of people's current needs. People's care and support records were electronic although some additional records were paper and stored in a separate locked office. We reviewed the electronic moving and handling care plan for one person instructed staff to use a handling belt to support the person but this was not referred to in their electronic moving and handling risk assessment. One of the staff told us the handling belt was not always necessary and was dependent upon the abilities of the person at the time of the transfer, but this detail was not reflected in their electronic care records.

We also reviewed the care file for a person who required staff to use a hoist to transfer them. A risk assessment was in place which included information regarding which hoist to use and how to apply and fit

the sling. However, when we observed staff transferring the person on two occasions, they did not use the sling identified in their care plan. We asked the head of care about this, they told us the person had two slings which were used dependant up on the transfer staff were undertaking. It is important to ensure this information is accurate to reduce the risk of harm to either staff or the person they are supporting.

Risk assessments included information regarding the support people needed to access the bath and shower. One assessment recorded the need for staff to ensure the arms of the bath chair were 'securely in place'. Another person's assessment recorded staff were to ensure the person was 'sat safely on the chair and stay with [person]', although their assessment made no reference to the chair arms on the bath chair. This meant staff may not engage the chair arms, this would increase the risk of a fall from height. We brought this to the attention of the registered manager following the inspection.

Where people were not able to evacuate the building independently in an emergency situation a personal emergency evacuation plan (PEEP) should be in place to provide person-centred information for those helping people to evacuate. At the last inspection we found PEEPs had not been updated and were not in place for some people who were living at the home. At this inspection we found electronic and paper copies of a PEEP were in place for each person whose records we had reviewed.

The registered manager told us all staff had received a fire drill and the induction process for new staff incorporated a discussion regarding fire awareness; although the registered manager did not have a system in place to enable them to have oversight of when each staff member last attended a drill. We also asked the registered manager if staff had practised a simulated evacuation or a demonstration on how to use the evacuation sledges which were located on the first floor of the home. The registered manager told us they had not. This meant staff may not all be confident of the action they would need to take in an emergency situation.

We saw evidence external contractors were used to service and maintain equipment, for example, gas appliances, electrical wiring and the fire system. We also evidenced the passenger lift, hoists and slings had been serviced in line with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). A list of all the slings in the home was not kept; this reduced the risk of slings being missed when LOLER checks were completed by the external contractor. This had been identified at the previous inspection in August 2017 but had still not been implemented by the registered manager.

At the previous inspection in August 2017 we identified the temperature of cold water had regularly been over 20°C. Health and Safety Executive 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' and recommends cold water be maintained, where possible, below 20°C. Action had since been taken by the registered provider to rectify this matter and at this inspection the cold water records we saw all recorded temperatures of between 8 and 14°C.

Relatives we spoke with did not raise any concerns regarding the numbers of staff on duty at the home. A relative said, "There seems enough staff." A staff member said they felt the staffing numbers were adequate for the current number of people who were living at the home.

We observed there to be sufficient staff visible within the home and people's needs were met in a timely manner. The registered manager told us they completed a dependency tool on a monthly basis to establish the homes staffing requirements. We saw the weekly staffing hours provided to people was above the number the dependency tool calculated the service needed for their present occupancy. Aston Manor can accommodate 32 people; at the time of the inspection 24 people were living at the home. Therefore, future

inspections will continue to monitor staffing levels to ensure sufficient numbers of suitable staff are available to support people to stay safe and meet their needs.

We checked staff had been recruited in a safe way and that all the information and documents as specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 were in place. We reviewed the recruitment files of four staff and saw application forms had been completed, references obtained and a Disclosure and Barring Service (DBS) check had also been completed. DBS checks return information from the Police National Database about any convictions, cautions, warnings or reprimands a candidate may have received. We noted gaps in the employment history of two applicants. We asked the registered manager about this, they told us this had been explored at interview with the candidate but they were unable to evidence where this discussion had been recorded. Theses pre-employment checks are important as they help employers' make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups of people.

The registered manager told us there was no system in place to regularly check the professional qualifications of nursing staff employed at Aston Manor. We asked to see evidence of two nurse's professional qualifications but the documents we were shown did not evidence their registration with the Nursing and Midwifery Council (NMC) were current. Nurses must be registered with the NMC to enable them to practice in England, failing to check may result in a nurse who is not correctly registered and therefore does not have the legal authority to work in that role. We advised the registered manager of the process they needed to complete to confirm this and later that day they showed us evidence of the two nurses' NMC registration.

At the previous inspection in August 2017 we identified assessments of nurses competency to administer people's medicines had not been completed. At this inspection we saw evidence regular assessments of competency had been completed on four of the five nurses employed. The registered manager assured us a competency assessment had been completed on all the nursing staff but they were unable to locate the missing assessment document at the time of the inspection.

Medicines were stored safely and securely. We observed a nurse administering medicines to people; this was done discreetly and respectfully. Where people declined their medicines, we observed the nurse returned later to try again. We checked three individual medicines and found the recorded number of administrations tallied with the medicines stock.

At the last inspection in August 2017 we found 'when required' medicines lacked information to ensure they were administered safely and consistently. At this inspection we found improvements had been made. Of the 'when required' medicines we reviewed, only one did not have a protocol in place, although some required further detail to ensure they were person centred. For example, a protocol for a medicine to be administered in the event a person had a low blood sugar did not detail the point at which nursing staff would administer the medicine.

At the previous two inspections we identified poor practice regarding the management of people's creams. At this inspection we found topical medicines administration record's (TMAR's) were in place and they were signed regularly to indicate staff had applied the prescribed cream. Not all the TMAR's contained sufficient information to instruct staff as to when and where to apply individual cream but the registered manager told us discussions where ongoing with the GP's practices to ensure this information was provided by the GP at the time of prescribing.

During both days of the inspection we found the home to be clean and tidy. We identified one area of the

home which had an odour. We spoke with the registered manager about this, they told us they were aware and they were looking into how this could be addressed.

Personal protective equipment (PPE), for example, gloves and aprons were readily available for staff to use. Records indicated communal toilets and bathroom were checked and cleaned on a regular basis. This showed there were systems in place to manage infection control and prevention at the home.

We looked at the arrangements for reviewing and investigating safety and safeguarding incidents. The registered manager logged all accidents and incidents on a monthly basis and recorded if any trends had been identified and relevant action taken. Although this demonstrated the registered manager collected and used information to improve people's safety at the home the system in use meant each month had to be reviewed in isolation as it was not possible to see a pattern which may emerge over an extended period of time.

Requires Improvement

Is the service effective?

Our findings

We asked the registered manager how they ensured peoples care and support was delivered in line with current legislation, standards and evidenced based practice. They told us they were aware of how to access good practice guidance for example, through the National Institute for Health and Care Excellence (NICE) website. They also said the input of external healthcare professionals ensured care practices were up to date. When reviewing peoples care files we saw current good practice guidance was implemented, for example, to assess peoples risk of developing pressure ulcers. One of the care files we reviewed included detailed guidance from a tissue viability nurse regarding management of their skin integrity. Staff were able to access the registered providers polices and nursing staff were able to contact their dispensing pharmacist and consult a recently dated British National Formulary (BNF) in the event they required further guidance regarding peoples medicines.

There was a system in place to support new staff in their role. One staff member said, "The manager chatted to me, I shadowed shifts." We saw evidence in staff's files that an in-house induction had been completed. At the previous two inspections we found staff with no previous experience of care work had not completed 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. At this inspection we checked the personnel file for both staff who we had reviewed previously. The registered manager told us the Care Certificate had been completed for one of the staff, but the staff member had the documentation at home. The second staff member told us they had not completed the Care Certificate but they had completed a national vocational qualification level one in care work and they were nearing completion of level two. This meant there was limited evidence either staff had completed relevant induction training to ensure they had the skills to meet the expectation of their role during the initial period of their employment.

At the previous three inspections, in July 2016, April and August 2017 we identified a breach of the regulation relating to staffing as the training matrix evidenced not all staff had attended relevant training. Staff told us training was a mixture of e-learning and face to face. We saw evidence in the four personnel files we reviewed that a range of training had been completed. The training matrix recorded the majority of staff had completed the listed training although there were some gaps. For example, of the 36 staff listed, 16 staff had not yet completed mental capacity training and six staff had not completed infection prevention and control training. We asked the registered manager about this, they showed us a training certificate for a member of staff who, according to the matrix had not competed training in infection prevention and control training. We asked the registered manager about the discrepancy, they said staffs' previous certificate dates must not have been entered on the matrix. This meant there was no reliable system to evidence staffs training compliance.

The registered manager told us the training matrix recorded mandatory and supplementary training. They told us the mandatory training was refreshed annually but we noted a number of instances where training had not been refreshed within this timescale. For example, nine of the 36 staff listed last completed this training in 2016. The record of supplementary training evidenced the majority of staff had not completed the

majority of courses available. For example, of the 35 staff listed on the matrix, only four had completed person centred care and only five staff had completed diabetes training. Ensuring staff receive thorough training and regular updates mean staff have up to date skills and knowledge to enable them to meet people's needs in line with current standards of good practice.

The registered manager told us an external consultant had provided additional face to face training for staff around dementia care and dignity and respect. They said this included a lunchtime experience where staff assisted each other to eat to enable them to feel what it was like to be a person who needed support to eat. We did not see any evidence of this training within any of the staffs file we reviewed. Following the inspection the registered manager emailed a certificate to confirm training had taken place on 15 February 2018 but they did not supply evidence of which staff had attended.

We also identified concerns at the previous two inspections regarding staff supervision and appraisal. We asked a member of staff about their supervision, they said, "The manager asked me if I was happy, if I had any concerns, where I wanted to be in two years." Another staff member said, "I have just had an appraisal. It gives you chance to tell them what you think."

The registered manager told us they had completed an annual appraisal on all staff in January 2018. Supervision was completed by either themselves or a designated member of the staff team throughout the year, with staff receiving six supervisions per year. We reviewed four personnel files; we saw evidence an appraisal had been completed for three of the staff during January 2018 but there was no evidence of an appraisal for one staff member. Records regarding supervision were conflicting. For example, the last documented supervision for one staff member was August 2017 but the supervision matrix recorded they had received supervision in August and October 2017. There was documented evidence of supervision in another staff file but one was subsequently located by the head of care dated August 2017, although this was not found in the relevant staffs' file. There was no evidence any supervision had taken place for two staff who had commenced employment in October 2017 and November 2017. The supervision matrix also recorded the most recent supervision for four staff as being September 2017 and there was no evidence on the matrix they had received an appraisal. The registered manager, they told us the matrix was up to date. This meant staff were still not receiving regular management supervision.

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

A relative we spoke with said, "The staff are brilliant my [relative] is a lot happier here than where they were. The meals are good and [relative] takes ages to eat and the staff leave [relative] there is no rushing or forcing, if [relative] wants to take an hour over breakfast they can do. [Relative] likes their pudding." Another relative we spoke with told us their family member had put on weight since their admission to the home.

We saw cold drinks were available in the communal lounges and we observed staff offering them to people throughout the day. On the first day of the inspection we saw staff took a trolley around the home with hot drinks, biscuits and yoghurt. We noted this did not arrive until 11.45am on the ground floor, and 12 noon on the first floor which meant some people did not have very long to digest this before staff began serving lunches to people at 12.40pm.

At the previous inspection in August 2017 people were not always enabled to make their own choice about what they wanted to eat and drink. This remained a concern at this inspection; where people were able to verbalise their preferences, we noted staff were more likely to ask them their preferences. For example, on the ground floor some people were asked what they wanted from the drinks trolley in the morning, other

people were not. On the first floor people were each given a plate with a selection of biscuits on, but we did not see or hear anyone being asked for their preference or given the opportunity to choose the biscuits they wanted. At lunchtime in the ground floor dining room no-one was offered a napkin or the option of any condiments, staff asked some people what they would like to eat while others were simply served their meal on the plate. On the first floor staff gave a pudding to a person but did not offer choice or tell them what it was when they put the bowl in front of them.

We asked a member of staff how they knew what people wanted, they told us people had the same every day (midday drinks and snacks), they also told us some people were on a soft diet. They said a list of needs and preferences was in a folder on the trolley, we looked with them, but this information was not present. We spoke with a member of the catering team, they were knowledgeable about people's needs and we saw a list of people who required their diet to be of a specific consistently was also on display in the kitchen. But they told us no information was kept in the kitchen regarding peoples individual likes, dislikes and preferences. This is important, particularly when people have memory impairments and may not always be able to communicate their preferences. This had also been previously highlighted at our inspection in August 2017.

Where people required encouragement and support, we saw staff provided this in a timely manner. For example, at lunchtime, we saw staff sat with a person supporting them to eat and drink, at tea time we saw and heard staff providing verbal prompts to another person who had stopped eating their meal.

Staff recorded people's dietary intake, we reviewed two people's records and saw they contained sufficient information regarding the food people had eaten. Each of the care plans contained an eating and drinking care plan, a nutritional risk assessment and evidence people were weighed at regular intervals We reviewed the care plan for one person which evidenced weight loss, we saw staff had begun to weigh them on a weekly basis and their GP had also been informed. The registered manager kept a log of people's weight however, the way in which this was done meant it was not easily identifiable where people may have lost small amounts of weight over a period of months. We brought this to the attention of the registered manager at our inspection in August 2017 but the matter had still not been addressed.

The registered manager said they felt team work and communication had improved among all staff at the home. We observed the handover between the day and night shift on the first day of the inspection, a written handover record was also retained. The handover ensured key information and actions taken by nursing and care staff was shared. Effective communication helped staff to deliver effective person centred care and support to people.

We reviewed the care file for a person who had been admitted to the home since the last inspection. We saw an assessment had been completed by the registered manager and head of care prior to the person being admitted to the home. This is an initial assessment used to determine people's care and support needs, providing relevant information for staff and reducing the risk of information not being communicated between health care providers.

One relative said, "[Person] is on antibiotics so the doctor must have been called." We saw evidence in each of the care files we reviewed of the input of other health care professionals. This included GP's, opticians, speech and language therapists and dieticians. On the first day of the inspection we heard a nurse speak with a person about a health concern, when we returned for the second day of the inspection we saw evidence the nurse had sought appropriate medical advice. This showed people received additional support when required for meeting their care and treatment needs.

We have found improvements have been made to the environment at the previous two inspections. The registered manager told us these changes were continuing and we saw a re-decoration programme was on display in the reception area. We saw during the beginning of 2018 downstairs corridor walls and doors were to be painted to make bedroom doors more identifiable and murals had been put on walls. This showed that changes were continuing to ensure the environment met the needs of people living at Aston Manor.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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, and whether any conditions on authorisations to deprive a person of their liberty were being met.

A file was kept in the registered manager's office with information relating to individuals DoLS applications and authorisations. We saw evidence applications had been submitted by the registered manager where appropriate, including one for a person who had been admitted to the home since the last inspection. This demonstrated that although some people had been deprived of their liberty, the home had requested DoLS authorisations from the local authority in order for this to be lawful and to ensure people's rights were protected.

The previous three inspections, in July 2016, April and August 2017 identified concerns regarding compliance with the Mental Capacity Act. At this inspection we found staff still had limited understanding of mental capacity and how decisions might be made in someone's best interest if they lacked capacity. One member of staff told us, "DoLS is deprivation of liberty; it can be for a number of things, for the best interests of the patient. It could be if somebody is soiled and it's in their best interest to not leave them soiled." Another staff member said, "It's about putting something in place for when they want to do something but can't when it's not in their best interest." Another staff member said, "I don't really know as I'm not involved in it."

Each of the electronic care files we reviewed contained a mental capacity care plan. We also reviewed four people's mental capacity assessments and records of best interest decision making. Each capacity assessment was decision specific; administration of medicines, washing and dressing capacity and continence care but the form used was generic and not specific to the needs and abilities of the individual. For example, each form contained the statement 'use of written or drawn material' to indicate if the assessor had used other methods of communication to enable the person to understand the question. The assessor had placed a tick to indicate 'yes' but no other details were recorded. This meant we could not evidence this was thorough assessment of the persons capacity. Three of the people whose assessments we reviewed had a DoLS in place but no assessment of capacity had been made by the service regarding this decision. A DoLS can only be applied for where a person lacks capacity, capacity assessment needs to be undertaken to establish this. This demonstrated a limited understanding of the principles and requirements of the MCA.

These examples demonstrate a continuous breach of Regulation 11 (1), (2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where someone lacked capacity to make a specific decision we saw evidence of best interest decision making. Following this process demonstrates openness and transparency in providing services for people who lack capacity as prescribed in the Mental Capacity Act 2005.

Where a person lacks capacity to consent, then nobody should sign a consent form unless they have specific legal powers to do so, for example, health and welfare lasting powers of attorney. We saw evidence the registered manager had taken steps to gather relevant information regarding this.

Requires Improvement

Is the service caring?

Our findings

Relatives told us staff were caring, "Staff are absolutely brilliant, I have never thought any other they make [relative] laugh. If [relative] wants anything they are so helpful. [Relative] has a bath or shower when they want" and "The carers are smashing." Another relative told us their family member always "looked clean."

Our previous two inspections in April and August 2017 have rated this domain Requires Improvement. At this inspection we saw predominantly good interactions between staff and people who lived at the home. Staff spoke with people as they entered communal areas and as they passed them on corridors, there was friendly banter between staff and people. When staff spoke with us about people, they referred to them in a respectful manner and as individuals. Staff, including the registered manager, all knew people well. For example, a member of staff told us how and why a person liked their bed to be made in particular way, a member of the catering team told us about the dietary likes of one person, this reflected what we had seen in their care plan.

However, we also observed examples which demonstrated a consistent caring and dignified approach to people was not yet fully embedded. For example, we saw a member of wipe a person's face without asking their permission or explaining what they were going to do and at breakfast time we saw a member of staff support someone to eat as they also completed some paperwork. At lunchtime we saw a member of staff stand up next to a person while they supported them to eat rather than sitting down next to them. As we have also evidenced in the Effective domain, where people were unable to verbalise their choices, we did not see evidence of staff implementing other methods to communicate with people, for example, words, pictures or body language and hand signals. We asked one of the staff we spoke with if they had access to alternative communication methods, for example, pictures; they told us they did not.

These examples evidence a continuous breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were able to describe how they maintained people's dignity and privacy. They told us, "You cover them; ask them if it's alright. It's just normal things you do, respect them. Just say to them, is it alright if we can give you a shower or wash? And you respect their choice" and "It's about dignity and respect, keeping the curtain shut (when changing/showering) when using hoist, cover with blanket."

Information was displayed in the reception area on how to promote and maintain dignity in care home. We also saw 'Dementia dignity' was listed on the training matrix but only eight of the 35 staff listed had competed the training at the time of the inspection. Although during the inspection we saw a number of examples where staff took steps to maintain people's dignity. We saw a person in a communal lounge required minor treatment by the nurse; staff placed mobile dignity screens to shield the person from others while the nurse attended to them. We also saw staff ensured peoples bodies were not un-necessarily exposed while being transferred in a hoist.

Staff respected people's individuality and cultural or religious preferences. We saw information displayed

regarding a weekly bible reading, when we spoke with a member of the catering team they were aware of how people's culture or religion may impact upon their choice of food.

Information regarding advocacy was on display in the home. On the first day of the inspection representatives of the advocacy service came into the home on a pre-arranged visit to speak with the registered manager about the services they were able to offer people. An independent advocate is a person who does not know the person who uses the service and comes to support them in making significant decisions if they do not have anyone else that they would want to assist them. Using advocates helps to ensure that people's rights are protected and that their voice is heard when making decisions as an advocate would help them to communicate their wishes.

At our April 2017 inspection we saw no evidence people or relatives had been involved in developing or reviewing their care plans. Following our inspection in August 2017 the registered manager told us they would write to people's relatives to arrange care plan review meetings. At this inspection the registered manager showed us a matrix which evidenced they had planned and completed 20 review meetings with relatives during January 2018. Copies of the letters sent to relatives inviting them to a review were also seen, and confirmation of the review was recorded in people's electronic records. This showed family members were consulted about the care and support their relative received, although there was no evidence the person living at the home had been involved in the process or been supported to provide any feedback.

Records were stored confidentially. Electronic records were password protected, paper records, were stored in a separate locked office. Although on the first morning of our inspection we found the door was only secured with a bolt, this was rectified during the morning and we found the door to be appropriately locked on the second day of the inspection. This helps to reduce unauthorised access to confidential information.

Requires Improvement

Is the service responsive?

Our findings

At the previous two inspections, April and August 2017 we identified a breach of the regulation relating to person centred care as the provision of activities for people living with dementia and access to meaningful activity was limited. At this inspection we found this had not improved.

We asked relatives what activities were available for people. One relative said, "Once a week a young man comes in [for activities]. Outside entertainers come twice a year, they all enjoy that." Another relative commented, "There aren't many activities in terms of outside people coming in." We saw comments from two relative's survey dated December 2017 'are there enough activities' both respondents had written 'no'. A member of staff said, "There's not enough to keep them occupied, they need more, like someone coming in-house."

We spoke with the head of care whose role involved organising and implementing activities for people. They told us "It's quite difficult; we try to talk to them, colour in, go for walks, listen to reminiscent music they enjoyed. We have a fitness man that visits every fortnight and bible reading every Wednesday. They read the bible to them, talk about the stories, do some hymns, we have a dance. We have mittens and buttons, a lot of them like to clean. We do some baking." They also said, "I try to do a weekly schedule, it depends on the residents moods, today I've printed some Easter things out to colour it in. A lot of females like the dancing and males exercising. I go with what they like to do."

We did not see any activities or meaningful engagement for people on the ground floor on the first day of the inspection, other than the television. In the first floor lounge we saw copies of Beano comics and copies of newspapers relating to specific events in modern history were available for people. It was not until the afternoon when we saw a member of staff sit with a person and look at the old copies of newspapers with them. These newspapers were designed to use as reminiscence aids. This interaction was carried out in an unhurried manner by the Dignity Champion at the home and the person appeared to enjoy the exchange as it held their attention for a while. We also saw another person drawing and colouring, who had been supported to do this by a member of staff.

We reviewed the activity records for nine people during March 2018. The majority of entries were brief and lacked detail, for example, one record noted 'watching tv and interacting with staff', another entry recorded 'been talking with staff, walking around'. Where people declined an activity, there was rarely evidence to suggest an alternative had been offered. Some of the entries clearly evidenced the person's enjoyment, for example staff had supported a person to walk in the car park and garden where they had enjoyed looking at the cars and flowers, but this engagement only took place on four out of 29 days. Another person's records did not evidence any activity or engagement had taken place for four days and on a further six days the only recorded engagement was with a family member. This evidenced meaningful person centred engagement was not custom and practice at the home.

Work had begun on developing life history books for people. This is a simple tool which records information and pictures or photographs, of the people, places and events that have happened to the person through

their lifetime. These can be used for reminiscence and enable staff to engage in meaningful conversations with people. A member of staff told us some were stored in people's bedroom and others were located in the office. We asked to see the life history book for one person but the head of care did not know where it was. While we acknowledge this work had only just begun to be implemented, during the two days of the inspection we did not see any evidence of these being used by staff when engaging with people.

We asked the head of care what activity related training they had received, they said, they had completed e-learning activity training. We saw the certificate for this training and saw it was a generic course and not specific to the needs of people living with dementia. This meant they were fulfilling a role for which they had not been provided with the necessary knowledge and skills.

The head of care was due to go on a period of extended leave on 30 March 2018; they told us they were not aware of any plans to provide activities for people in their absence. The registered manager told us they had two staff members they planned to talk with about taking on an activity role in the absence of the head of care. We reviewed the duty rota for the following three weeks but saw no evidence any staff member had been assigned any time dedicated to providing or supporting people to engage in any form of activity.

These examples evidence a continuous breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's access to meaningful activities had not improved.

At the previous two inspections, April and August 2017 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 support and care staff told us they did not read peoples care plans. At this inspection care staff told us they had opportunity to read peoples care files. One staff member said, "I read some last week, I looked at peoples washing and dressing care plans. It was really interesting." Another staff member said "You can read them whenever you want." This helps care staff find out about people's needs, likes, dislikes and preferences. This is especially important when the people they are supporting may have memory or communication problems.

Peoples care files were person centred and contained a range of care plans to evidence the care and support people required, for example, mobility, eating and drinking, sleep and continence care. We saw entries and updates were made at regular intervals. However, we observed one person being wheeled backwards in a wheelchair; their feet were dragging on the floor. We asked staff about this and they explained the rationale for this, however, when we reviewed their care file with the registered manager, this information had not been recorded or risk assessed. We also noted one the pre-admission assessment or a person recorded they had a pacemaker fitted but we noted this was not recorded on the handover record. We spoke with the registered manager about this and they assured us they would add this information to the record.

The Accessible Information Standard requires staff to ask record, flag and share information about people's communication needs and take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it. Each of the care files we reviewed contained a communication care plan, one person's plan recorded '[Person] sometimes is very limited, can say very short words like yes or no'. Another plan noted 'Speak clearly, simple instructions'. However, as noted within the Caring section of the report we did not observe any alternative methods of communication in use to enable people to communicate their choices and preferences to staff.

At our inspection in August 2017 we identified a breach of the regulation relating to person centred care due to concerns around the support people received when they experienced behaviours that may challenge

others and the records kept about such behaviours. At this inspection improvements were noted. For example, on the morning of the first day we saw a verbal exchange between two people in the main lounge. Staff responded in an appropriate and respectful manner, encouraging one person to spend time in another area of the home. Staff also spent time reassuring the other person who had become agitated as a result of the exchange.

We reviewed two care files for people who could display behaviour which challenged others. Both care plans noted the potential triggers to their behaviour, how they presented when their behaviour escalated and tactics staff may deploy to de-escalate the situation. The care plan for one of the two people provided good detail for when the person was in their bedroom, but lacked information regarding de-escalation techniques when the person was in a communal area or in the community with staff. We brought this to the attention of the registered manager.

We checked to ensure people's concerns and complaints were listened to. One relative told us, "If I had a complaint I would go to the manager or senior nurse." Another relative said "I would complain if I was worried."

At the last inspection in August 2017 we identified a breach of the regulation relating to complaints. This was because information on the complaints procedure was displayed in the home's foyer which was not accessible to people who lived at the home. We saw the complaints procedure was displayed on a notice board by the 'café' in the reception area which meant it was now accessible. However, no change had been made to the design or format of the document, this meant people living with dementia or a cognitive restriction may not be able to understand it.

The registered manager told us, and we saw evidence in the complaints log, only one complaint had been received since the last inspection. The log noted the date, the issues raised and subsequent actions taken by the registered manager. This demonstrated where a complaint was raised, action was taken.

Two of the relatives we spoke with told us staff had spoken with them regarding their family member's end of life wishes. One relative said, "End of life has been discussed and [person] has a Do not Attempt Resuscitation (DNAR) instruction in place." This enabled staff to easily identify if a person had a DNAR in place.

At the time of our inspection no one was receiving end of life care at the home. We asked staff about the care a person may receive as they entered their final days, one staff said, "When they are at their last stages, we just spend more time with them and be there for them. Even if they can't respond to you, just talk about anything with them. Hold their hand and reassure them they're not on their own." Another staff member told us, "You've just got to treat them with respect and dignity, talk to them like a normal person. They're still there, they can still hear you." This showed staff had insight into the specific needs of people at the end of life.

Requires Improvement

Is the service well-led?

Our findings

Feedback about the registered manager was positive, comments included; "Now the home is well run, a lot has changed; the staff who are here really care. I just wish they had more money for staff", "[Registered manager] is good, friendly, interested and available", "[Registered manager] is always approachable, and always gets on with it. They ring me straight away if something is going off so I don't have to worry" and "[Registered manager], oh she's brilliant, I have all the time in the world for her. If a staff member has to go out then she gets another one in. It's always clean and the room is lovely there are no problems."

Feedback from staff regarding the management of the home was also positive. One staff member told us they felt comfortable raising concerns and thought the managements approach to staff was fair. Another staff member said, "Yes, the manager is very approachable."

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of our inspection and therefore this condition of registration was met.

The registered manager spoke positively about the improvements at the home. They told us the admission of new people to the home was being carefully managed to reduce the risk of putting too much pressure on staff and to allow new people a couple of weeks to 'settle in' before they accepted another admission. The registered manager said they were feeling more positive, this was in part down to the input and support from an external management consultant, employed by the registered provider, and from attending an industry specific management course run by the local authority. This showed the registered manager had received support appropriate to their role and responsibilities.

The registered manager told us they were trying to ensure where new systems of ways of working were introduced, these were clearly embedded and understood. They told us they spent time out on the floor, observing and speaking with people; they said they had recently visited the home at night time to observe the care people received overnight. Observation of staffs' performance enabled the registered manager to assess the quality of care people received. We saw a number of 'knowledge awareness' checks had been completed with staff. However, the checks had failed to ensure staff understood the content or relevance of the documentation, simply ensuring staff understood, for example, where care plans and DoLS information was kept.

A range of audits were completed in the home but these had failed to identify or address the ongoing concerns highlighted throughout this report. For example, we saw a care plan audit had been completed in February 2018 by the registered manager. The form evidenced the documents which were in the care plan but did not assess the quality or accuracy. Regular audits had also been completed in regard to the mealtime experience at the home. The first one, dated 8 December 2017 had been completed by the management consultant and included details of their observations and actions required, subsequent audits had been completed by the registered manager or the head of care. We noted in the section 'was choice offered' the management team consistently said 'yes'. The audit had failed to identify the concerns we

raised regarding staff not offering choices in a way that was appropriate to the needs of the individual.

The previous two inspections, April and August 2017, highlighted concerns about the scope of the audit completed by the registered provider. The registered manager told us the registered provider visited the home on a weekly basis, speaking to staff, the registered manager and completing a walk around of the home. We saw evidence of regular visits to the home by the registered provider. We also saw a provider report was completed each month; we reviewed the reports dated December 2017, January and February 2018. The report had a set format with areas for the provider to review; each report had a number of gaps. For example, the sections; care plans, medication and accidents were all blank. The section for training was blank in December 2017 and January 2018.In February 2018, the registered provider had recorded 'moving and handling' but there was no further detail as to the relevance of this entry. This demonstrated the provider reports were still not robust and were failing to identify or action issues within the home.

The registered manager told us an external consultant visited the home on a weekly basis. They said the consultant had not visited the home for about three weeks due to illness but was due to visit during the week of our inspection. We saw information about the consultant and their input with the home was displayed on a notice board. However, after the inspection the registered provider told us the management consultant was no longer involved with the home and a new company had been engaged.

One of the relatives we spoke with told us they attended meetings at the home, "I go to the family meetings, they make a note and the things come true. I'd like more activities and outings and things." We only saw minutes from one meeting held on 2 November 2017, topics discussed included the publication of the homes CQC report from the August 2017 inspection. A notice was displayed in the reception area to inform relatives of the next scheduled meeting, 28 March 2018. Meetings are an important way to gather feedback from people and assess the quality of the service provided.

We saw blank feedback surveys were available in the foyer for people to complete as they wished. We reviewed six completed questionnaires, feedback was mixed; 'The laundry staff are excellent', 'The staff are brilliant, my [relative] has excellent care at this home and we couldn't ask for more'. In response to the question 'Is choice offered' the respondent had written 'Put food on a plate in front of them'. A visiting healthcare professional had commented 'staff attended to client's if/when agitation occurred'. The submission and completion of surveys was ad hoc and we saw no evidence feedback had been reviewed or any required action taken.

We saw no evidence to suggest people who lived at the home where offered any means of providing feedback about any aspect of the service they received.

We saw minutes of staff meetings held at the home, these included general staff meetings and meetings for specific teams, for example, nurses or domestics. One of the staff told us, "If I have a point, I'll say it. We sometimes sit down, and talk about if there any things that could be improved, such as supporting people who need assistance to eat their lunch first, before giving lunch to those who are more independent." Another staff member said, "We get questionnaires and have staff meetings." Staff told us information was shared with them at staff meetings and through handovers at the beginning of their shift. The registered manager also told us information and feedback from CQC inspections and audits by the local authority contracts team was shared with staff.

At the previous two inspections, April and August 2017 we identified a breach of the regulation relating to good governance due to a lack oversight by both the registered provider and registered manager. At this this inspection we did evidence improvements had been made. For example, improvements to the management

of peoples pressure ulcer risk, addressing the cold water temperatures to reduce the risk Legionella and involving family members in the review of their relatives care plan. However, we were not satisfied the improvements were sufficient to ensure people received consistently safe, effective, caring and responsive care. Concerns identified at previous inspections had still not been addressed. As noted earlier within this report concerns raised at the previous inspections regarding a central log of hoist slings, weaknesses in the system to monitor peoples weight, shortfalls in staffs training and supervision and people not being offered choices had still not been resolved despite the registered managers assurances these matters would be addressed.

These findings demonstrate a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents. During our inspection we identified a DoLS had been approved by the local authority but the registered manager had not notified us of this. We were satisfied this was an oversight as other notifications had been submitted in a timely manner. However, we reminded the registered manager of the responsibilities under this legislation.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not enabled to access meaningful activities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not consistently treated with dignity and respect. There was insufficient support to enable people to make choices where people had limited verbal communication.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The requirements of the Mental Capacity Act 2005 had not been met.

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 Systems of governance were ineffective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate training,

Diagnostic and screening procedures

Treatment of disease, disorder or injury

professional development or supervision.