Aaroncare Limited

Aaron Crest Care Home

Inspection report

Tanhouse Road
Skelmersdale
Lancashire
WN8 6AZ

Tel: 01695558880
Website: www.newcenturycare.co.uk

Date of inspection visit:
06 February 2018
07 February 2018

Date of publication:
16 April 2018

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

This inspection took place on the 6 & 7 February 2018. The first day of the inspection was unannounced which meant the home were not expecting us on the first day of the inspection.

Our last inspection of the home was carried out 25, 26 and 31 May 2017. At that inspection we rated the service as 'Requires Improvement' overall and for the domains of responsive and well-led. We rated the home as 'Inadequate' for the safe domain and 'Good' for the domains of effective and caring. At the last inspection we found the home to be in breach of five regulations of the Health and Social Care Act Regulated Activities Regulations 2014. These were Regulation 9, Person-centred care, Regulation 12, Safe care and treatment and Regulation 17, Good governance, Regulation 18, Staffing and Regulation 19, Fit and proper persons employed. At this inspection we found the home had met three of the previous regulation breaches, however were still in breach of Regulation 9 and Regulation 19. We also found the home to be in breach of Regulation 14 meeting nutritional and hydration needs. We have made a further six recommendations for areas needing further improvements.

We saw evidence of enough improvements made to show that the home was no longer rated as 'Inadequate' in any of the domains and therefore the home was removed from special measures. The overall rating of the home remains as 'Requires Improvement'.

The home is situated in Skelmersdale and is easily accessible by public transport. The home provides nursing or residential support for up to 66 people. Nursing care is provided on the top floor of the two story building with the ground floor area supporting people mostly living with dementia. At the time of our inspection there were 56 people living in the home.

Each floor has a lounge and dining room and a smaller quieter lounge used mostly for activities. The kitchen and laundry facilities are on the ground floor of the building and each floor is accessible by a lift and stairs.

Aaron Crest Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

There was a manager in place at the time of our inspection who was in the process of registering. 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 service had systems in place to record safeguarding concerns, accidents and incidents and take

necessary action as required. Staff had received safeguarding training and understood their responsibilities to report unsafe care or abusive practices.

Risk assessments had been developed to minimise the potential risk of harm to people during the delivery of their care. These had been kept under review and were relevant to the care provided.

Staff had not always been recruited safely and in line with the home's recruitment policy.

Staff were appropriately trained and supported. They had skills, knowledge and experience required to support people with their care and social needs. However formal support in the form of supervisions and appraisals were not, at the time of the inspection, routinely carried out.

Medication procedures observed protected people from unsafe management of their medicines. However processes did vary between the two floors of the home and needed to be made consistent.

Staffing levels were seen to be sufficient to meet the assessed needs of the people at the home. Staffing had been an issue prior to the new home manager coming into post but we saw evidence to show that these issues had been resolved and that agency use was now limited.

We looked around the building and found it had been maintained with pleasant decor, was clean and hygienic and a safe place for people to live.

People's nutritional needs were not always met due to records not being consistent across the home. For example some people's care plans were not replicated within the home's kitchen records.

Capacity assessments were not always in line with other areas of people's care plans and best interest decisions were not always decision specific or completed in enough detail.

Staff we spoke with had a good understanding of protecting and respecting people's human rights.

The home had provided information with regards to support from an external advocate should this be required by people living in the home.

Various methods of communication were used with people according to their needs and preferences.

We saw a large range of activities were undertaken within the home setting. It was cold at the time of our inspection but we were told that during the summer month's people accessed the courtyard and occasional trips out were made by people who were able to and wanted to.

A number of audits were undertaken to ensure the on-going quality of the service was monitored appropriately and lessons were learnt from issues that occurred. A number of the issues raised at this inspection had already been highlighted through the homes audit process and plans were in place to address them.

Our last report and rating was on display within the home and on its website. This helped people to make an informed choice about the quality of the home.

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.

Staffing levels were in place to safely meet the assessed needs of people.

People told us they felt safe living at the home and staff were aware of how to recognise and report potential safeguarding issues.

Systems were in place for people to receive their medicines in a safe and efficient manner, however these process were not followed consistently across the home.

The homes recruitment policy was not always followed to ensure that appropriate background checks and other processes were followed prior to people being employed to work with vulnerable adults.

Is the service effective?

Requires Improvement

The service was not always effective.

The home did not always work within the principles of the Mental Capacity Act 2005.

Staff told us they felt supported however there was no programme of supervision and appraisals in place for staff.

The design of the home was appropriate for the needs of the people residing at Aaron Crest.

People's nutritional needs were not always provided for consistently.

Is the service caring?

Good

The service was caring.

People and relatives told us that they felt involved in making decisions about their or their loved ones care and support needs.

The majority of the comments we received were positive in terms of staff support and their approach.

Advocacy support was available for people who did not have family or friends to represent their views.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People told us they felt comfortable raising concerns or complaints and we saw evidence that complaints were handled in line with the homes policy.

A number of activities took place within the home and the home employed two dedicated activities coordinators.

Care plans were not always reflective of people's latest assessed needs.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People and relatives spoke positively about the new management team and staff team.

The home had a wide range of audits in place that had highlighted many of the issues presented during the inspection. We could see that actions were already being taken by the home as a result of audits and quality monitoring.

The home worked in partnership with a number of health professionals.

There were no registration issues and the homes latest rating was clearly displayed in the home and on its website.

Aaron Crest Care Home

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6 & 7 February 2018 and the first day was unannounced, so the home did not know we were coming to undertake an inspection.

The first day of the inspection was completed by two adult social care inspectors and two experts 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. Both experts-by-experience had experience of caring for older people and one expert had experience of caring for people with dementia. There was also a student social worker shadowing one of the adult social care inspectors to look at how the inspection process was carried out. On the second day the inspection was completed by two adult social care inspectors.

Prior to the inspection the lead inspector gathered the available information from Care Quality Commission (CQC) systems to help plan the inspection. This included the detail of any notifications received, any safeguarding alerts made to the Local Authority, any complaints and whistle-blowing information.

We spoke with 12 people who lived at the home and five visiting relatives. We also spoke with the Local Authority safeguarding team and commissioners of the service following our visit.

We spoke with 14 staff including the home manager, area manager, quality director, cook, maintenance worker and nursing and care staff.

We reviewed eight care records and associated records in detail. We reviewed seven staff files, training records and records relating to the management of the home including quality audits and monitoring information.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we found the home to be in breach of the regulation associated with the safe recruitment of staff. We reviewed seven staff files at this inspection to see if the issues previously identified had been resolved. We found several areas of the homes recruitment procedure were not being followed. This included one file not containing any references on their file or a record of that person's interview. On another person's file we found that identification checks had been made, however, the addresses of two pieces of identification did not match therefore a second type of identification with the person's current address was needed. On another person's file we saw that their record of previous employment did not include any dates therefore it was not possible to see if there had been any significant gaps in their employment. This was not explored during the interview process according to the interview notes on file. We also questioned the reference for the same person from their previous employer as it was written on lined A4 paper and was not dated or stamped by the organisation it was requested from. We would have expected this to be have been followed up in addition to the dates of employment.

There were several other areas of continued issues within the recruitment process including interview notes not being scored, therefore no benchmark being in place for who was deemed to be a successful candidate for each role. We also saw on one person's file that their photographic identification was a passport from when they were six years old. This of course was not suitable to accept as a form of identification for an adult. This issue was resolved the day after our inspection as the member of staff brought in more up to date and suitable identification. We were also sent an action plan by the home's area manager which included the home reviewing all recruitment files and addressing the issues we raised at the inspection. However due to the issues cited above we found the home to be in continued breach of Regulation 19 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of the people we spoke with told us they felt safe living at Aaron Crest Care Home . Visiting relatives told us they felt comfortable with leaving their loved ones in the care of staff at the home. One person we spoke with when we asked them if they felt safe told us, "The girls are never far away so I'm quite safe here." Another person said, "Oh yeah it's safe." And another person said, "Yes, knowing that I've got 24-hour care if anything goes wrong, or if I'm in pain or anything like that and that there is always a Senior Nurse on if anything goes wrong."

However one person told us, "There's nothing wrong with the staff but they sometimes take ages to come after I've pressed my button (call bell)." Another person told us, "There was lots of shouting. Residents would shout and swear at staff and staff would shout and swear back at residents, this would happen every day and it was more than one of them (care staff). It happened quite a lot and I got sick of it." During our inspection we saw call bells answered in good time and saw no evidence of staff speaking to people in an inappropriate manner.

The two comments were made in isolation as other people spoken with raised no similar issues. However we did see within team meeting notes dated 11 November 2017 a reference made to "..staff shouting and bawling at each other in corridors." We discussed with the home's manager, area manager and quality

director the comments made about staff shouting at people but could not go into detail as the person raising the concerns did not wish to be identified. The person raising the issues told us that it was no longer an issue but it had made them feel uncomfortable when it was happening.

The quality director contacted us following the inspection to share an internal investigation they had carried out as a result of the comments to ensure that people felt comfortable with the staff at the home. The investigation did not highlight any further issues with regard to staff approach or conduct and people questioned were happy with how their call bells were answered. We found this investigation to be prompt, thorough and addressed the issues raised during our inspection. We were also told by the quality director that the issues would be addressed via team meetings and would continue to be monitored.

At our previous inspection we found the home to be in breach of the regulation associated with staffing. We saw evidence during our inspection that staffing levels were in place to meet the needs of the people who lived at Aaron Crest, therefore the home had met this breach of regulation. As indicated above we did receive comments from one person who told us that when they used their call bell they could be waiting for a period of time. This was an isolated comment and whilst we could see that staff were busy we did not feel that staffing levels compromised people's safety at the home. Staff we spoke with told us that they were busy but that they felt people were cared for as they should be and that when fully staffed the current levels were appropriate for the needs of the people in the home. One member of staff we spoke with told us, "It is busy but there is a structure now." Another member of staff told us, "It's (staffing levels) fine, it's just an issue sometimes when people ring in sick at the last minute. I know they do their best to replace staff when this happens. If we ask the manager or deputy they will assist." We received similar comments from all the staff we spoke with.

From reviewing staff rotas we could see that staffing levels remained consistent. At the time of our inspection, based on the levels of assessed care and occupation at the time, the home was operating two shifts of 12 care staff in the day and six staff were on shift at night. The home manager told us that bank staff were used but that no agency staff were used to cover shifts. Historically agency nurses were used but the home had recently fully recruited to nursing posts so there was no longer a need to use agency cover. The home used a staff dependency tool which took into account the level of occupancy and people's assessed needs so could flex according to either changing.

We reviewed the home's procedures for managing medicines. We found the home had made a number of improvements in this area since our previous inspection. However there was a marked difference between how medicines were managed between the two floors at the home. The senior carer shadowed who administered medicines on the ground floor followed clear procedures and protocols and their knowledge base was found to be good in terms of following best practice.

As stated there was a distinction between how best practice was followed between the two floors. For example on the first floor we observed one person's medicines being given to them after being dispensed into a pot. The person was then given movicol to take their medicines. This person's care plan stated that the person must take their medicines separately with water. We observed another person having their eye drops administered. The member of staff doing so did not wash their hands prior to administration and did not follow the instructions within the persons care plan which stated that the drops be administered to the lower eye lid. The person was seen to blink the medicine away and wipe the remainder off their eye with a tissue. It was therefore not possible to ascertain if this person had received their eye drops.

Each Medicines Administration Record (MAR) contained person centred information and guidance for staff to follow, including each person's preferred method of how they took their medicine. On

the ground floor of the home we found care plans and MAR's to be followed and staff knowledgeable about people's needs and preferences. This was not always the case on the first floor. However improvements were noted from the previous inspection and clear procedures were in place across the home for staff to follow. We saw that staff were trained and competency assessed either following a medicines error or at regular interval depending on their experience.

We checked the stock of controlled drugs and found they were accurate and controlled drugs were stored securely and safely. The temperature of the fridge used to store medicines was also correctly recorded each day ensuring the consistent temperature of medicines required to be kept cold. We saw safe systems where in place to ensure the safe ordering and disposal of medicines.

We recommend that medicines management systems are aligned across the home to ensure that all the people within the home receive their medicines as their care plans and MAR's state they should be. This could be achieved by the home replicating the processes that we clearly saw to be working efficiently on the ground floor of the home.

Within people's care plans we saw that accidents and incidents had been reported and in most cases investigated. However, we saw that in some cases it was unclear if any follow up or investigation had taken place. For example we saw information on ABC charts and within daily records referring to accidents and incidents but these had not been transferred onto an accident and incidents form so it was unclear of the action to be taken to mitigate future risk.

We discussed with the manager and area manager during our feedback to the home the importance of collating accidents and incidents centrally to enable the home it identify any themes or trends. This could then potentially assist with putting preventative measures in place to reduce the risk of accidents and incidents occurring again. We recommend that all accidents and incidents are recorded formally and held centrally to ensure that appropriate actions and learning takes place to help prevent or reduce future re-occurrences.

We looked around the home and found it was clean, tidy, well-maintained and pleasantly decorated. Staff had received infection control training and understood their responsibilities in relation to infection control and hygiene. Staff told us they had appropriate personal protective clothing such as disposable gloves and aprons. Hand sanitising gel and hand washing facilities were available to staff. This meant staff were protecting people who lived in the home and themselves from potential infection when delivering personal care and undertaking cleaning duties. Suitable arrangements were in place for the disposal of clinical waste and for handling COSHH (Control of Substances Hazardous to Health) equipment. A recent Infection Prevention Control Audit had been carried out at the home which had showed improvements in this area from the previous audit. We found no issues with infection control measures in place at Aaron Crest.

We spoke with the home's maintenance person who had worked at the home across various roles for 22 years. They told us they felt the new manager was good and had made a positive impact at the home. They talked us through the various tests they undertook at the home including water temperatures, carbon monoxide, window restrictors and bed rails. They also took us through the home's fire procedures including testing of equipment, alarms, drills and fire doors. The maintenance worker had organised records that were up to date and well maintained.

We saw evidence via service certificates, that equipment used in the home was serviced and checked in line with manufacturer's guidelines. One member of staff we spoke with told us that one of the hoists in the home needed repairing and that several wheelchairs did not have the correct footplates on them. We were

told, and saw evidence, that the hoist was due to be repaired the week following our inspection. The area manager told us that they would ensure that wheelchairs would be matched up with the correct footplates and that they were removed for the purpose of storage. However, there was an admittance that footplates should be made readily available even if they needed to be removed for storage purposes and we were assured this would be the situation moving forward.

The home had an up to date and relevant safeguarding policy and procedure in place. We spoke with staff about the home's safeguarding procedures to ensure they understood them. They were all aware of the safeguarding policy and how to report any potential allegations of abuse or concerns raised. They were also able to tell us who they would report issues to outside of the home if they felt that appropriate action was not being taken and displayed good knowledge of local safeguarding protocols.

The home had a safeguarding file in place which recorded any referrals made and any actions taken as a result which evidenced that the home learnt from issues. We saw that some appropriate safeguarding referrals had been made to the Local Authority and notifications made to the Care Quality Commission (CQC) when needed. We did however see some examples of incidents within people's records that could have been referred as safeguarding concerns to either the Local Authority, CQC or both. We discussed these issues with the quality director who assured us that systems were now in place to ensure that all potential safeguarding issues were either referred appropriately or at least discussed with the Local Authority Safeguarding team.

Care plans we looked at contained completed risk assessments to identify potential risk of accidents and harm to staff and people in their care. We saw some good examples of risk assessments within care plans that were reflective of people's care, support and daily living. One example was for a person who smoked. Risk factors identified included frequency, location, ability to light cigarettes and the person's capacity. If people did not have capacity then further considerations were made in terms of supervision by staff, how smoking equipment was stored and disposal of cigarettes. The risk to flammable clothing was also included in the risk assessment, i.e. if the person used paraffin based skin products.

The home had a business continuity plan in place that catered for a number of emergency situations such as the loss of accommodation, energy supply and in the event of a major incident such as a fire. The plan contained a list of contacts both internally to the local authority and externally for specific incidents, for example local tradespeople.

Requires Improvement

Is the service effective?

Our findings

The majority of the people and relatives we spoke with told us that in their opinion, staff had the skills and experience which met their or their family member's needs, they liked the staff that cared for them and were asked for consent when care and support was being provided. One person told us, "I have a bath and they (staff) use a hoist, my choice for both. Staff are definitely respectful. I obviously have to strip off, the girls (staff) and I don't bother, they wash my back gently and ask me before they do so." Another person told us, "They (staff) are very respectful; they always knock before they come into my room. I get asked before anything happens."

We reviewed how people were supported to have their nutritional and hydration needs met. Care plans in this area, as with some other areas did not always fully reflect people's needs. Each person had a dietary profile which was not always updated as people's needs changed. We have detailed some examples within the 'Responsive' domain of this report. We did see that referrals had been made to appropriate professionals such as dieticians and the speech and language therapy team. However we felt that some people we pathway tracked could have been referred for specialist assistance due to weight loss.

We spoke with the cook on the first day of our inspection. The cook was standing in for one of the full time cooks on the day of the inspection but had fulfilled the training requirements to do so and had experience of working in the kitchen. Whilst speaking with them it became apparent that they did not have a complete knowledge of people's dietary needs and the records within the kitchen, as with some care plans, were not always current. The menu on the first day of the inspection was changed, and this was discussed at the daily 'flash' meeting in the morning and the reasons for doing so were valid. However, this was not explained to people dining so the menus that were displayed on the table did not match the food offered to people. As many people were living with varying degrees of dementia this had the potential to confuse people who had read the menu.

We saw that one person whose care plan stated they needed a soft to pureed diet was fed corn beef hash with beans. Beans are not classed as a soft food. This put this person at risk of choking. We saw one person had guidance from the dietician within their care plan for them to be given 30ml shots of cream in their hot drinks and for all their food and drinks to be fortified. This information was dated 8 November 2017 but the kitchen did not hold these records. We did see evidence of people gaining weight by following fortified diets but this, as with other aspects within the home, was not done routinely.

When information around the associated risks of poor nutrition or hydration are not shared with the relevant staff there is a risk people will not get the support they need. When people's special dietary requirements are not followed, action needed to reduce risks is not effective. When people do not get the support they need to maintain their nutritional needs this is a breach of Regulation 14 (1) (2) b of the Health and Social Care Act (Regulated Activities) Regulations 2014

We observed lunch on the first day of our inspection on both floors and found it to be a pleasant experience with staff attentive to people's needs. If people needed support it was given in a calm and caring manner

and if people were unable, or did not want to eat in the dining area they were able to eat in their bedrooms. The home had a food hygiene rating of five which is the maximum rating possible. We recommend that the home's dietary profiles are updated to reflect each person's current needs and abilities and that staff, especially those working in the kitchen are made aware of any changes so they can implement advice and guidance effectively.

We found a number of consent forms within people's care plans, such as a 'consent on admission form'. This form was signed to give permission for the home to share information with health professionals and listed friends and relatives. Other examples of consent found included; satisfaction surveys, auditing purposes, photographs, medication and use of bedrails. We found a number of issues with how consent was gained when reviewing people's care plans. As stated in other areas of this report the home had identified consent as an issue within a recent care plan audit that had taken place a few weeks prior to our inspection in January 2018. They had identified two care plans that did not have the relevant consent forms in place.

In addition to some files not having the necessary consent in place we found examples within two care plans of consent being given by relatives who did not have the legal rights to do so. There was no suggestion that this consent was given for any other reason than to act in the best interest of the person in question however no formal processes were in place. There was also no indication within one care plan that the person did not have capacity to sign their own consent forms. As the home had already identified a number of issues with regard to consent, and we saw files where consent had been gained appropriately, we felt confident that the home were addressing the concerns we raised with them. As with a number of issues the quality director informed us of the actions taken by the home shortly after the inspection to assure us that process were in place to remedy the issues we raised, and to fully audit the home's care plans to ensure consent was gained and signed for in line with legal requirements.

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, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that capacity assessments were undertaken for people living at Aaron Crest. However we found limited best interest decisions in place for those people who were deemed to lack capacity. The best interest decisions we did see within people's care plans were not decision specific or contain sufficient information.

Staff we spoke with had some knowledge around MCA and DoLS and we saw that they had received recent training in this area. Some care plans we looked at did have contradictions within them with regards to people's ability to retain information. We recommend that the home review all capacity assessments and ensure that the information within best interest decisions are detailed and decision specific.

The majority of staff we spoke with told us that they were supported well and that this support had improved since the new manager had come into post. However, when reviewing staff files it became apparent that staff had not been receiving regular formal supervisions or annual appraisals. Staff confirmed

this when we spoke with them. One member of staff told us, "I've never had a supervision or appraisal in all the time I have been here." They had worked at the home for several years.

Due to the number of issues at the home when the new manager had come into post formal staff support in the form of supervision and appraisals, whilst recognised as being important, had not yet had chance to be implemented with any sort of consistency. Staff did however tell us that they did feel supported and could always approach peers or any of the management team with issues. We saw that specific supervisions did take place if necessary, for example if there had been a medication error.

The home manager was aware of the lack of formalised supervisions and this formed part of the homes action plan going forward. This would then ensure staff had the opportunity, via this forum, to discuss their performance, raise issues and discuss personal development and that this was recorded. We recommend that formal supervisions for all staff take place at a regular frequency alongside annual appraisals of their performance to ensure that staff have a formal and recorded way of discussing their work performance and any other issues.

We saw, via staff files and the homes training matrix, that staff were well trained. Staff we spoke with confirmed this. One member of staff we spoke with told us, "There is always lots of training to do, most of it is online but we also get to come into the home and do practical training or go to other homes." Another member of staff told us, "Yes, we get loads (of training) and you get chased up if you don't do it." Staff had specialist leads in a number of areas and received training in these areas. We saw area leads in a number of areas including; medication management, safeguarding and infection prevention control.

The home's design was fit for purpose and was suitably decorated. There were further plans in place to improve the décor and make the home more dementia friendly. It was evident that the home was maintained well and updated to meet the needs of the people living within it.

Good

Is the service caring?

Our findings

The majority of the comments we received from people living at Aaron Crest with regard to staff and their approach were very positive. Comments included; "Staff are nice, there are some very nice young carers." "Yes, very caring." And "Staff are very good, the girls are very pleasant." Relatives we spoke with also told us that they felt staff were caring and pleasant to them and their loved ones. As mentioned in the 'Safe' domain of this report we were told by one person that they had experienced staff shouting at people and we saw evidence of such behaviour being reported via safeguarding referrals and within team meeting minutes in November 2017. However there were no recent reported incidents of this nature and we observed positive interactions between staff and people in a relaxed environment.

Staff we spoke with had a good understanding of protecting and respecting people's human rights. They were able to describe the importance of respecting each person as an individual and spoke well and knowledgeably about people's privacy and dignity as well as how to maintain confidentiality. We saw relevant policies and procedures in place with reference to human rights, privacy, dignity and confidentiality and staff knew how to access them.

People told us they could make choices regarding their day to day life at Aaron Crest as well as issues that may affect them longer term. One person told us, "I do have choice, for example sometimes I have a shower, sometimes I have a bath, it depends on how I'm feeling. Staff are respectful with personal care and ask my consent politely." Another person told us, "Yes, I'm satisfied in that respect, a nurse came around last week and filled in a form with me asking my views and how I like things doing."

Relatives also told us that they felt part of their loved ones care and support design. As well as being included in the care plan review process, if they wished to be, they told us they were asked their opinion and were free to suggest improvements or raise issues. Relatives told us they were also free to come and go as they pleased as long as they did not turn up unannounced at unsociable hours. One relative said, "There's no set time, we can come anytime which is good and gives us confidence." All the relatives we spoke with told us much the same in regards to being able to express their views, be involved and see their loved one when they wished. Staff told us that they had an open relationship with families and were respectful of their views and needs as well as the people they cared for.

People, and their relative's involvement, were evidenced within care plans. The new home manager had begun the process of reviewing care plan documentation and we could already see the positive impact this process had in terms of their content. As with a number of areas within the home we could see that the new management team had begun to make progress in this area. As with other areas there were still some improvements to be made in terms of how people's involvement was formally recorded however, from speaking with people and relatives we could see that this did happen in practice.

We saw evidence of various methods of communication used to engage with people, relatives and staff including; care reviews, meetings, telephone contact and surveys. People were given a service user guide when they came into the home and the homes website had useful information on it.

If people did not have support from family then they had access to formal advocacy support. The service had information details for people and their families if this was needed with regards to the different types of formal support they could be entitled to if needed. This ensured people's interests would be represented and they could access appropriate services outside of the home to act on their behalf if required. No-one at the home was receiving support from a formally appointed advocate at the time of our inspection.

Requires Improvement

Is the service responsive?

Our findings

Care plans were in the process of being updated by the new home manager and we could see that this had begun to have an impact as there were some really good, current examples of care plans being updated to reflect recent changes, for example a change in someone's mood or physical capability. However, there were a number of examples of information not reflecting people's current needs or abilities, for example one person dietary profile did not reflect the fact that this person had lost significant weight and were now deemed a higher risk. Another person's care plan stated that they were able to wash themselves without assistance but it became evident during our inspection that this was not the case. This left a risk of them not getting the support they needed.

The home's own care plan audit in January 2018 picked up on several care plans that did not reflect people's current needs. One comment within the audit read; 'Care plan requires re-writing to reflect current requirements' and another comment regarding a person's dietary profile read, 'No dietary profile on file. Increase in waterlow score not recorded'. There were several other similar issues highlighted. This meant the action required to reduce any associated risks with an increased waterlow score (pressure and skin integrity) may not be identified or undertaken.
We reviewed eight people's care plans in detail at the home during the two days of our inspection and reviewed parts of others in response to specific detail. In all the care plans we reviewed we found some good, person centred information about individuals, their histories, preferences and how to provide their support. However, parts of some people's care plans did not fully reflect their current needs therefore staff did not always have the most recent information they needed to provide people with the care and support they needed. The audit completed in January 2018 highlighted many of the issues we found during our inspection. This included; various areas of consent not being gained or signed for by appropriate people, dietary profiles not always being up to date, various care planning information being out of date following people's needs changing and missing information from care plans. We also observed, on a number of occasions, people's care plans not being adhered to. One person's care plan clearly stated that they were to be encouraged or assisted to eat. On two separate occasions, once after we had highlighted the issue to staff at the home, we found food at this person's bedside and they had been left unassisted. On the first occasion the person's food was uncovered and left by them when they were asleep. The person's care plan also stated that they preferred their food in a bowl and to eat with a spoon. On the first occasion the food was left by them on a plate with a fork.

Staff we spoke with told us they found care plans useful in assisting them to support people effectively and that they found the information within them helpful. Staff admitted that some of the information within care plans was in need of being updated and they were aware of this process being started. They also told us that they felt they found it difficult to find the time to read updates although these were covered at handovers.

Due to some information within care plans not being up to date and reflective of people's most recent needs alongside care plans not always being followed we found this put people at risk of not receiving person centred care. We found a continuedbreach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people if they were able to take part in activities and partake in any hobbies and interests they may have. Most people we spoke with told us they were, others were not interested in doing so and some people were unable to answer our questions in this area. One person we spoke with told us, "[Activity Coordinator] is very good. I have hand and head massages. There's a singer who's really good. The hairdresser's marvellous and will come downstairs (salon upstairs)." One relative we spoke with told us, "They (staff) come and chat with [Name]. She doesn't like parties but the Christmas party was very well organised. [Name] has her hair done every week and likes that."

The home employed two activities coordinators, one of whom worked 24 hours per week and one who worked 18 hours per week. We spoke with both of them during the two days we were at the home. They told us that there were plenty of activities happening throughout the home on a daily basis, including most weekends. Some of the examples they gave us included; Musical memories, famous faces, quizzes, name that tune, floor skittles, exercises with a ball and indoor parachute and reminiscing exercises. They told us they also did one to one work with people who did not want to or were unable to engage in group activities. We were also told that when care staff had time, they also got involved in activity work. We were shown 'Remember I'm Me' charts that were in the process of being hung from people's doors so staff could initiate conversations with people based on their history, preferences and hobbies.

We did not see anyone undertake any activities outside of the home but it was cold outside at the time of our inspection. The activities coordinators told us that they did access the courtyard outside and on occasion they took people to eat out or to local parks but this was weather permitting. The home had recently introduced a therapy dog which was still in training. The dog travelled to and from the home with a member of staff and was kept in reception when not engaging with people in the home. From our observation and from speaking to people and staff this was seen as a positive introduction and research evidences that some people with dementia benefit from the company of pets.

All of the people we spoke with said that staff responded well when help was required. No-one we spoke with told us they had needed to make a formal a complaint but felt comfortable talking to staff and raising issues if necessary. Relatives we spoke with told us similar. The service had a complaints procedure which was made available to people via the service users guide and was on display in the home. The procedure was clear in explaining how a complaint should be made and reassured people these would be responded to appropriately. Contact details for external organisations including social services and the Local Government Ombudsman had been provided should people wish to refer their concerns to those organisations.

The home had received nine formal complaints within the 12 months period prior to our inspection which were kept within a complaints file. All had been acknowledged and investigated appropriately following the homes complaints policy.

We discussed end of life care with the home manager who told us that going forward the home were looking to become a specialist end of life provider. We did see some references to end of life care within care planning documentation to show that discussions had taken place with people and families, if appropriate. However, this was still an area for development and the home's own internal care plan audit carried out in January 2018 highlighted a lack of detail around end of life as an area to improve.

The home did have a good relationship with the local hospice and sought advice from there when required. They were also looking to begin to introduce six steps training through their local hospice. The six steps programme was developed in the North West of England by the Cheshire & Merseyside Clinical Network and

the Greater Manchester, Lancashire & South Cumbria Clinical Network with support from the National End of Life Care Programme and is now a nationally recognised end of life training programme. We were assured this area of work would be implemented as required and more formally across the home in the coming months.

People who requested one had a DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) document within their care plans. The examples we saw were correctly documented, in date and reviewed as necessary.

Requires Improvement

Is the service well-led?

Our findings

A home manager was in place who was in the process of applying to be registered.The home had lacked consistent management for some time and we were assured the new manager intended on remaining in post. 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.

People and relative's comments were very positive when asked about the manager, leadership and staffing at the home. All the people we spoke with said there was a good atmosphere in the home and told us it was calm and organised. These views echoed our own experiences of the two days we were in the home. All the people we spoke with found the staff and the manager easy to talk to and considered the home to be well managed and a pleasant place to be in. All the relatives we spoke with mirrored these views. Comments included; "The atmosphere is wonderful, the manager is very good, nothing to improve, it couldn't better this place." "It's a quiet atmosphere, never any trouble and it's run very well." "It's a pleasant atmosphere from what I've seen so far." And "It's pretty good, I wouldn't stay here if it wasn't."

We spoke with the home manager as well as the homes area manager, peripatetic manager and the organisations director of quality. They all acknowledged the difficulties the home had experienced over the past couple of years but were all confident that issues were being addressed and that going forward they would continue to progress. The home were working to an action plan, that was shared with the CQC. An update was issued shortly after our inspection to address, or begin to address any issues raised.

The area manager told us that they were looking to focus on quality and that they were assisting this process by bringing in as much consistency across the group as possible in terms of procedures, processes and recording. They explained to us that Aaron Crest had been designated as a 'focus home'. This was partly as a result of the previous reports but also due to the newness of the management team. The area manager came into the home on a fortnightly if not weekly basis to help support the new management team.

The service had procedures in place to monitor the quality of the service provided. Regular audits had been completed. These included reviewing the services medication procedures, care plans, infection control and environment. Senior managers from the wider organisation regularly carried out their own audits and we saw recent evidence of these on our inspection. The home manager worked nursing and care shifts in order to have a first-hand experience of the care provided and what staff experienced. She told us that this practice would now reduce to one shift per month but that she was always willing to provide assistance. Staff we spoke with confirmed this to be the case.

As mentioned in previous domains many of the issues we came across during our inspection had been highlighted via the home's own auditing process, for example the detail within care plans. We therefore saw that plans were in place to address many of the areas we discussed. As part of their home visits the area manager reviewed any audits that had taken place. It was accepted that further time was needed to fully

address a number of areas and that there were few instant remedies or 'quick wins' to bring the home to the required level in order to attain an overall 'Good' rating. The home manager told us that progress had been slow due to the amount of issues that were present when she first arrived and that the home had been "rebuilt from the foundations up." She told us that she expected the home to be where she wanted it by Easter time if the same rate of progress was maintained.

The service worked in partnership with other organisations to make sure they were following current practice, providing a quality service and the people in their care were safe. These included social services and healthcare professionals including General Practitioners.

The service had on display in the home their last CQC rating, where people who visited the home could see it. The latest rating was also on display via the homes website. This has been a legal requirement from 01 April 2015. Notifications were sent into the CQC as needed and all other registration requirements were evidenced to be met. There was also lots of other information on display for people and visitors to reference including a board with photographs of the entire staff team so people could locate staff easily.

Staff we spoke with told us that the current leadership within the home had made an impact on the staff morale within the home and that increased staffing levels and improved communication and a better structure had played a big part in this. However, some staff told us that their own morale was still low. This was understandable due to the number of personnel changes at all levels across the home over a sustained period of time. One member of staff told us, "The change of managers at the home has been a real issue. Morale was affected. I feel we now have the right manager. She is strict but also motivates staff. The leadership is now there, we all work for each other." Another member of staff told us, "The new manager has been fantastic, just what we needed." As stated some staff told us that morale could be better but again that this was an area that was much improved.

We were confident however that the new home manager alongside other senior staff had recognised this and begun the process of turning low morale into a more positive scenario. Staff surveys had been sent out shortly prior to Christmas to give staff the opportunity to voice their concerns, anonymously if desired, and a monthly staff recognition scheme had been introduced called 'Caring Heart'. The home manager told us they were looking to introduce other schemes to boost staff morale.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Due to some information within care plans not being up to date and reflective of people's most recent needs, alongside care plans not always being followed this meant people were not always receiving person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	People did not always get the support they needed to maintain their nutritional needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed
Treatment of disease, disorder or injury	Appropriate safe recruitment checks were not always followed including suitable references, identity checks and thorough interviews were not always carried out.