HC-One Limited

Aston House Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service: Aston House Care Home is a care home providing accommodation with nursing care for up to 48 older people. There were 41 people living at the service at the time of our inspection. Aston House Care Home is a purpose-built building which accommodated people over two floors. People who used the service were older people with nursing needs and/or living with the experience of dementia.

People's experience of using this service:
● The provider had systems in place to help ensure people who used the service were safe from avoidable harm and these were effective.

● Where there were risks to people who used the service, these had been assessed and management plans included clear guidelines to help ensure people were safe from harm.

● People's nutritional and healthcare needs were met and we saw that staff took appropriate action when concerns were identified.

● The provider had robust systems in place to monitor the quality of the service and put action plans in place where concerns were identified. People's care records were reviewed and updated monthly or more often if their needs changed.

● People received their medicines safely and as prescribed. Staff received training in the administration of medicines and had their competency at managing medicines safely checked.

● Care plans were developed from pre-admission assessments and contained relevant and up to date information about people's needs and preferences, so staff knew how to care for and support them.

● People were supported by staff who were suitably trained, supervised and appraised.

● Where possible, people had an end of life care plan in place which stated their individual wishes when they reached the end of their lives.

● Recruitment checks were carried out before staff started working for the service and included checks to ensure staff had the relevant previous experience and qualifications.

● People were protected by the provider's arrangements in relation to the prevention and control of infection. The home was clean, tidy and well maintained throughout.

● The environment was tailored to the individual needs of people who used the service, including those living with the experience of dementia.

● The provider acted in accordance with the Mental Capacity Act 2005. People had their mental capacity assessed before they moved into the home. Where necessary, people were being deprived of their liberty lawfully.

● The provider had processes for recording and investigating incidents and accidents. We saw that these included information about the actions which had been taken and lessons learned.

● People were engaged in a wide range of meaningful activities. People were consulted about what they wanted to do and were listened to. People reported they were very happy with the activities on offer.

● Staff were responsive to people's individual needs and knew them well. They supported each person by spending time with them and listening to them. They ensured that each person felt included and valued as an individual.

● The manager led a caring and dedicated team. Together, they met people's individual needs and improved their quality of life.

Rating at last inspection: At the last inspection on 3 and 4 October 2016 the service was rated good.

Why we inspected: This was a planned inspection based on the previous rating.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective

Details are in our Effective findings below.

Is the service caring?

Good

The service was safe

Details are in our Safe findings below.

Is the service responsive?

Good

The service was responsive

Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well-led

Details are in our Well-led findings below.

Aston House Care Home

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by one 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.

Service and service type:
Aston House 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.

The service had a manager who was in the process of registering with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The inspection was unannounced.

What we did:
We reviewed information, including notifications we had received about the service since the last inspection. Notifications are about incidents and events the provider must notify us about by law, such as abuse. We also sought feedback from the local authority and professionals who work with the service. The registered manager completed a Provider Information Return (PIR). This is a form that asks providers to give us some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection:
We spoke with eight people who used the service and three relatives of other people and asked them about their experience of the care provided. We spoke with the operations manager, the manager, a senior nurse, four care workers, the wellbeing coordinator, ancillary staff and a visiting food supplier. We also spoke with a healthcare professional who was visiting on the day of our inspection.

We reviewed a range of records. These included five people's care records, audits and quality assurance reports. We also looked at five staff files in relation to recruitment, supervision and training and reviewed records relating to the management of the home and a sample of policies and procedures developed and implemented by the provider.

Good

Is the service safe?

Our findings

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

Good: People were safe and protected from avoidable harm. Legal requirements were met.

Learning lessons when things go wrong

● The manager had put in place a 'Sharing lessons learned from incidents' procedure. This looked at 'What happened', 'investigation' and 'outcome'. These were discussed with the staff team during staff meetings and clinical review meetings. From these discussions, the team reviewed the lessons learned to prevent reoccurrence.

● The provider had an accident and incident policy and procedures and staff were aware of these. The provider kept a log of all incidents and accidents, and where necessary, for serious incidents, they carried out a root cause analysis (RCA). This was a tool which enabled them to look deeper into an incident or accident and find out why these might have happened and how to prevent reoccurrence. For example, where a person using the service had a fall and had sustained a fracture, we saw evidence that a thorough investigation had taken place, which included any possible contributing factors such as underlying conditions, the environment at the time of the accident.

● We saw that some RCAs were not always fully completed. For example, one person had sustained a fracture when they had fallen. Whilst the form identified the possible contributing factors, such as the person's condition and a problem with their chair, no explanation had been provided, and there was no recorded action plan or recommendations. However, we saw evidence in the person's care records that appropriate action had been taken. A referral had been made for the person to have a more suitable chair and we saw that this had been delivered in a timely manner. The manager acknowledged that they should have recorded all the actions taken on the form and this was an oversight. They assured us they would do this in future and had completed the records by the end of the day.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe and well looked after and relatives we spoke with echoed this. The provider had a safeguarding policy and procedures. They kept a log of all safeguarding incidents, actions taken, and the outcome. There were no current safeguarding concerns and we saw that in the past, where there were concerns, appropriate action had been taken, including involving the local authority's safeguarding team. Staff knew who to contact if they had concerns about the safety of people who used the service and were aware of the whistleblowing policy. They added that they were confident any issues reported to the management team would be addressed.

Assessing risk, safety monitoring and management

● Where there were risks to people's safety and wellbeing, these had been assessed. Individual risk assessments were thorough and included measures in place to prevent reoccurrence. For example, a person who was at risk of skin deterioration and who had suffered skin tears had a risk assessment in place and a

Waterlow score. This gives an estimated risk for the development of a pressure sore in a person. We saw that the person had been provided with relevant pressure relieving equipment such as a pressure mattress. Staff were required to reposition the person regularly and we saw evidence that this was carried out as per care plan.

● Where people were at risk of malnutrition, we saw that staff used a Malnutrition Universal Screening Tool (MUST) to establish the level of risk, and where there were concerns, we saw they were referred to the relevant healthcare professionals, so advice could be sought about how to support the person and prevent weight loss. MUST is a five step nationally recognised and validated screening tool to identify adults who are malnourished or at risk of malnutrition.

● We saw that staff had taken appropriate action for a person who used the service who was at risk of choking. Following advice from relevant healthcare professionals, the person was required to have their food pureed. We saw that a risk assessment was in place and this was regularly updated. There were instructions for staff to follow about what constituted pureed food, and which food textures posed a risk to the person.

● There were also environmental risk assessments which included the use of washing machines and dryers, wet floors, chemical products, using the deep fat fryer, driving in adverse weather conditions, blood borne viruses, moving and handling and kitchen equipment. Health and safety checks were undertaken regularly and were up to date. These included gas and electricity checks, water safety and fire equipment, including emergency lighting, fire panel and fire extinguishers. Certificates for all the safety checks were kept in a file and were up to date.

● There were regular fire drills undertaken and these were recorded. Records included the time of the drill and the staff members who attended. Any concerns were recorded, and an action plan was in place where improvements were needed. For example, when a staff member failed to attend, this was immediately addressed. There was a fire risk assessment in place and this was up to date.

Staffing and recruitment

● There were enough staff deployed to meet the needs of the people using the service. The manager told us they occasionally used agency staff in the event of staff absence. They ensured however, that all agency staff had an induction of the service and tried as much as possible to have regular staff to promote continuity for the people. We saw evidence of this in the records we viewed.

● Recruitment practices ensured staff were suitable to support people. These included checks to ensure staff had the relevant previous experience and qualifications. Checks were carried out before staff started working at the service. These included obtaining references from previous employers, reviewing a person's eligibility to work in the UK, checking a person's identity and ensuring a criminal record check was completed. We viewed the recruitment files for five staff and saw evidence that all checks were appropriately carried out.

Using medicines safely

● There was a medicines policy and procedures in place which was up to date. The nurses were responsible for the management of people's medicines. They received regular training in medicines administration and had their competencies assessed.

● We observed a nurse supporting people with their medicines and saw they followed the provider's

procedures. Where people were prescribed PRN (as required) medicines, such as pain killers, they were asked if they had any pain before administering these. Where people were unable to express this, staff used a pain assessment tool which took into consideration people's expression, body language and vital signs to inform them if a person was likely to be in pain and required pain relief. The provider had a policy and procedure where people were required to receive their medicines covertly.

● Prescribed medicines were recorded on Medicines Administration Record (MAR) charts. We saw these were clear, and included details about each medicine, such as dosage and frequency of administration. Staff signed appropriately after administration and we saw no gaps in signature. All medicines were supplied in their original boxes so that information leaflets were available for every medicine prescribed. The nurse in charge told us, "It takes more time, but it is really good, as we don't just pop tablets out. We look more carefully and know what each medicine is for." We checked the number of tablets in stock for twelve people, and saw these corresponded to the staff signatures, indicating people were receiving their medicines safely and as prescribed.

● Some people were prescribed controlled drugs (CD). These are prescription medicines which are controlled under the Misuse of Drugs legislation. We saw CDs were well managed and recorded appropriately. We checked the running balance of a random sample and saw these were correct.

● Each person's medicines record including a cover sheet which had the person's photograph, known allergies, any difficulties in taking medicines and how they preferred taking these. For example, with orange juice.

● The medicines room was airy, clean and tidy, and well ventilated. Daily temperatures were recorded, and these were within range. There were sample signatures of all the staff responsible for administering medicines. Medicines requiring refrigeration were kept at the right temperature and this was recorded daily.

Preventing and controlling infection

● People were protected from the risk of infection and cross contamination. There were regular infection control audits and staff had received training in infection control. There was an infection control policy in place and this was up to date. We saw staff using appropriate personal protective equipment such as gloves and aprons and all areas of the home were clean and hygienic. We saw the nurse in charge washing their hands before administering medicines to people who used the service.

Good

Is the service effective?

Our findings

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

Good: People's outcomes were consistently good, and people's feedback confirmed this.

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

● People were assessed before they started using the service. Assessments we viewed were detailed and thorough and included all aspects of the person's needs and what support they needed to meet these. Areas assessed included, health conditions and medicines prescribed, communication needs, eating and drinking, personal care needs, mobility and sleeping. Pre-admission assessments were used to write care plans which reflected people's needs and wishes.

Staff support: induction, training, skills and experience

● People were supported by staff who were well trained, supervised and appraised. New staff were expected to complete a thorough induction before they were allowed to work unsupervised. This included undertaking the Care Certificate and shadowing more experienced staff members. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. One staff member told us they had been told by their manager to 'concentrate on their induction' and 'not to work until fully confident and competent'. Another staff member felt that their induction had been 'well planned and really supported their integration to the team and the company'.

● Following their induction, and when assessed as competent, staff were expected to undertake training the provider identified as mandatory. This included training in safeguarding, moving and handling, medicines administration, first aid, fire safety, food safety and infection control. They were also expected to undertake training specific to people's individual needs such as dementia care, falls awareness, care planning, dignity, nutrition and hydration and person-centred care. We viewed the training matrix which indicated that staff were up to date with their training requirements.

Supporting people to eat and drink enough to maintain a balanced diet

● Menus were displayed in both dining rooms on a stand. There were also colourful photographs of all the meals available, so staff could show these to people who were not able to read the menus either because of their conditions, or sensory impairments. The manager told us they also supported people to choose their meals by presenting them with a range of plated meals. We saw that there were three choices of meals each day including a vegetarian dish, a range of vegetables and desserts and a cake of the day. The manager told us, "After breakfast, the chef goes around and asks residents what they prefer from the three options and the two most popular items will be cooked."

● People who used the service and relatives were positive about the choice of meals offered. One relative told us they regularly visited and there was a good choice of food. We observed lunch in both dining rooms and saw positive interactions between staff and people who used the service during meal time. Staff

consulted people about what they wanted to eat and drink and their choices were respected. The manager told us, "We are happy to print any information the residents required to see, such as the recipe or country of origin of the dish." Staff were attentive to people's needs, asking if they wanted help or more food or drink, and encouraging them to eat their food in a gentle manner. Care records showed that nutritional assessments were completed regularly and informed people's plan of care.

Staff working with other agencies to provide consistent, effective, timely care
● Care records showed that people who used the service were supported to access healthcare professionals when this was required. Hospital discharge information was seen in the care records we checked, which indicated that information was shared appropriately when people were transferred from hospital.

Adapting service, design, decoration to meet people's needs
● The provider had created some areas of interest for people who used the service, for example, the upstairs dining room included a 'garden', with a realistic-looking lawn, garden furniture, artificial plants and a water feature. There were areas to facilitate reminiscence, such as objects and clothing of the past, which people could identify with and touch, tactile and sensory objects and sensory dolls. There were large murals such as a London scene in the reception area, and a variety of framed photograph of film stars of the past. Overall, the home was nicely decorated and looked comfortable and inviting. However, the lounges were not arranged in a way to facilitate interaction and conversation between people and did not reflect how the rest of the home was arranged. We discussed this with the manager who told us they were planning on rearranging the furniture in the lounges to make these more inviting and help people socialise.

● Bathrooms and toilets were large enough to accommodate wheelchairs and hoists and were equipped with specialist baths and handrails for people to use. People's bedrooms had been personalised with their own possessions and looked homely. There were small plaques outside each person's bedroom indicating their name and something personal about the person, so they could identify their room. For example, "I love music", "I used to be a passionate golfer" and "I come from [Country of origin]."

Supporting people to live healthier lives, access healthcare services and support
● People's healthcare needs were recorded and met. We saw evidence of visits by the GP and other healthcare professionals such as the tissue viability nurse. The home kept a record of the visiting professionals' visits, including the reason for the visit, diagnosis and action taken. We saw that any instructions or changes were discussed in meetings and prompted a review and update of the person's care plan. People were supported to attend relevant healthcare appointments and we saw evidence of this in the records we looked at. These included the posture and mobility service and hospital consultants.

●There were medical history records in place to inform staff about people's medical conditions and how to ensure they remained as healthy as possible. Records included body maps where any wounds or bruises were recorded and written observations. For example, where a person who used the service had very fragile skin, we saw that every mark or bruise was recorded with a date and time, and photographs of any injuries they had. Risk assessments were in place and regularly reviewed and updated.

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

● People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. We found the manager understood their responsibilities under the MCA. Where necessary, they had made applications to the local authorities responsible for funding people's care for authorisation to deprive people's liberty in order to keep them safe. We saw no examples of people being deprived of their liberty unlawfully.

● Staff were observed to ask people for consent when supporting them. For example, prior to administering medicines and before putting clothes protectors on people. Additionally, we saw staff offering people choices regarding their daily routine. Staff we spoke with demonstrated they understood the implications of the MCA for their day to day work. People signed their care records when they were able. When unable, we saw that a form was in place, indicating whether the person was unable to sign or if they had a representative signing on their behalf.

● Some people who used the service had a Do Not Attempt Resuscitation (DNAR) order in place. This is a legal order to withhold resuscitation or life support in case the person's heart was to stop or if they were to stop breathing. We saw these documents were appropriately completed and signed by the relevant people, such as the GP and the person's representative.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

● People who used the service told us the staff were caring and they were treated with respect. One person said they were happy at the home and stated, "It is the best place for me."

● Throughout our inspection, we saw that staff supported people in a kind and caring way. We observed staff interact with people, for example, during lunch time and saw plenty of examples where people were showing enjoyment. Staff approached people in a natural and friendly way, sharing jokes and banter, making people laugh. There were people chatting together at small tables whilst eating. Where people required support with eating, we saw staff supporting them in a respectful way, taking their time and communicating with them.

● Relatives told us they could visit anytime they wished and always felt welcome. One relative told us they came regularly at random times during the day and knew all the staff. They added that they never had any concerns and felt the home was well run. Another relative explained that when they were looking for a home for their family member, the manager had invited them to come and visit the home whenever this was convenient for them. They said, "From the very beginning, I had a good feeling about the place and I am very pleased that my [family member] is here." Relatives added that they were kept informed and included in the wellbeing of their family members.

● People's religious and cultural needs were recorded and respected. A Catholic priest visited the home every week to conduct mass for people who wished to participate. One person who required to eat food from their country of origin had built a good rapport with one of the kitchen staff who spoke the same language. They told us the food was as they liked, "Spicy" and added they made a "Good dhal." The wellbeing coordinator told us, "[Person] likes going to a [particular [restaurant] and we go to Southall. They really enjoy it."

Supporting people to express their views and be involved in making decisions about their care

● People were consulted and involved in decisions about their care. Each care record included a resident profile, which highlighted the person's likes, dislikes and personal wishes. We saw that people were asked whether they had a preference about the gender of the staff who cared for them and this was recorded. There were details about which equipment they needed, important things about the person's life, what they enjoyed doing during the day, their preferred way of communication, for example, "[Person] needs clear information prior to any activity or moving and handling" and any personal instruction when providing personal care. For example, "Skin very fragile, please be gentle."

● People and relatives were encouraged to express their views through regular meetings. These included discussions about any staffing updates, planned events and activities, healthcare appointments and any other important and relevant information. The manager told us people were consulted and involved in the service and its development and we saw evidence of this.

Respecting and promoting people's privacy, dignity and independence
● The staff had introduced 'Stop the clock'. This meant that every day, for half an hour, all the staff from all departments stopped what they were doing to engage in wellbeing activities with people who used the service. This was to promote kindness in care and make a difference. Staff said this had been successful and brought everyone together in supporting and caring for people. The manager told us, "We have played balloon games, floor games, one to one chats have been happening, beauty and pampering and so on. One of the residents even taught everybody (residents and staff) a yoga session! During this time the chef has got to know some residents' favourite foods he didn't know about while the home administrator has been seen to exchange gardening tips with a couple of residents who used to be keen gardeners."

● There was a 'Dignity board' in the communal area which listed the members of staff who were dignity champions. A Dignity Champion is someone who believes in treating people with dignity and that care services must be compassionate, and person centred. There were posters illustrating the meaning of dignity and to remind staff how to show respect to people who used the service.

● We saw evidence that staff respected people's privacy and dignity. We saw they knocked on people's door before entering and gave people choice about what they wanted to do and where they wanted to spend their time. Staff were able to give examples about how they ensured that people's dignity was maintained at all times.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Good: People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● The provider employed a wellbeing coordinator who was studying for a level 3 Leadership and management course with the National Activity Providers Association (NAPA). The wellbeing coordinator, staff and management team felt strongly about improving the lives of people who used the service and believed that reminiscence improved people's quality of life. There were a variety of items to remind people of the past, tactile objects and decorated areas, such as a library corner and an 'indoors garden space'.

● People had 'life story' books in place. These were detailed and written in a person-centred way. They included details about the person's family and friends, important events, likes and dislikes, religious and cultural needs, how they liked to dress and what was important to them, including activities they liked to take part in.

● People had their own activity plans which recorded all activities they had participated in. These were written in a person-centred way and included what the activity was and how the person felt about this. This enabled staff to evaluate which activity was meaningful for each person. It also included if the person had received visitors and any relevant interaction.

● The wellbeing coordinator was passionate about providing meaningful activities for people who used the service. They were proactive in raising money for the benefit of the people, and this had contributed to making improvements to the home and organising various events. They told us, "We have a good group of relatives who support us. We manage to raise quite a lot of money", "I am trying to get money for the garden, like a mural to the outside wall so people who are bedbound can have something cheerful to look at. Last year, I raised money by doing snail races, washing relatives' cars etc. So, I am trying to keep thinking of different things."

● The wellbeing coordinator was in the process of organising a one to one experience for a person who used the service who was mostly bed bound but a big supporter of a football team. They explained, "I got [them] some scarves and stuff, and I have emailed the club who is willing to welcome us. I am encouraging [Person] to gradually to come out slowly for small amount of time. It's [their] dream and our plan."

● Relatives were encouraged to be involved in activities and fundraising and this had contributed to a positive and fruitful relationship. There were a number of volunteer groups involved in the service who provided activities for people who used the service. Representatives of Methodist and Catholic churches visited on a weekly basis to conduct mass. Local college students visited two or three times a year to perform a concert, and a local primary school visited twice a month to undertake activities with a group people who used the service.

● The wellbeing coordinator told us they ensured people had the opportunity to go out as much as possible. They said, "We have weekly trips out, without fail. We go places relatives suggest and other places like museums, the zoo, etc. We have male and female chosen outings and mixed ones. We went to a James Bond exhibition in London and visited Wembley. We go to local garden centre and other local places of interest. Last year we went to Bournemouth. Another person loves opera and ballet, and we are trying to organise something for [them]. We are going to the Chelsea flower show this year and went last year." They also supported people to remain involved in family events. The manager told us that the wellbeing coordinator had planned and organised for two people using the service to attend family weddings early this summer.

● The provider had a 'Memory Care Programme', called Harmony. This was a programme designed to deliver the best health and care experience for people living with the experience of dementia. Two members of staff had been nominated as harmony ambassadors and were also advocates for people with dementia. The manager told us they were "kind, knowledgeable, skilled and passionate." A healthcare professional stated, "There are quite a lot of activities. Environmentally, it is bright and welcoming" and "This is the best home for mental health. They manage people and understand mental health. They quickly get to know the individual."

● Other activities included a visiting 'sensory dog' for people to interact with, arts and crafts, and hairdresser and barber sessions. The wellbeing coordinator told us, "We do a lot. We have the care home open day soon and are planning for this. We have a chicken hut outside and we will be getting chickens soon. We are liaising with another care home to get tips and advice about caring for them."

● Care plans were detailed and person-centred. They were developed from the pre-admission assessments and regularly reviewed and updated. Care plans included all aspects of the person's care and support, their likes and dislikes and wishes, in a range of areas such as personal care, communication, food preferences and healthcare needs.

● Staff we spoke with demonstrated they knew people's individual needs and how to meet these. A visiting healthcare professional told us, "Some people have complex needs and have had several admissions. Once they are here, they don't relapse as frequently. Some of that is tolerance level. I think training is good. Staff are more visible here. People's records are up to date. Regular observations are done." A relative told us their family member had displayed behaviours that challenged before they started living at the home. They explained, "[Family member] has quickly settled here. [They] are calm and smiles, [they] are not hitting out".

Improving care quality in response to complaints or concerns

● There was a complaints policy and procedures and these were available to people and relatives. There had been very few complaints, and we saw these were taken seriously and addressed in a timely manner.

● The provider kept a log of compliments they received from people and relatives. We viewed a sample of these. Comments included, "Bless you for all your kindness and thoughtfulness to all residents", "The staff and management made [family member] feel very welcome and safe. They quickly learnt [their] little habits and how to get the best of [them]" and "The service and care my [family member] receives is one of the highest quality. The care home is very clean, staff go above and beyond."

End of life care and support

● Where relevant, people had an advanced care plan in place, which recorded the person's wishes when they reached the end of their life. Where people were unable to discuss their end of life wishes, the manager

engaged with relatives to try to find out any specific needs the person may have. On relative told us, "Recently, we have talked about what happens in the end. I am really not ready for that yet, [Manager] understands that and has told me when I am ready [they] will talk to me again. We have sorted all the practical things like the burial plan. [Manager] has been so kind."

The manager told us, "We make sure a representative from our care home is present at every funeral of our own residents, while it usually marks the end of one partnership we still want the relatives to feel our support through this transition and difficult time. And encourage them to visit care home in the future."

Good

Is the service well-led?

Our findings

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

Good: The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● People and relatives thought the service was well-led and were very happy with the care they received. Staff we spoke with said they felt well supported. One staff member told us, "I feel involved and listened to." Another staff member described how the manager was supporting their ambition to gain further qualification. A senior staff member praised the manager and said they had received "Great support" from them. They added that there was a focus on keeping both people who used the service and the staff happy. A visitor stated, "This home is said to be the best."

● The service worked to best practice in dementia care based on support from the provider as well as the knowledge from the manager's own professional development. The whole team was constantly looking to improve and as well as an active business plan had a marketing plan to promote engagement with the local community.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● There was a clear governance framework in place. The registered manager and management team carried out daily, weekly and monthly audits and these were effective and included all aspects of the service and people's care and support. Staff were aware of these systems and understood their role and expectations of their job. We saw that when improvements were needed, these were recorded and included recommendations and date for actions to be completed.

● The manager conducted regular audits which included infection control audits, catering safety and equipment including fire equipment. We saw these were regular and thorough. The area quality director undertook bi-monthly visits of the service. They spoke with the manager, walked around the home, spoke with staff and people who used the service, and reviewed any concerns, complaints, and looked at care plans. They also reviewed any feedback received from relatives and undertook medicines audit. Any action needed was recorded and checked if completed at the next visit. We saw that actions were taken in a timely manner.

● The manager undertook out of hours visits of the home, so they could ensure that the home was well managed in their absence. Any concerns were addressed there and then. We viewed a sample of the out of hours recorded visits and saw that no serious concerns had been highlighted. We saw a minor complaint had been addressed without delay.

● There were contingency plans in place in case of events that would have an impact on the running of the service or the safety of people who used it. These included how to manage a heating or hot water failure.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were involved in decision making and were consulted about the running of the home. The staff recognised individual people's strengths and utilised these in meaningful ways. For example, one person who had always been passionate about cooking had been nominated as a food Inspector. They were involved in discussions with the chef and took part in food tasting to help ensure the quality of the food was of a high standard.

● Another person whose background was in the healthcare section had been nominated as a care inspector. They told us, "My view is, if you don't care, don't do the job" and "If there is one thing I won't tolerate, it's abuse of anybody. This is why they trust me. My experience and knowledge. I look, I observe, and I feedback. I must say, this place is excellent." They added that they liked to promote care workers to nurses from day to day depending on their performance.

● A third person had been nominated as cleanliness and hygiene Inspector and was waiting for their badge to be delivered. These people had been awarded their own badges and certificate stating their roles. The manager told us, "All are very proud and very valued by everybody here at Aston House." From our observations and conversations with people, we saw evidence of this. The three inspectors were invited to health and safety and quality meetings, so they could feedback about their areas of expertise. We saw they provided their own reports based on their observations. We view these and saw evidence they were happy with the service. The manager told us, "Since we made the ladies inspectors, they have felt really empowered and important and take their role seriously."

Continuous learning and improving care

●The manager was a qualified registered nurse and had achieved a Level five Diploma in Leadership in Health and Social Care. They were also undertaking a 'My home life' management qualification which was funded by Skills for Care. They were supported by a clinical lead, an administrator, and a team of nurses. The clinical lead was completing their fourth week of induction at the time of our inspection.

● Staff were supported to develop their skills not just through training but also through taking on roles as champions. Champions were responsible for promoting good practice in particular areas such as a safe handling to help ensure people were safe and staff were following the right procedures and ensure people's care plans and risk assessments were accurate and up to date. There were also falls champions to raise awareness about falls and fracture prevention and pressure ulcer prevention champions who ensured staff were aware and updated on treatments and pressure relieving equipment. These had helped the service achieve 365 days pressure ulcer free for which they had received an award.

Working in partnership with others

● The staff had daily flash meetings where they discuss any important issues about people who used the service, organised the day and allocated duties to individual staff. This helped ensure that everyone knew what they were doing, and helped the day run smoothly.

● There were regular relatives' meetings. Subjects discussed included communication, any events planned, refurbishments and any concerns. Residents' meetings included discussions about activities, food and any concerns they may have. People were consulted about any developments and encouraged to take part and

give their opinions. Documents we viewed confirmed this.

● There were six monthly quality governance meetings, where any concerns within the company were discussed with senior managers. For example, health and safety, compliance, hospital admissions and accidents and incidents. From these, action plans were put in place with date for completion. We saw that any actions needed were addressed without delay and completed by the home.