HC-One Limited

# Aspen Court Nursing Home

## Inspection report

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Date of inspection visit:
22 June 2022

Date of publication:
21 July 2022

## Ratings

| | |
|---|---|
| Overall rating for this service | Inspected but not rated |
| Is the service safe? | **Inspected but not rated** |

# Summary of findings

## Overall summary

About the service
Aspen Court Nursing Home is a residential care home providing nursing and personal care for up to 72 adults. At the time of the inspection 65 people were living at the service, including older people, people with physical health conditions and those living with dementia. The second floor can accommodate up to 26 people with nursing care needs.

Aspen Court Nursing Home accommodates people in one building across three floors, with each person having their own bedroom and en-suite bathroom. There were also communal living and dining rooms, a main kitchen, smaller kitchenettes on each floor and access to a secure garden.

People's experience of using this service and what we found
There were systems in place for safeguarding procedures across the home to ensure people were protected from the risk of abuse.

Staff were positive about the training and discussions they had around safeguarding and were regularly reminded about their responsibilities. Staff were confident in the management team dealing with any concerns they raised.

The management team were open and transparent when we discussed the concerns with them and the reason for the unannounced inspection. They were continuing to work with the local authority in response to an incident that led to this inspection.

We did not speak with any people who used the service as part of this inspection.

Rating at last inspection
The last rating for this service was requires improvement (published 18 April 2020) and there were two breaches of regulations. The provider completed an action plan to show what they would do and by when to improve.

Why we inspected
The inspection was prompted by a notification of a serious incident and information from the local authority safeguarding team. Following which a person using the service was alleged to have been subjected to a serious assault. At the time of the inspection this incident was subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated possible concerns about the safeguarding systems in place at the service. This targeted inspection examined those risks.

We found no evidence during this inspection that people were at risk of harm from this concern. Please see

the safe section of this full report. The overall rating for the service has not changed following this targeted inspection and remains requires improvement.

We use targeted inspections to follow up on Warning Notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

You can read the report from our last inspection, by selecting the 'all reports' link for Aspen Court Nursing Home on our website at www.cqc.org.uk.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inspected but not rated**

At our last inspection we rated this key question requires improvement. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

# Aspen Court Nursing 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

This was a targeted inspection to check on a concern we had about safeguarding systems in place in the service.

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

Inspection team
The inspection was carried out by one inspector.

Service and service type
Aspen Court Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Aspen Court Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post. The previous registered manager left in April 2022. The new manager had only been in post since the start of June 2022 and was in the process of starting their registered manager application.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included any significant incidents that occurred at the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed the previous inspection report and had discussions with the local authority commissioning and safeguarding team who shared information of concern with us on 17 June 2022. We used all of this information to plan our inspection

During the inspection
We reviewed a range of records related to safeguarding processes across the home. This included staff training records, samples of daily meeting records, staff supervision and minutes of team meetings. We also reviewed key policies and procedures, quality assurance checks and examples of learning being shared across the service.

We spoke with ten staff members. This included the manager, an area director, the deputy manager, the clinical lead, three care assistants, a senior care assistant, an activities coordinator and the head of housekeeping.

We carried out observations throughout the day in relation to infection prevention and control procedures and staff awareness of best practice. We also reviewed records related to the management of infection control procedures across the home.

We continued to seek clarification from the provider to validate evidence found related to safeguarding policies and procedures. We provided formal feedback to the manager and area director via email on 30 June 2022.

We also spoke with four health and social care professionals who were involved in the safeguarding incident to provide feedback about the inspection. We received confirmation from the local authority on 27 June 2022 the police had confirmed there was no evidence of any criminal offence and had closed their investigation.

Inspected but not rated

# Is the service safe?

## Our findings

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

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check if the provider had safeguarding systems and processes in place and to look at the infection control and prevention measures in place. We will assess all of the key question at the next inspection of the service.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- There were systems in place to ensure people were protected from the risk of abuse. Staff completed safeguarding training and had regular opportunities to discuss safeguarding issues and scenarios to support their learning. This included during daily meetings, staff supervision and team meetings.
- Staff had a good understanding of their safeguarding responsibilities and were able to explain in detail the types of abuse people could be at risk of and what they had to do if they had concerns. Staff also gave examples of signs they should look out for which could mean a person was being subjected to a form of abuse.
- Comments from staff included, "We are always reminded about safeguarding and discuss the actions we need to take" and "As I see residents every day, it is so important for me to spot any tell-tale signs. We also discuss safeguarding scenarios about this."
- All the staff we spoke with were confident in the management of the service and any concerns they raised would be dealt with right away. One staff member said, "They do not let things lie and deal with them immediately." Staff also added they discussed whistleblowing procedures as part of their training and to escalate concerns to senior management if they felt action was not being taken. The manager told us staff were aware they could also go direct to the local authority as well if they felt they were not being listened to.
- Daily 'flash' meetings also gave staff the opportunity to review each person and if staff had noticed any issues or concerns. Staff discussed if there had been any accidents or incidents, skin integrity issues or hospital admissions. There was also a section to document any unexplained bruising and we saw examples where any concerns were reported to the relevant health and social care professionals.
- There were procedures in place for the reporting of any incidents and accidents across the home and outcomes of investigations were used as a learning experience for the staff team. The manager and area director reviewed all accidents and incidents on a monthly basis to ensure all actions had been completed. The area director was also responsible for ensuring all the relevant bodies were notified about any incidents that occurred, including the local authority and CQC.
- The provider shared examples of incidents that had occurred across the home and the provider's other care homes with staff to ensure that lessons could be learnt and improvements could be made. Staff confirmed this and spoke positively about how this was a key part of their role.
- Staff told us they had opportunities to sit down and discuss incidents during daily meetings or team meetings. One staff member said, "We discuss what happened, what we did right and what went wrong. We discuss across the team to ensure we prevent any future incidents and learn from it."

● The manager and area director told us the safeguarding responsibilities of staff was regularly discussed across the home with reminders about staff following reporting and recording procedures, which staff confirmed with us.
● Although we were not able to fully examine the circumstances of the incident which led to the inspection, the provider had been proactive and had already started identifying areas of improvement as part of their internal investigation.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● We saw the provider was facilitating visits for people living in the home in accordance with the current guidance.