Bupa Care Homes (BNH) Limited

Aspen Court Care Home

Inspection report

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Date of inspection visit:
15 November 2016
17 November 2016

Date of publication:
29 March 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 15 and 17 November 2016. The first day was unannounced. The service was last inspected in August 2015 when it required improvement in all five areas inspected.

The service is registered to care for 40 people living at Aspen Court. On the day of inspection there were 30 people living there.

There was a registered manager 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.

We found the service was not always safe. Medicines were not consistently well managed and people were at risk of not receiving their medicines as prescribed. There were not enough staff available to care for people and they were not deployed effectively. Call bells were not always answered promptly and owing to a lack of staff available to supervise people in the communal lounges, relatives felt responsible for keeping people safe or alerting staff if there was a problem.

The service was not always effective. Staff did not have time to read care plans and familiarise themselves with the needs and preferences of the people they cared for. Staff did not always follow the directions given to them by specialist community health professionals. People were offered a nutritionally balanced diet and individual diets were catered for; however the meal time experience was not a particularly sociable occasion and it was not well managed.

We found the quality of care was variable and relatives told us it also depended on who was on duty. We found some staff did not care for people respectfully, did not promote their dignity and did not always put their needs first. However, we observed some good care and interaction between staff and people which was person centred.

At the last inspection in August 2015, we found the care people received was not person-centred and constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found things had improved and staff were more aware and responsive to peoples individual interests, wishes, and preferences for how they wished to be cared for. People told us staff understood how they liked things done and responded to their individual needs. There was a planned programme of activities and an activity worker who spent time engaging with people and enabling them to participate in activities and maintain their interests. People and their families spoke highly of the activities worker, the activities and the events organised. Relatives meetings took place and information was fed back to the staff team via the registered manager.

At the last inspection, 15 months earlier we had identified poor governance which constituted a breach of

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found there had not been sufficient improvement to the management and governance of the service, which meant they were still in breach of Regulation 17. The service had not been consistently well led since the last inspection. There had been three managers during this period and many changes in practice. Staff were not always adequately supervised or supported to carry out the duties they were asked to do. The staff team did not consistently work well together, were not motivated and did not take responsibility for their own development. This affected the quality of care and led to a negative culture within the home. We found the systems and processes in place were not used effectively to identify and address areas for improvement within the service and had not addressed all the improvements identified at the last inspection.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff were not always available to keep people safe. Medicines were not always managed safely and people were at risk of medicine errors.
Staff were recruited safely and all pre-employment checks were completed before they cared for people.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always know or understand people's care needs and did not have time to read care plans. Staff were not appropriately supervised and supported by the management team.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always cared for by staff who were kind and compassionate. Staff adopted a task focused approach at busy times which was not very dignified or respectful of people.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their individual needs. Relatives meetings took place every month. There was a programme of activities during the week that was developed with the needs and preferences of people in mind.

Is the service well-led?

Requires Improvement

The service was not well-led.

Owing to changes in management the service was not consistently well managed. Quality assurance systems in place were not used effectively to bring about improvements required within the service.

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

This inspection took place on 15 November 2016 and was unannounced. A second pre-arranged visit took place on 17 November 2016, to look at records and speak to relatives of people living at Aspen Court.

The service was last inspected in August 2015 when it was found to require improvements in all five areas inspected. It was also found to be in breach of two regulations – Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Person Centred Care; and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Governance. At this inspection we found it to be compliant in Regulation 9: Person Centred Care but we found improvements were still required in Regulation 17: Governance.

The inspection team consisted of one inspector, a specialist advisor and an expert-by-experience. The expert-by-experience had personal experience of caring for an older person and the specialist advisor was a nurse.

Before the inspection we reviewed any information we held about the service, including any information the provider had sent us. This included the provider information return (PIR). A PIR is a report that we ask the provider to complete which gives details of how they deliver their service, including numbers of staff and people using the service, and any plans for development. We reviewed any notifications the provider had sent to us. Notifications are reports the provider must send to us to tell us of any incidents or significant events that have occurred. We also asked for the views of other health and social care professionals who either commission care for people at Aspen Court, or work directly with the provider to care for people. This helped us plan our inspection.

During the inspection we spoke with ten people who used the service, or their relatives. We also reviewed information and concerns sent to us by members of the public, staff or other professionals who have

knowledge of the service. We spoke with 11 care staff, the registered manager, a regional director of BUPA and a regional quality manager. We looked at a range of records related to how the service was managed. These included six people's care records (including their medicine administration records), three staff files which included recruitment, training and supervision records, plus the provider's quality assurance system. We also carried out an observation over the lunchtime period using the Short Observational Framework for Inspections (SOFI).

Requires Improvement

Is the service safe?

Our findings

We found there was not always enough staff available to care for people. One person told us, "There's not enough staff" and a relative told us they were, "Slightly concerned about staffing levels". We had received complaints in the previous six months from relatives who were concerned about the staffing levels at the home. Relatives said people sometimes had to wait for up to an hour to be assisted, especially at weekends. We were told that people were left wet and distressed by waiting too long for assistance and relatives often had to go looking for staff. Relatives commented about the lack of staff presence in the lounge and how people did not always feel safe in there. One relative told us of a person slipping off their chair in the lounge and because there was no staff present, they had to go off and look for a staff member to help. They had rung the call bell but no-one had responded. Other people and relatives told us they had to wait, "A long time" for staff to respond to call bells. One person told us that even when staff responded to a call bell, "They (staff) just come and turn the alarm off and say they'll be back in five minutes and I can still be left waiting for ages". We saw minutes of relatives meetings over the previous three months where this had been brought up at consecutive meetings, relatives complained of people waiting over 30 minutes to be assisted to the toilet. This indicated that this was an on-going problem, which relatives thought was not adequately addressed by the service.

Staff told us they were alerted to people's need for assistance by the pagers they carried around with them. However, they also told us that half of the pagers they had been given were either broken or had disappeared. This meant there were not enough pagers available for all staff on shift and they had to share them. This made it difficult to respond to people in a timely manner. We saw this had been discussed in staff meetings and the registered manager said new ones were on order. This demonstrated that there were not enough resources available to care for people safely and staff were not deployed effectively.

Staff told us that sometimes when they were assisting a person, they had to tell other people to wait for assistance. They told us they were not happy to do this but that sometimes there was not enough staff to attend to everyone's needs at the same time. They told us they often did not get time to read people's care plans which meant they were not always familiar with people's care needs and risk management plans. They said this was particularly the case, for people who had come in for short term and respite care, as staff did not always have time to get to know people or their care needs. Staff said this put extra pressure on them and people felt neglected as staff were unable to respond to them in a timely manner. This demonstrated that there was not always enough staff available to meet the needs of all people safely.

People, relatives and staff told us it was worse at weekends when staff often rang in sick. They said this put extra pressure on the staff on duty to care for all the people in the home. Relatives told us this impacted on their visits to their families as they sometimes felt responsible for other people, especially in the lounge. One relative said, "We can't always relax as we are watching everyone else"; another said, "It's worse at weekends, I think it's the morning after the night before". Staff told us there was a problem with sickness and when we looked at the rotas, we saw there were many incidences of sickness or changes made to accommodate annual leave, which had left the service with less staff than originally planned. One staff member told us, "It's the same people; it's not fair on others. The manager needs to discipline more but it's

not easy with human rights". Another staff member told us, "Staffing can be an issue, more so at weekends" and a third said, "One person phoned in sick this morning, we do have a problem with sickness".

The registered manager said they were taking steps to manage staff absence through back to work interviews and disciplinary where necessary. They told us they had taken steps to ensure there was a staff member in the lounge at all times. However, this was not enough to ensure people's safety as we saw that staff were usually supporting people with planned activities or writing care plans, rather than being available to respond to people's needs. The registered manager told us they had reduced staffing levels recently due to lower occupancy levels; and the regional manager confirmed that staffing levels were determined by the use of a 'banding tool' which helped identify the needs of people and the number of staff required to care for them safely. Staffing was identified as an area requiring improvement at the last inspection and we felt this had not been fully addressed by the provider. There was not enough staff or resources available to care for people efficiently; and staff were not deployed effectively to keep people safe.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing.

Risk assessments were reviewed regularly but were not consistently updated to reflect people's current needs. For example we were told by a staff member that one person had 11 teeth removed the previous week and was "Doing really well and was eating much better". They told us they were on a softened diet with fortified supplements and a spoonful of thickener in drinks. We found reference to the dental visit in the person's daily logs but the care plan and risk assessment had not been updated since the dental appointment. There was no after care plan or advice regarding pain relief, eating or drinking. The person had been on a softened diet with supplements before they had their teeth removed and this had not been reviewed since their teeth had been removed. Therefore staff could not be sure that this was the most appropriate diet for this person.

People were at risk of receiving unsafe care, because up to date information about their needs and risks was not consistently available to staff.
Medicines were not managed safely and effectively. We found medicine administration records (MAR) were not always accurate. We checked eight MAR against the stock of medicines. Some records did not accurately reflect the number of tablets people should have received; and others had medicines that had not been signed for. Staff were unable to demonstrate people had received those medicines. We found a staff signature form in place with the MAR; however it did not include the signature of one of the two staff administering medicines on the day of our inspection. This meant the provider's policies and procedures for safe administration of medicines were not being followed and the provider could not be assured people had received the right amount of medicines as prescribed.

We found the administration of medicines was not always as prescribed. One person's medicine was administered by the application of a patch applied directly to their skin. The manufacturer recommended a space of 3-4 weeks before applying to the same site and suggested eight areas on the upper body to apply the patch. Yet the records showed that the patch was applied alternately to one of two sites. This meant the skin did not have time to recover from each application and it would be at risk of developing sensitivity in these areas, making further application difficult or ineffective.

We witnessed unsafe practice in the administration of medicines. We saw a staff member bring medicines to a person who was sitting at a shared table eating their lunch. The staff member placed the medicine pot down on the table and said, "Here you are [person's name], this is for after you have finished"; they then

walked off without watching the person take the medicines. At the end of the lunchtime period a staff member found the medicine pot on the table, still containing the medicine. The staff member said to the person, "You forgot your medicine [name of person]. I'll have to stand here and watch you take it this time". The staff member then became involved in a conversation with other staff in the lounge area and turned round and walked away, without observing or checking that the person had taken their medicine. This was unsafe practice and put the person at risk of deteriorating health if they did not take all the medicine prescribed for them and it put other people at risk of harm if they were to take medicines not prescribed to them.

When we checked the MAR for this person we found it clearly stated that the medicine should be administered 1-2 hours before eating or on an empty stomach. We checked with staff who told us the medicine was always administered with lunch or meals and they were not aware of the requirement for it to be administered before eating. This meant the medicine would not have been as effective as it could have been and it put the person at risk of vomiting or stomach upsets due to it being administered incorrectly. People were at risk of harm to their health by not receiving medicines as prescribed and from unsafe administration of medicines. Medicine administration records could not be relied upon which meant medicines were not managed safely.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe Care and Treatment.

We found the medicines storage area to be well maintained. We saw drugs, including controlled drugs, were stored separately in locked cabinets; procedures were in place for recording of medicines delivered and disposed of; medicine fridge temperatures were recorded and all within safe limits. Medicines were managed and administered by registered nursing staff. They were assisted with medicine administration by senior care staff, who told us they received medicines training and had competency assessments before they were allowed to administer medicines. Senior care staff told us they were supported by the nursing staff in respect of developing their skills and knowledge regarding the management of medicines. We also saw medicine policies and protocols for the administration of PRN (as required) medicines, topical creams and covert medicines. This meant there were systems and processes in place to support the management of medicines, but they were not always followed.

We saw staff records which showed that staff were interviewed and all pre-employment checks were carried out before they started work, including requesting written references and a disclosure and barring (DBS) check. A staff member confirmed they did not start work until the DBS had been returned. This meant the provider took steps to ensure that staff were suitable to care for people.

People told us they felt safe living at Aspen Court. One person said, "Yes I am safe" and another person said, "I have not heard anyone shouted at or witnessed any mistreatment". A relative told us, "My [family member] is nice and safe". A staff member told us, "We keep people safe" and another said, "Some staff have family members here; they wouldn't be here if it wasn't safe". Staff told us they understood their responsibilities to keep people safe, they had completed training in safeguarding adults and knew how to recognise abuse. We saw policies and procedures in place to support them. Staff told us they knew how to report concerns and would use "Speak-Up" (their own internal concerns line) or they would ring CQC if they felt things were not being managed safely. We had received whistleblowing concerns in the 12 months prior to the inspection visit, which demonstrated that staff understood their responsibilities to keep people safe and took appropriate action when they were concerned about safety.

Requires Improvement

Is the service effective?

Our findings

Communication between staff was not effective. Staff told us that due to low staffing levels they did not always have time to read care plans and keep themselves up-to-date with people's changing needs. One staff member told us that afternoon handovers did not always take place or if they did they were so brief as to be ineffective. They recalled being told at one handover, "You were here yesterday, nothing's changed". They also recalled an incident where a new resident had not received any breakfast because the staff coming on duty the next day had not been informed about the new admission; and another incident where a person had been left on a commode for 90 minutes at the end of a shift, because information had not been passed on to staff coming on duty. We saw this had been recorded in the complaints folder and action taken by the registered manager. We observed staff talking in the lounge after lunch asking each other for updates on particular people. This was indicative of a poor handover for the staff coming on the afternoon shift.

The provider used agency nursing staff to fill job vacancies, but staff told us this was not always effective, as agency staff did not always have enough time to read people's care plans. This meant they were not familiar with peoples care needs and preferences for how they wished to be treated. This concern was shared by East Midlands Ambulance Service who had reported to us their concerns regarding nursing staff not understanding the medical condition or the medical history of people, when they had been called to attend to an emergency. Poor communication impacted on the ability of staff to care for people effectively.

Staff did not always have the skills and knowledge to care for people safely and effectively. At lunchtime we observed a person being assisted to eat in their bedroom by a staff member. Their risk assessment stated they were at risk of choking due to difficulties swallowing and had been assessed by the speech and language team (SALT). When we spoke to the staff member assisting with lunch, they told us they were not aware of the swallowing risk and advised us they were a domestic assistant and were "Helping out at lunchtime". They said they had not had training on assisting people to eat but they had done it before and were happy to help. We were concerned that a staff member, who had not received relevant training or information regarding a person's risks, was assisting a person to eat without supervision and in an isolated room. This put the person at risk of choking and a staff member in a vulnerable position, carrying out care they were not trained to do.

There was a staff supervision policy in place which stated that all staff should take part in six supervision (support and development) meetings each year. However, staff told us they did not receive supervision regularly and records we saw confirmed this. One staff member told us they had not had supervision for six to seven months. We spoke to the registered manager who confirmed that supervisions were not up-to-date, but senior staff were available to support staff at any time. This meant that staff were not always adequately supervised and the registered manager could not be assured that all staff had the knowledge and skills to care for people effectively.

A staff member told us they had not had training in the previous 12 months. Other staff told us they were not up-to-date with training. For instance one staff member told us they had not had mental capacity

training, which is considered to be good practice for services that cared for people with dementia. Another staff member told us they would like training on specific health conditions, so they would have a better understanding of how to care for people effectively. Staff told us they preferred face-to-face training but that much of their training was via the completion of work books which they told us was not always as effective as face-to-face training. Records we saw confirmed that staff were not all up-to-date with the training required by the provider. This meant staff had not received the training required to meet the varied and complex needs of the people they cared for.

This was a further breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing.

We spoke with community healthcare practitioners before the inspection and relatives during the inspection who shared concerns regarding staff not always following advice and directions given by community healthcare practitioners. One practitioner said they had recently been involved in training staff and had seen some improvements.

A relative told us they were unhappy with the care their family member received. They told us their family member was at risk of losing a foot due to poor management of their medical condition. They told us, the GP and foot clinic had given directions on when and how to change the dressings on the wound and on appropriate sleeping arrangements and use of medical aids. They said staff were not following this advice and their family member's condition was deteriorating. When we checked this person's care plan we found inconsistencies in the directions given to staff regarding the frequency of dressing changes. We found advice in different parts of the care plan stated dressings should be changed, every other day, every day, every three days or when there was 'breakthrough'. This meant that the advice and directions given by the foot clinic were not accurately recorded and staff were not clear when dressings should be changed. We also found that directions from the foot clinic to keep this persons foot elevated and the correct positioning of the air boot, were not consistently followed. This impacted on the ability of the wound to heal properly and could put the person at risk of deteriorating health.

We found discrepancies in weight records. We were told of one person who had been at risk of losing weight before they were admitted and staff were advised by the GP to keep a weekly record of weight following admission. When we checked records we found two different recordings of weight since admission and the weight chart had not been completed as required. It was not clear from the records what this person's weight was on admission; therefore it was not possible to determine whether this person had gained 3kg or lost 3kg. Staff did not always follow advice and directions given by healthcare professionals which put them at risk of on-going ill health and poor recovery.

This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe Care and Treatment.

People's daily health needs were generally met by the nursing and care staff on duty. People told us they were supported to access community healthcare services and register with the local GP if they wished. We saw records of people being referred for specialist healthcare, for instance, speech and language therapy, dieticians and the falls prevention team; and we saw records documenting advice and directions from health professionals in people's care plans.

Staff told us they completed an induction period which involved training online, workbooks, observing other staff and competency assessments carried out by senior staff. One new member of staff told us they had not completed all parts of the medicines training and had not yet had a competency assessment as part of their

induction, so they were not yet able to administer medicines. The new deputy manager told us they were still completing their induction which included observing and working alongside managers from other services, as well as classroom based training and the completion of work books. They said the induction was thorough and gave them the skills, knowledge and confidence to carry out their role. Other new staff told us the induction period gave them the confidence to carry out their roles and the opportunity to get to know the people they were caring for. This ensured that new staff had the skills, knowledge and confidence to carry out their role and care for people effectively.

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. We saw examples of 'best interest' meetings with people, relatives and professionals when decisions were made regarding people's care. Staff told us people were assumed to have capacity to make decisions about their care unless they had been assessed as not having capacity to make particular decisions; in which case they would follow the advice and guidance from any 'best interest' meetings. Staff were aware and understood people's needs and preferences for how they wished to be cared for and were able to support them with their daily care needs.

People told us staff asked for consent before carrying out care tasks and knew how they liked things done. We saw staff asking for consent during our visit, for example, a staff member was overheard to ask, "Shall I move you into the conservatory" and another asked, "Would you like a blanket to cover your knees". This showed the provider supported people to make decisions about their care and had safeguards in place to ensure that decisions were made in their best interest, if they did not have capacity to decide for themselves.

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 found DOLS were in place for people who required some form of restrictive care to keep them safe and the provider was complying with the conditions in authorisations. This showed that the provider took responsibility to ensure that they were operating under the principles of the MCA and were not placing unlawful restrictions on people.

People told us they enjoyed the food and had plenty of choice. One person said, "The food's very good" and another said, "The food's excellent". Relatives told us the kitchen staff were very good and understood people's dietary needs, one relative said, "The food is really good, my mum is putting on weight and if she has not eaten everything, they will offer her something else. She doesn't go hungry", another relative said, "The food's lovely and they do normal food, pureed, for those that need it". Meal times were flexible depending on people's choices and preferences, and people had choice in where they preferred to eat. For example, some people ate breakfast in their rooms and others chose to sit in the dining room. People were offered regular drinks and snacks throughout the day.

Staff knew people's food preferences and dietary requirements and provided individual meals to suit people's needs. We saw people were given food that had been blended or softened to suit their particular requirements, following the advice from speech and language therapists (SALT). Low sugar diets were provided for diabetics and fortified supplements were provided for people at risk of losing weight, following advice from dieticians. We saw nutrition and hydration charts were maintained where people were at risk of

losing weight or becoming dehydrated due to their health condition. The registered manager told us there had been a big improvement in weight management since these charts had been put in place.

We observed the lunchtime meal service and saw that most people sat at tables in the dining room, although some people ate in their rooms by choice. In the dining room, people were brought their meals already plated up from the kitchen and they were served individually, not by table. This meant people sitting at the same table could be at different stages of eating their meal. We saw one person was given their meal when everyone else on the table had finished eating and people were moved away from the table when others were still eating. We saw adaptive cutlery in use and some people were being assisted to eat by staff. It was very quiet at lunchtime with little chat or conversation. Although people ate the food and told us later they enjoyed their meal, it was not a sociable occasion for most people. We found the lunchtime service was disorganised and task focussed, rather than the sociable occasion it could be.

Requires Improvement

Is the service caring?

Our findings

Staff did not always demonstrate respect and compassion when caring for people. Relatives and staff told us there were 'cliques' within the staff team which impacted on the quality of care people received. A relative told us, "It depends on who's on shift. If there's a good senior on, it's OK". Another relative told us, "There are some fantastic carers, but some of them let the team down". We observed poor interaction from staff, particularly at lunch time when it was busier. For example, a person was watching TV just before lunch, whilst sat in a wheelchair, it was almost the end of the programme, when a staff member came up to them and said, "Are you going to sit at the table?", the person replied "I ought to"; the staff member said, "You ought to". They then placed the person's feet on the foot plate rather clumsily saying "Oooh dear". As they started to move the person away they said, "Ugh, what's this you're watching" and then whisked them away without asking if they were ready or would like to see the end of the programme. This person was then sat at a table for 15 minutes before their food arrived. We felt this was neither caring nor respectful and the staff member was clearly focussed on the task in hand, rather than the wishes of the person.

There was very little communication between staff and people at lunchtime; it was limited to a comment when their meal was placed in front of them and when their plates were removed when they had finished eating. There was no acknowledgement of other people at the table or any attempt at further conversation. At one point there was loud music playing which made it difficult for people to talk to each other at the table. Towards the end of lunch we saw four or five staff completing food records in the dining room. They entered the room, took files off a shelf by a dining table and whilst standing up, used the table to lean on whilst they updated the records and loudly discussed what people had eaten. During this process there were two people still sat at the table eating their lunch. None of the staff spoke to the people eating their lunch or even acknowledged them, which showed a lack of respect for people and their personal space. We felt this was not a very caring approach and staff were focussed on the tasks rather than people.

We were told by one person and their relative that some staff do not always respect people or their dignity. They told us how some staff talked to each other about their personal lives when they were providing personal care. This person told us this made them feel "Like a nobody". However, they also praised other named staff who they said were pleasant and chatty and more respectful. A staff member told us, "Some staff don't always think about dignity, I put a stop to any personal talk if I hear any. I tell them to keep it outside work". We overheard a conversation between staff in the communal lounge area, they were talking about a person who was at that moment in bed and one staff member was giving an update to another. This was not appropriate to be discussed in the lounge with other people and relatives present and did not protect the person's privacy or dignity. We saw comments in relatives meeting minutes that referred to staff discussing their personal lives in the presence of people they were caring for and standing around in groups chatting about personal things. This was also discussed in the team meetings that had taken place recently and was raised by the registered manager as unacceptable. Staff did not always demonstrate respect or compassion and did not always promote the privacy and dignity of people.

We reviewed information we received from staff, people and their families before the inspection; and there were repeated concerns about staff not always respecting people or promoting their dignity. We were told of

people being left for long periods waiting for assistance to the toilet, of people being left wet and soiled and of people being left in the lounge for long periods without staff available for assistance or interaction. A staff member told us that people had to wear two incontinence pads at a time due to the poor quality of pads available. They said this was not very dignified and people still had 'accidents' which people found upsetting. We saw minutes from relatives meetings in the previous 4 weeks which discussed cases of people left without assistance to the toilet, of people becoming distressed and staff neglecting to attend to the personal care needs of people. For example, relatives had visited to find their family member unwashed and with dirty hair; another person was found to be wearing inappropriate clothing for the season and other people were found to have long and dirty finger nails. This demonstrated that improvements were still required and people were not always treated with dignity or respect.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Dignity and respect.

During the inspection we spoke to family members who advised us they had seen some improvements recently but there were still issues with response times, especially at weekends. They said the registered manager was aware of the issues and was working with the staff team to improve response times.

We also saw positive responses to people's care needs. For example, at lunchtime a staff member was heard to ask, "Have you finished your lunch [person's name]", "Yes", "Where would you like to sit now, would you like to go into the conservatory", "Yes, please", "Would you like to take your tea with you or shall we wait until you've finished", "I'll take it with me, thank you". This demonstrated a caring response to individual need and an understanding of personal preferences. We also overheard another staff member saying to a person, "You're lovely you are. Would you like me to take you through to breakfast now". We also observed a person being assisted to eat at lunchtime by a staff member who was engaging the person in conversation and including other people sat at the table. This demonstrated person centred care and made the meal time more sociable, rather than a task to be completed.

People told us they had been involved in planning and reviewing their care and we saw evidence of this in people's care records. We saw that people's preferences and wishes had been included and formed part of the care planning process. Relatives told us they were informed and consulted about changes in care and were included in 'best interest' decisions where appropriate. We saw records that demonstrated that where relatives had power of attorney to make decisions on behalf of their family members, they were consulted and their decisions recorded. People were involved in their care planning and made their own decisions or were supported to do so, where appropriate.

Good

Is the service responsive?

Our findings

At the last inspection in August 2016, we found the care people received was not person-centred and constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found things had improved and they were no longer in breach of this regulation. Staff were more aware and responsive to peoples individual interests, wishes and preferences for how they wished to be cared for.

People and their relatives told us they were consulted about their care needs and preferences. One person said, "They (staff) know how I like things done" and another said, "I love it here". People told us they had good relationships with staff and a person told us, "The quality of staff is very good, top hole and [staff member] is brilliant". People and relatives spoke favourably about the catering and laundry staff, a relative said, "Nothing is too much trouble" and they told us how the laundry staff had assisted their family member when they had lost some clothing. Another relative told us how good the catering staff were at providing alternative meals for people and responded positively to changing taste buds and dietary needs. They told us, "They know what she likes". We observed people given choice regarding participating in activities and choice of meals. We also saw that people had been involved in care planning and their preferences and wishes were recorded in care plans and assessments. This meant people's care plans reflected their assessed needs; and their wishes and preferences in relation to nursing and personal care.

We saw relatives visiting people during our inspection visit and there was plenty of space for people to receive visitors in privacy. Relatives told us, apart from mealtimes which were 'protected', they were made welcome at any time. Relatives were invited to join their family members for entertainment if they wished and encouraged to go out together on outings and trips. Many people lived in the local area before they came to Aspen Court, where many of their relatives and friends still lived. They told us they liked the community feel of Aspen Court, where people and families knew each other. Staff also told us they liked working in the community in which they lived and had cared for different members of the same families. They said this helped people to settle in the home, and maintain their relationships with family and friends, which was good for their wellbeing.

Staff told us they could usually accommodate requests for male or female carer's and told us how male carers offered something different to people as well as the opportunity to talk about different interests. They told us the service had links with various spiritual and cultural organisations and could accommodate people's spiritual and cultural needs. One person told us, "I have been a chorister all my life and my spiritual needs are well catered for here". We also saw a notice advising people if they needed information in a larger font or another language, to ask a member of staff. This meant the service considered equality and diversity when planning care for people.

There was an activity worker who worked Monday to Friday and provided a programme of activities for people. We received lots of positive comments from people and their relatives about the activity worker and the volunteer who sometimes supported them. People told us this staff member was, "Brilliant, she can't do enough for you" and relatives said, "She's very kind and caring and a hard worker". We saw the activity

programme and the variety of activities available for people; some were suitable for groups and others were suitable for individuals to do on their own or in pairs with the assistance of a staff member. We saw people were supported to participate in activities in the lounge or engage in conversation, if they did not wish to join in the activity. The activity worker knew which activities people liked and what their hobbies and interests were. We saw activity records included people's interests and preferences, as well as recording feedback and reasons why people did not participate. Staff used these records to make sure the activities programme was varied enough to include as many interests as possible. A staff member was able to tell us about the personal interests of people they cared for and how they engaged people in discussions about their family and hobbies. People were supported to pursue their hobbies, interests and maintain relationships with friends and family. This promoted people's sense of identity and wellbeing.

People and relatives were full of praise for the remembrance service that had been arranged the previous week and many people and families had attended. On the day of the inspection, people were able to attend a communion service at the home, held by a local priest who visited each month. People were supported to attend their chosen place of worship, when they were able to do so. This meant people's spiritual needs were met.

There was a complaints policy in place and people were aware of it. We saw records that demonstrated that individual complaints had been received and responded to appropriately. There were also annual customer and family surveys, staff surveys and partner surveys which asked for feedback and views on the quality of care. We saw evidence of the latest customer survey in the latest newsletter and on the website and many of the comments were positive.

In the ten months prior to the inspection, we had received a number of concerns regarding the quality of care at Aspen Court. We had discussed these concerns with the registered manager at the time and followed these up during the inspection. Families told us they were now asked for their views on how the home was managed and they had seen some improvements in the quality of care, since this had started. They told us a group of relatives met each month to discuss their experiences which were fed back to the registered manager. For example, relatives had complained about the lack of staff presence in the lounge and the risks to people of falling and requiring other assistance. The registered manager told us a member of staff was now in the lounge at all times. Relatives told us they had complained about the lack of activities at weekends when people had little stimulation or activity, especially if they did not have visitors. The registered manager told us they had requested a second activity worker to work weekends and double up with events and outings. They had also encouraged all staff to provide meaningful activities for people as part of their care role. Members of the relatives group told us there were regular complaints regarding the general lack of staff and the impact on response times to call bells and requests for assistance. The registered manager told us they were addressing staff absence using policies and procedures in place; and had ordered more pagers, so all staff would be alerted when a person needed assistance.

We found there had been some improvements to how the service responded to comments and complaints and changes had been made where possible. This included regular consultation with people and families, who told us they now felt more involved.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection, 15 months earlier we had identified poor governance of the service which constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found there had not been sufficient improvement to the management and governance of the service. We also found the quality assurance systems and processes in place had not been used effectively, to bring about the improvements required at the last inspection.

There was a quality assurance system in place. The system processed information about the number of admissions, incidents, complaints as well as clinical indicators, staffing numbers, training and staff management data. This data was then processed and monthly performance reports were produced for each service. This was a data driven process and the registered manager said data collection was a time consuming process. They told us, they were, "Still getting used to, BUPA's systems and processes", which they were not yet using to their full capacity. We saw copies of the monthly audits, minutes of meetings held with relatives and staff; and the results of the last staff survey 'People Pulse'. The registered manager told us there was low participation in the staff survey due to apathy and low morale. The report we saw was not very informative or person centred and used a lot of 'business language' which may have contributed to the low response rate. For example the summary of the staff survey stated that, "50% of staff were 'promoters', 30% were 'passive' and 17% were 'distractors'", we felt this was not positive or reader friendly terminology and did not help staff identify areas for improvement or take responsibility for their own development.

We spoke with the regional quality manager who was present on the day of inspection. They explained that the regional team had been providing additional support to the service in respect of medicines management because they were aware that this was an area that needed improvement, as identified at the last inspection. They had recently reviewed wound documentation and the post medicine checklist. On the day of the inspection they were checking whether their recommendations had been implemented but were disappointed to find some errors were still not picked up at local audits. They told us, "Messages are not always getting through. Staff have to own the paperwork but they don't always know why they are doing it". This demonstrated that the monthly service audits were not effective at identifying errors or areas for improvement. It also demonstrated that staff were not following the policies and procedures in place to support and protect them.

The registered manager showed us how complaints were managed within the home and we saw compliments and thank you letters from people and families, regarding the care they had received from the staff team. However, they were not able to explain how the audits or surveys were used to improve care or the working environment for staff; partly (they said) due to the short time they had been in post. We found the quality assurance systems in place did not easily identify on a local level, the improvements or adjustments that were required to improve the quality of care for people at Aspen Court.

Whilst the provider had started to address some of the issues we identified at the last inspection, the process had not been well managed. We found some of the areas identified in the improvement plan had still not been completed and others had not been applied consistently. For example, there were still

vacancies in the nursing staff; staffing levels remained a concern for both relatives and staff; supervisions were still not taking place regularly and staff did not always have the training they needed, to carry out their roles safely and effectively. Whilst there had been some improvement in the quality assurance processes since the last inspection, we felt the time spent on the data collection process and the reports produced; were not effective at identifying and bringing about the improvements required in people's care at Aspen Court or in addressing the improvements identified at the last inspection. This demonstrated continued poor governance.

This is a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Governance.

We found a negative culture within the service and low morale. We had received 'whistle-blowing' concerns in the previous 12 months about poor staffing arrangements and the impact on the care people received. Relatives told us they had been approached by staff to raise concerns with management regarding staffing levels, which they did not think was appropriate or professional. They felt some staff undermined the registered manager and told us of staff standing around in groups talking, when people needed assistance. Staff told us there were 'cliques' within the staff team, which affected relationships and team working. One staff member said, "This has to be considered when planning rotas". When we asked about team culture, a staff member told us, 'It's not too bad, I try and put a stop to cliques as I don't feel it promotes good teamwork. Morale took a bit of a dip after last inspection. People have had to get used to change". Staff told us there was resistance from some staff towards the changes and it made it difficult for the registered manager to bring about the necessary improvements. A staff member said "We are suffering from change overload" another said, "Some people (staff) make it personal, they don't want change". Staff were not motivated to change and did not accept responsibility for their own development.

Staff told us of high sickness levels at weekends which impacted on other staff and the quality of care people received. We observed three occasions during the day when a small group of four or five staff left the building to visit the 'smoking shelter', leaving few staff 'on the floor' to care for people. This went against the request of the registered manager for only two staff at a time to take a break. It was a further example of staff undermining the registered manager and of the culture within the organisation. This affected the quality of care people experienced, as staff were not always available, respectful or focused on the needs of individual people.

Some staff told us they did not feel managers were listening to them. One staff member said, "Managers have an answer for everything" they went on to say, "Most people need two staff, they are not very independent and people in short term beds can be very demanding. We just don't have enough staff to meet people's expectations". Staff told us they felt the service was often short-staffed and they had to rush people or ask them to wait for assistance, which they did not like doing. We looked at the rota and discussed staffing levels with the registered manager and the regional manager who confirmed that staffing had been reduced recently due to fewer people using the service. They explained they used a 'banding tool' to determine the level of staff required for each shift and they quite clearly felt they were not under staffed. However, they were still recruiting for permanent nursing staff and used agency staff particularly at weekends and nights to cover vacant posts. We felt the concerns about staffing had not been adequately acknowledged or addressed by the management team; and the views and concerns of people and staff had not been fully considered or respected.

The registered manager told us they were aware of the negativity of some staff and how this impacted on team working and morale. They explained how they were working to resolve this and told us there had been three staff meetings with senior management in the last month; in response to concerns raised by people,

families and staff, about the culture and staffing arrangements. They hoped this was the start of a more open dialogue between staff and managers and would address some of the comments about poor communication and staff feeling they were not informed or consulted about service development.

We found the registered manager responded appropriately to concerns we had raised with them over the previous six months and was open and honest with us during the inspection. They were aware of the improvements required and the challenges they faced in becoming accustomed to the systems of a larger corporate organisation and managing a team that was resistant to change. They had complied with all CQC registration requirements and provided reports and notifications to us as required under the terms of their registration. We received positive comments from staff who supported the changes being made and said they found the registered manager to be approachable and fair; but they also acknowledged that the registered manager was in a difficult position due to the team dynamics. Relatives told us things had improved since the new registered manager had arrived and they thought she understood their concerns and listened to them.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff did not always demonstrate respect for people or promote their dignity. Staff were often task focused rather than focusing on people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed or administered safely. Staff did not always follow advice or direction regarding the care and treatment of people's health conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always ensure effective and consistent, leadership and management of the service. The quality assurance systems in place were not used effectively, to identify and bring about the necessary improvements in the service; or respond to the improvements identified at the last inspection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always enough trained and qualified staff to care for people and they were not deployed effectively. Staff did not always

Treatment of disease, disorder or injury

receive the support, supervision and training required to carry out their role safely.