

Equinox Care

# Aspinden Care Home

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

**Requires Improvement** 

Is the service well-led?

**Requires Improvement** 

# Summary of findings

## Overall summary

### About the service

Aspinden Care Home is a residential care home providing personal and nursing care to 26 people. At the time of our inspection there were 25 people living at the service. People had their own rooms with shared bathroom facilities. The home supported people who had a history of long-term homelessness and alcohol dependency.

### People's experience of using this service and what we found

There continued to be improvements at the home but we identified that medicines were still not being managed safely. This meant people were at risk of not receiving their medicines as prescribed. Risk assessments were not robust and were not updated when people's needs changed. This meant people were at risk of receiving unsafe care.

Accidents and incidents were analysed but actions were not always completed following incidents. We identified that there was at times poor record keeping of client information and it was stored in different formats, which meant it was hard to locate and there was a lack of guidance for staff.

The providers governance and auditing systems did not always identify issues with the quality of the service. This meant appropriate action had not been taken to ensure people received good quality care.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The provider had effective processes in place for managing and preventing infection. The provider had systems in place to safeguard people from the risk of abuse.

Staff spoke positively about the improvements at the home, and they told us they felt supported by the registered manager.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

### Rating at last inspection and update

The service was inspected but not rated at the last inspection (published 11 January 2022). At our last inspection we found breaches of the regulations in relation to safe administration of medicines, person centred care and good governance. The provider completed an action plan after the last inspection to tell us what they would do and by when to improve. At this inspection we did not look at key question relating to the breach of regulation 9 (person centred care). We will look at this when we next inspect.

### Why we inspected

We received information of concern in relation to how the provider was assessing and managing risk. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. You can see what action we have asked the provider to take at the end of this full report.

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 COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Aspinden Care Home on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

#### Enforcement and Recommendations

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to assessing risk, medicines and good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

#### Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. 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?**

The service was not always safe.

Details are in our safe findings below.

**Requires Improvement** ●

### **Is the service well-led?**

The service was not always well-led.

Details are in our well-led findings below.

**Requires Improvement** ●

# Aspinden 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. 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.

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

Two inspectors carried out this inspection.

#### Service and service type

Aspinden care 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. Aspinden care home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

#### Registered Manager

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 a registered manager in post.

#### Notice of inspection

This inspection was unannounced.

#### What we did before the inspection

We reviewed information we had received about the service, such as notifications. These are events that

happen in the service that the provider is required to tell us about. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give 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 the registered manager, clinical lead nurse, acting deputy manager, five care staff and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We had a tour of the building and reviewed a range of records. This included four people's care documentation, two staff files and a sample of people's medication records. Following the inspection, we continued to seek clarification from the provider to validate evidence found. We also reviewed a range of records relating to the management of the service.

# Is the service safe?

## Our findings

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

At our last inspection we did not rate this key question because we only looked at part of the key question.

At this inspection the rating is requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At the last inspection we found risks to people had not always been considered, assessed or planned for to ensure they received care safely. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 12.

- Risks to people had not always been assessed and planned for. We found risks had not always been assessed and risk assessments had not always been updated following a change in people's needs. We noted that all falls risk assessments were generic and were not personalised to people's risk. For example, one person who had two unwitnessed falls did not have their post risk assessment updated which meant there was no recorded information about how to mitigate the risk to this particular person.,
- One person had a seizure, but they had not had their seizure risk assessment updated following this incident. This meant risk management strategies had not always been developed to guide staff on how best to mitigate risks to people's safety, health and well-being.
- Another person was diabetic, and we requested to see their risk assessment. The clinical lead nurse told us this assessment was completed but when we checked their risk assessment there was no information to guide staff to care for this person in a safe way.
- We identified three people who were using walking aids and one wheelchair which were all in need of repair. The clinical lead nurse told us, there was no formal process in place to ensure wheelchairs were safe to use.
- One person had an electric radiator in their room but there was no risk assessment in place to mitigate risks associated with its use.
- Since the last inspection the registered manager had implemented changes to how incidents were recorded. Whilst these changes were positive, we identified that actions were not always completed following incidents. For example, increased welfare checks when people had falls and training for falls prevention.

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

- On the day of the inspection the provider took prompt action to address the immediate concerns found.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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 appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- People had their capacity assessed and where required, decisions were taken in their best interests and recorded.
- We saw DoLS applications were made appropriately, and staff were aware when a DoLS had been approved.

#### Using medicines safely

At the last inspection we found systems were not in place to ensure the safe management of medicines. This placed people at risk of harm and was a breach of Regulation 12 (safe care and treatment) of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 12.

- Medicines were not always managed safely. The provider was using an electronic medicine administration record (EMARS) which was not always accurate as we identified one occasion when the record stated a person had been given their medicine, but this was out of stock and staff were unable to explain what action had been taken to ensure this medicine was restocked.
- At the last inspection we identified some people were prescribed medicines to be taken 'as required' (PRN) for specific needs and conditions but there were no protocols in place. The provider had introduced these PRN protocols, but they were still not robust. For example, one person was using an opiate medicine as a PRN four times a day. This medicine was also not meant to be taken with alcohol and this person was drinking every day.

Failure to safely manage medicines placed people at risk of harm and was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- On the day of the inspection the provider took prompt action to address the immediate concerns found.

#### Staffing and recruitment

- At our last inspection we made a recommendation to the provider to review their staffing levels at the



home. At this inspection we found this recommendation had not been followed. However, the provider had increased their staffing levels since the inspection. For example, there was an increase in nursing hours at the home. Staff told us there were enough staff to care for people and the rota confirmed this.

- Staff were recruited safely. We saw the provider carried out checks as part of their recruitment process. This included disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe, and they were happy living at the home. Staff understood their responsibilities to safeguard people from the risk of abuse. One staff member told us, " If I noticed anything, I would speak to the person straight away. I let the manager know. I would also report it and I would ensure it was investigated. I would want to know what the cause was, and we find out what happened."
- Safeguarding concerns were appropriately referred to the local authority and internal investigations were completed.

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.

Visiting in care homes

People were supported to have visitors and maintain contact with their friends and families in line with government guidance. We observed visitors talking with people in all areas of the home during the inspection.

# 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.

At our last inspection we did not rate this key question as we did not look at the whole key question. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At the last inspection, we found system and processes for improving the quality of the service were not always operated effectively. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At this inspection we found not enough improvements had been made and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding the quality performance, risks and regulatory requirements; Continuous learning and improving care.

- The providers systems and processes for the monitoring of the service were still not robust. This meant people were not always protected from the risk of receiving unsafe care.
- For example, at the last inspection we identified that people did not always have PRN protocols in place and the provider had not taken action to address this. We also identified that people were not always getting their medicines as prescribed and again we found evidence that this was still happening.
- We continued to identify whilst accidents and incidents had been recorded and reported to the senior team there was a lack of clarity on what actions were taken to mitigate further risks.
- We identified there was a lack of formal processes in place to review people's medical equipment which meant they were at risk of harm.
- We identified that staff were not always completing and storing records in the correct way. This meant it was not always possible to see actions taken after incidents occurred. Some records were stored in files and others online. There was a lack of auditing to ensure records were updated when people's needs changed.
- People's risk assessments were not always updated to reflect any changes in support when their needs changed.

This was a continued breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Staff told us they were able to speak to the registered manager and senior staff and they felt supported.

They told us there continued to be more positive changes since the last inspection. One staff member commented how the feel of the home was positive as it had been painted.

- There was a positive atmosphere at the service, and it was clear staff knew the people well. Two people told us they were happy with the care they received.
- The provider had introduced a quality handbook for staff which was a "go to guide" for staff on how to support and care for people. Senior staff spoke about using this handbook as a "tool to drive improved staff performance."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager and senior staff were aware of the need to comply with duty of candour regulations.
- The registered manager had met their registration regulatory requirements of notifying the CQC of appropriate information through statutory notifications.

Working in partnership with others

- The registered manager and their deputy's worked with health and social care organisations, such as GPs, substance misuse services and the social services.

This section is primarily information for the provider

## Action we have told the provider to take

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

| Regulated activity   | Regulation   |
|--|--|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider did not always assess risks associated with people's health and care needs. Medicines were not always been administered safely. |
| Regulated activity   | Regulation   |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Management systems in place were not robust or sufficiently comprehensive to demonstrate adequate oversight of the quality of care at the home.      |