HC-One Limited

Aspen Court Nursing Home

Inspection report

17-21 Dodd Street
Poplar
London
E14 7EG

Tel: 02075389789
Website: www.hc-one.co.uk/homes/aspen-court

Date of inspection visit:
27 September 2018
28 September 2018
12 October 2018

Date of publication:
17 December 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was conducted on 27 and 28 September, and 12 October 2018. The first day was unannounced and the other days were announced. Aspen Court Nursing Home is a 'care home' that provides personal care or nursing care and accommodation for older adults. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during the inspection. Aspen Court Nursing Home can accommodate up to 72 people and 68 people were residing at the service at the time of the inspection. The premises are purpose built and divided into three separate units. People are provided with a single bedroom with en-suite facilities, and the service provides permanent placements and respite care. The ground floor and first floor units can accommodate up to 46 people with personal care needs in relation to frailty due to old age and dementia. The second floor can accommodate up to 26 people with nursing care needs.

The previous comprehensive inspection of this service took place on 10, 11 and 15 February 2016. The service was rated overall as Good. Safe was rated as Requires Improvement, and effective, caring, responsive and Well-Led were rated as Good. There were no breaches of Regulation and one recommendation was made for the service to seek guidance from a reputable source about measures to prevent and control the spread of infection. This recommendation had been made as we had observed that a sluice room was not clean and staff had not always worn gloves and aprons as appropriate, which had placed people at the risk of infection.

We subsequently carried out an unannounced focussed inspection of this service in September 2017. This inspection was conducted in response to information of concern received by CQC from different sources in relation to how the provider ensured that people were provided with safe and appropriate care to meet their identified health and social care needs. We had spoken with the provider about the concerns at the service, which were being investigated through safeguarding protocols by the local social services. The provider had developed and begun to implement an action plan to address areas for improvement, as identified by the provider's own monitoring system and feedback from external authorities. Although the sluice rooms were hygienically maintained and staff appropriately wore personal protective equipment to protect people who used the service from the risk of infection, other safety practices at the premises were not sufficiently rigorous. We had observed that two unlocked bathrooms were being used for storage of equipment such as wheelchairs, which placed people at risk of trips and/or other accidents. A linen chute was also unlocked and incorrect cleaning apparatus was being used by a member of staff. These issues were addressed by the provider at the time of the inspection.

At the time of the inspection there was a registered manager in post, who was present on all three days of our visit. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager commenced in her management role after the previous inspection.

The systems for managing and monitoring the administration of people's medicines were not sufficiently robust to identify an incident where staff had failed to follow medicine instructions from a person's GP to promote the person's physical and emotional comfort, and other occasions when medicine was not signed for to evidence that it had been administered.

People told us they felt safe with staff, who had received safeguarding adults training and understood how to protect people from abuse. Safeguarding notifications were appropriately sent to CQC, in line with the law. Risk assessments had been developed to identify and mitigate risks to people's safety and welfare. However, some of the risk assessments were generic and did not address people's individual needs and circumstances. The provider had implemented systems to enable staff to assess people's capacity to make decisions and support people to make their own choices, where possible.

Staff received training and support to undertake their roles and responsibilities. Aspects of the mandatory training were not up to date, however the provider had identified this and had scheduled training in place to rectify this. The training programme had a useful course for care staff to develop their knowledge of health care issues that impacted on the health of older people, but end of life care training was limited.

People were supported to eat a nutritious diet that took into account their preferences, and any cultural and/or health care needs. The catering staff met with people who used the service to check if they had any comments and suggestions about the food service.

Staff supported people to meet their health care needs and we received some positive comments from relatives in relation to how staff had escorted their family member to a hospital appointment or supported a family member to appropriately gain weight by adhering to a clinically advised diet. We also received negative comments from relatives about staff failing to provide adequate support to people, including a person was receiving end of life care.

Interactions between staff and people were positive. We received some mixed views from relatives in relation to whether their family member were treated in a respectful way that upheld their entitlement to dignity and privacy.

The care plans explained how to provide people's care and support in practical terms so that new staff could follow the plan to provide safe care. However, there was limited information within the care plans to demonstrate that people's preferences were taken into account so that their care reflected their unique and individual likes and wishes.

People were supported to take part in activities and entertainments. This included visits from key members of the local community, for example staff from the local fire brigade and a city farm within the borough had engaged with people who used the service as part of ongoing connections. The wellbeing coordinators were developing their knowledge and skills for working with people who were living with dementia.

People who used the service and their representatives were provided with information about how to make a complaint. We saw that the registered manager responded to complaints, however one relative had to try on several occasions to get an acceptable response to their complaint.

There were shortfalls with the quality of end of life care. Although the people we met during the inspection were comfortable, the complaint from a relative identified issues in relation to staff training and the ability of staff to communicate with relatives in a professional and sincere manner.

People who used the service and relatives were mainly positive about the registered manager's welcoming approach and leadership skills. Staff were unanimous in their comments about the registered manager's supportive management style. The provider had systems in place to monitor the quality of the service, support and advise the registered manager and listen to the views of people and staff. However, the quality monitoring was not rigorous enough to swiftly identify a range of concerns in relation to the ability of the service to provide consistently valued and reliable end of life care.

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.

People's medicine needs were not safely addressed at all times.

Risk assessments were in place to minimise risks to people's safety. However, some risk assessments were generic in style and did not consider people's individual needs.

People felt safe with staff, who understood their responsibilities to protect people from abuse and harm.

Sufficient staff were deployed and they were safely recruited.

Is the service effective?

Requires Improvement

The service was not always effective.

People received their care from staff who had received training, supervision and support. However, the training programme was limited in relation to how to meet people's end of life care needs.

People were provided with a balanced and healthy diet.

Systems were in place for people to access health care to meet their needs. Some relatives expressed concerns in relation to the care and support given to their family members.

There were processes in place for staff to assess people's capacity to make decisions and support people to make their own choices, where possible.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed some positive interactions between people and staff.

Some relatives had observed care that did not promote people's dignity.

Staff ensured that people's privacy and confidentiality was protected, although we observed an incident when this did not occur.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The care plans did not consistently demonstrate that people's preferences and wishes were sought so that individual care and support could be planned and delivered.

People were encouraged and assisted to take part in meaningful activities and meet supportive members of their local community.

Complaints were not consistently properly managed.

End of life care was not always provided in a professional and caring way.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality monitoring systems were in place. However, difficulties in relation to the abilities of staff members to provide good end of life care were not initially discovered through the provider's own monitoring processes.

People and relatives predominantly expressed that the service was well managed.

Staff felt supported by the registered manager and were able to voice their views at staff meetings and one to one meetings.

The registered manager appropriately informed external organisations about significant events that must be reported to ensure the safety of people who used the service.

Aspen Court Nursing 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 was carried out over three days. The first day was unannounced and the other days were announced. The inspection team comprised two adult social care inspectors on the first two days, accompanied by a specialist professional advisor (SPA) and an expert by experience on the second day. The SPA is a registered nurse with expertise in the care of people with complex health care needs and palliative care needs. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. One adult social care inspector returned to the service on the third day to complete the inspection and give feedback to the registered manager.

Prior to the inspection we contacted the local authority contracts monitoring and safeguarding teams to check if they had any information to share about the service. We also reviewed the information we held about the service, which included statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required by law to send us. We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The completed PIR was sent to us within the given timescale.

Some people who used the service were not able to tell us their views about living at Aspen Court Nursing Home so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us about the quality of their care and support. At the inspection we spoke with four people and nine relatives, as well as five care staff, an administrator, two registered nurses, two wellbeing coordinators, a chef, the deputy manager and the registered manager. We also sought the views of a visiting local health care professional during the inspection and spoke by telephone with two relatives after our visit to the service.

We looked at a variety of records which included eight care plans and the accompanying risk assessments,

five staff files for evidence of recruitment practices, training, supervision and appraisal, the complaints log, medicine administration records (MARs), accident and incident records, minutes of meetings for people who use the service, their representatives and staff, and the provider's own quality monitoring reports and audits.

Requires Improvement

Is the service safe?

Our findings

We checked the systems in place to ensure that people who used the service were safely supported with their prescribed medicines. Medicines were kept in designated locked rooms and appropriate secure arrangements were in operation to store medicines that needed to be refrigerated. Daily room and fridge temperature checks were undertaken and the staff we spoke with were aware of the actions to take on any occasions that the temperatures were not within the required safe ranges.

During the inspection we looked at 21 medicine administration record (MAR) charts. These charts were completed with a running total left for medicine once it had been given to a person, which enabled staff to maintain an audit trail to refer to in the event of any discrepancies being identified. The MAR charts contained written guidance for staff to safely administer any medicines that were prescribed to be given PRN. 'Pro Re Nata' is a term for the administration of medicines to people 'when required'. Where one person was assessed to require covert administration of their medicines, suitable procedures had been followed to ensure that the decision was made in line with the provider's medicine policy. This included written evidence of consultation with the service's visiting GP and nursing staff employed at the care home.

Medicines were correctly stored in the controlled drugs cupboard. However, we observed that there was a bottle of oxycodone currently in use that was mislabelled by the dispensing pharmacy, as the label on the box stated that it was oxybutynin. The medicine had been in use for three days but no one had noticed the error in the labelling. Although the person was receiving the appropriate medicine as the bottle itself was correctly labelled, this finding highlighted that staff had not been sufficiently vigilant when checking the medicine prior to dispensing. We discussed this matter with the registered manager and were told that the pharmacy would be informed, so that appropriate measures could be taken.

There was evidence of prescribed anticipatory medicines for two people with end of life care needs, which meant that staff could respond more promptly to changes in people's needs. A syringe driver is a small battery powered pump that delivers medicine at a constant rate through a very fine needle under the skin. It is used in different circumstances, for example when a person might find it difficult to swallow tablets or liquid medicines, or their body is unable to absorb medicines. Syringe drivers are often used in the last few weeks and days of a person's life. We were informed that a syringe driver had been ordered and in the meantime the service could borrow one from a neighbouring service managed by the provider, as Aspen Court Nursing Home did not own one.

We observed three documentation errors on the MAR charts we looked at. On two occasions staff had not signed to confirm that medicines had been given and staff had not carried out the weekly monitoring of person's blood sugar levels, which was overdue by six days. Staff told us that the medicines had been given. A person using the service had been reviewed by their GP and prescribed an increase in their pain relieving medicine, however this was not actioned by the service for 13 days. We discussed this finding with the registered nurse on their unit, who told us that they had been on leave when the person was seen by the GP and they had noticed the GP's instructions when they returned to work. The person was now receiving the correct dosage of their pain relieving medicine, as the registered nurse had liaised with the pharmacy. This

demonstrated that the provider's arrangements to ensure that people who used the service swiftly received the medicines they required were not adequately rigorous.

The issues of concern we found highlighted in the paragraphs above are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed remarks from people who used the service and their relatives as to whether the service provided safe care and support, and whether there were sufficient staff deployed. Comments included, "Oh yes, I feel safe and I feel very positive about the home. When you need help they are there 100%. They check you are okay and whether you need help. I have never had to ring the call bell. I have never had an accident or a fall. The staff are as good as gold. I can't take [type of medicine that some people are allergic to], they give me something else", "I think the service know how to keep me safe, this is why I came here. I feel safe and I don't feel so lonely. The staff here are very good. I don't have to use my call bell very often but they do come quickly. They give me my tablets. I have had no falls or accidents in the home", "[Our family member] has been here almost a year. [He/she] is definitely safe here, is kept clean and we genuinely believe they (staff) look after [him/her] and like [him/her]. They attend to [his/her] personal care appropriately. [He/she] had had no accidents or falls. Somebody from our family visits every day and we have no concerns. Staffing levels are good and there is always plenty of staff" and "I think my friend is very safe, [he/she] wasn't at [a different service]. [He/she] is well looked after here…there is a lot of staff to care for [him/her], I have no concerns."

However other people who used the service and relatives expressed concerns about the safety of the service. One person stated, "We are sometimes very short staffed, they can't cope at mealtimes but we do get lovely food and three meals a day. We all get served." A relative told us, "We have concerns about our family member being here. [He/she] is doubly incontinent and we came in one day and there was excrement between [his/her] toes. There are no staff in this place. One girl (member of staff) is left to look after 15 people. I come up three or four times a week and when I come in the morning there is sometimes eight people sitting waiting for breakfast and there is nobody to serve them. I have put in a request to suggest that an additional carer is employed to serve breakfast." Another relative expressed concern about how frequently the staff attended to their family member's incontinence needs, as they had found their family member in saturated incontinence pads and soiled clothing. The relative was worried about their family member's dignity and the risk of developing sore skin. A third relative stated, "They do keep [him/her] safe, [he/she] is always in a good position when I come here, always clean and tidy and never distressed. I don't think there is enough staff but they do work hard. Good staff do go, they are low paid even though they are doing a most important job. Sometimes the sitting room has not got staff as they get called away."

Our observations during the inspection indicated that there were sufficient staff rostered on duty, although we observed short periods when people in the communal lounges were not supported by a member of the care staff being present. Following the inspection the provider informed us "There is no one to one funding for people who use the service and no requirement for constant supervision of the lounge area. Our expectation is that staff check back frequently, which is in line with our policy. In addition, people who use the service are able to verbally call verbally or use the call bell system to gain assistance in the intervening and short periods when staff are supporting other people." We carried out observations on three different units at lunchtime and saw that people received sensitive support to meet their nutritional needs. People were offered the choice to either have lunch in the dining room or in their own room. Staff did not rush people and gentle music was played in the background to create a relaxing environment. There were sufficient staff present on each unit to ensure that people's eating and drinking needs were safely and respectfully met. The staff we spoke with told us they felt supported at busy times during their shift by their colleagues and the management team. The registered manager stated that she walked around the units as

part of her daily routine, to check whether the staffing levels and skill mixes were appropriate to meet people's needs.

The staff recruitment files showed that the provider carried out a range of checks to ensure that applicants had appropriate skills and experience to safely support people who used the service. The provider obtained a minimum of two relevant references and ensured that prospective employees had proof of identity and the right to work in the UK. Checks were undertaken with the Disclosure and Barring Service (DBS) before prospective staff were allowed to begin employment at Aspen Court Nursing Home. The Disclosure and Barring Service provides criminal record checks and a barring function to help employers make safer recruitment decisions. The local authority had recommended that DBS check were renewed every three years, so that there was a process in place to periodically identify whether there were any relevant changes that staff had failed to voluntarily advise their employer about. We noted that some of the DBS checks we looked at had been carried out over three years ago and discussed this finding with the registered manager. The registered manager confirmed that she would raise this matter with her line manager.

Staff had received safeguarding training and the staff we spoke with understood their responsibilities in relation to keeping people safe and protecting them from abuse and neglect. The registered manager had appropriately informed the Care Quality Commission (CQC) of any safeguarding concerns, in line with legislation. Staff were aware of the provider's whistleblowing policy and knew how to raise any concerns to their employer and externally to other organisations, for example the local social services and CQC.

There were processes in place to ascertain and mitigate risks to people's safety and welfare. The risk assessments we looked at showed that risks were recognised, assessed and reviewed, and were up to date. We saw that a bed rails risk assessment had been carried out for a person who did not speak English as their first language. The person had been consulted by a member of staff who spoke their first language, which demonstrated that an individual approach was used to support the person to understand the risks associated with using bedrails or choosing not to. We saw a risk assessment for another person who was described as being agitated and verbally abusive to staff at times, however we did not find detailed guidance for staff about how to manage the person's behaviour to ensure the person's safety and the safety of others. We were advised that the person had been reviewed by the local mental health team, however any guidance from external professionals had not been incorporated into the risk assessments. Some of the risk assessments were generic and did not contain any individual information about the person's needs. For example, generic risk assessments were used in relation to how to protect people who used the service during a heatwave. Although the general guidance was useful for promoting people's safety, comfort and hydration, the generic approach did not consider people's individual needs. For example, a person living with dementia could need additional support, encouragement and creative approaches by staff to increase their intake of oral fluids.

Systems were in place to ensure that people who used the service were provided with a safe environment to live in. Records demonstrated that health and safety checks were carried out and any concerns were reported to the appropriate external contractors for repairs. This included regular testing of the fire alarms, fire extinguishers, fire blankets, emergency lighting, hot water distribution and external exit door sensors routine room checks. The annual fire risk assessment was up to date and fire safety equipment was professionally serviced each year. Window restrictors were installed and checked as part of routine room monitoring checks

People who used the service had a current Personal Emergency Evacuation Plan (PEEP) in place. A PEEP is a bespoke 'escape plan' for people who may need help and assistance to leave the building in the event of an emergency evacuation. The PEEPs we looked at did not evidence that people's cognitive needs were always

considered, for example of people living with dementia needed additional reassurance during emergency situations.

Appropriate infection control practices were in place to protect people from the risk of cross infection. The premises were clean and there were no overwhelming odours. Where we did detect malodour on the first day of the inspection, we saw that housekeeping staff were in the process of cleaning. Staff had received infection control training and were observed wearing personal protective equipment where necessary, for example disposable gloves and aprons.

Records showed that accidents and incidents were recorded and investigated. The registered manager audited these events to identify any trends, so that action could be taken to reduce reoccurrence. Following a significant complaint from relatives about the quality of end of life care for their family member, we noted that the management team had recently spoken with staff at group meetings and individual supervision sessions. These discussions had emphasised the importance of monitoring people's safety and welfare when they are in their rooms and ensuring that accurate documentation is maintained to correctly evidence the checks undertaken.

Requires Improvement

Is the service effective?

Our findings

People's care plans demonstrated that their individual needs had been assessed in accordance with evidence based guidance. For example, the service had implemented the Malnutrition Universal Screening Tool (MUST) to identify people who were malnourished, at risk of malnutrition or obese. The tool contained management guidelines which were used to develop care plans. Other nationally recognised clinical tools were used to plan and deliver people's care including the Waterlow risk assessment tool, designed to recognise whether people are at risk of developing pressure ulcers.

People who used the service received care and support from staff who had received training to meet people's needs and wishes. We spoke with people and relatives about whether they felt staff had suitable training, support and supervision to effectively carry out their roles and responsibilities. Comments from people who used the service included, "Yes, I do think the staff know what I need and how to care for me. They are always there when you need them. If you have a problem you can go and talk to them, which is good. For example, I had [health care need] and the staff are always there for me", "I think most of them are not well enough trained. Sometimes carers chat together when they should be working. The ones that are working today are by far the best" and "They (staff) do know what I need and how to care for me. I have no complaints. The doctor comes around regularly. I get more than enough food and drink." One relative said, "The staff here are well trained and they do understand what dementia is. Right at the beginning we went through the care plan and we are happy with it" and another relative told us, "Staff are well trained, they know what [his/her] needs are and how to care for [him/her]. The carers do help."

We received comments from the relative of a person who received end of life care at the service. They had concerns about whether staff had the appropriate training to meet the complex needs of people in their final weeks and days. We found that there was no specific palliative or end of life care learning programme, although the basic principles were taught through an e-learning programme, known as HC One Touchstone training. Staff told us that they could contact the local hospice for support visits and advice when they needed to, and could contact the out of hours GP service if they needed medicines urgently out of hours.

The training schedule showed that staff received a programme of mandatory training and their compliance with the programme was monitored. Topics included safer people handling, basic life support, falls awareness, health and safety, dementia awareness and managing challenging behaviour, equality and diversity, food safety, safeguarding, emergency procedures and infection control. There was a care assistant development programme and other separate training for registered nurses. Care staff were undertaking 'Significant 7' training, which was designed to enable them to understand and respond to seven health care needs, which included breathlessness, pain and confusion. The guidance for care staff was presented in a non-clinical way and the service had appointed a care worker as a 'Significant 7' champion to encourage and support their peers with this learning. We noted that the compliance rate for some of the training was high, for example 91% of staff had completed the health and safety training. However safer people handling had a 52% compliance rate, although refresher training had been scheduled for the week after for this subject. Arrangements had been made for training to take place in coming weeks for other areas with a lower compliance rate.

We found there was a supervision matrix in place and the staff we spoke with confirmed that they felt supported by individual supervision sessions and group meetings. Staff told us they did not have to wait until a planned supervision session if they wanted advice or support from their line manager. The registered manager acknowledged that some supervision sessions were overdue, which we noted when we looked at six individual staff files. Staff were also due to receive an annual appraisal.

People spoke positively about the quality of the food service. Comments included, "The food is good and the kitchen staff are very good. The breakfast is delicious. I have porridge, tea or coffee and brown toast" and "The food is good here." A relative praised the diet given to people who need to gain weight for health care reasons, "[He/she] has put on weight, [he/she] was a bag of bones when [he/she] first came here. [He/she] likes [his/her] food." Where required, certain foods such as mashed potato were fortified with cream and butter to increase calories and nutrition. The chef told us that the registered manager had introduced a new initiative to prevent weight loss and fatigue for people living with dementia who walked about frequently. High protein snacks were sent to the units every afternoon, for example small 'party-size' sausages that people could eat without having to sit down. We observed that the food was attractively presented at mealtimes and people confirmed that it was served at the appropriate temperatures. The chef said they were provided with up to date information about people's dietary requirements and their requests. The chef explained to us that although the menus were devised at the head office to ensure the meals were nutritionally balanced, the registered manager enabled the catering team to shop locally for food items that people liked. This meant that people could request meals that reflected their heritage and preferences, for example African, Caribbean and Middle Eastern dishes. Other people were supported to follow diets in line with guidance from health care professionals, for example diets suitable for people with diabetes and diets for people who required their food to be prepared at a soft consistency. The chef described how they endeavoured to make these meals and desserts as appetising as possible, so that people enjoyed their food whilst meeting their dietary health care needs. The catering team ensured that items including cakes, scones, cookies and puddings were home-made wherever possible, which we saw being served during the inspection. The chef stated that the reason for this was to provide people with treats that were appealing and also wholesome, as heathy ingredients were used.

People's care plans showed that they were supported to access different health care professionals, in line with their health care needs. We noted that people who used the service were seen by a range of health care professionals that included podiatrists, dentists, opticians, speech and language therapists, and dietitians. Staff told us it was helpful that the GP visited twice a week. During the inspection the GP arrived for a 'best interests' meeting in relation to a person who used the service. We observed the interaction between the GP and members of the staff team and saw that the relationship appeared positive, with open and relaxed discussions. One person told us they were pleased with how staff understood and met their health care needs, "The GP comes twice a week. I admire him, he is brilliant at doing blood tests. I could get a service for my feet. They weigh me regularly. I get medication, I receive blood pressure tablets. I am a diabetic. They (staff) would be quick to call the hospital if needed." A relative told us, "They (GP and staff at service) got [his/her] medication regulated. Staff took [him/her] to Mile End Hospital for a diabetic eye screen. They have got a GP visiting here and [he/she] has had [his/her] toe nails done. We don't know of any other health care services."

Another relative expressed concern, "[He/she] has [health care condition]. [He/she] can't cut [his/her] toenails, we get fed up asking (staff) if [he/she] can get [his/her] fingernails cut. [He/she] has to see an optician and a dentist. [He/she] has seen an optician but not a dentist. We feel that [he/she] is suffering from neglect and there is not enough qualified staff." Following the inspection the provider informed us that although staff employed at the service do not cut toenails a podiatrist had been appointed to visit on Wednesdays and provide this service. A relative told us they were not kept up to date about changes in their

family member's health and wellbeing. The relative had been consulted about their family member's care plan, "I have been asked about [his/her] care plan, [he/she] has a body map every day." However, the relative told us they had not been informed about recent marks they had observed on the person's face, which we passed on to the registered manager. The relative explained that there had been a safeguarding investigation last year in relation to an unexplained skin damage, and stated that the service had not called them at the time to inform them that these signs of skin damage had been found by staff.

A relative told us that the service was not able to meet the fundamental health care needs of their family member during their end of life care. The service had run out of mouth care packs, which resulted in a visiting local health care professional having to bring in a supply of packs from their own stock when they discovered the provider had none in the premises.

The provider operated a 'resident of the day' system which enabled staff from different teams within the service to work together in a focussed way to understand what is important for each person living at the service, and identify how to make a difference to their quality of life. We looked at completed forms for 'resident of the day', which showed that people who used the service received visits from nursing and/or care staff depending which unit they resided on, as well as housekeeping, catering, maintenance, management and activities staff. The forms demonstrated that people, or their representatives, were consulted about what improvements could be implemented to personalise their care and provide a more stimulating and enjoyable environment. The registered manager also held short meetings each day, which were attended by the different heads of departments. These 'daily flash meetings' aimed to provide a forum for staff to plan how to work in a cohesive manner for the benefit of people who used the service.

The registered manager informed us that the service was working towards providing a more dementia friendly environment. We observed that there was a sensory room and quiet room on the second floor, and the plan was to convert the quiet room into a small cinema. There was also a quiet room on the first floor and a 'themed bar' that could be used for pub sessions for people who used the service, and booked by relatives to host a birthday party or other celebration for their family member. We saw that some of these rooms contained staff training materials, which suggested that they were underused as facilities for people living at the service. Although there were some examples of meaningful pictures on people's bedroom doors, there was scope for the provider to consider different good practice approaches to enable people to find their own rooms more easily. For example, the use of memory boxes and/or painting bedroom doors in various distinct colours. During the inspection we saw that people went out for a walk in the garden as the weather was pleasant. The registered manager told us she was keen to encourage people to wrap up warm and have a short stroll during the autumn and winter, if they liked being out in the fresh air.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 that people were encouraged to make their own choices about their day to day needs, for example their preferred routine for getting up ad going to bed, and whether they wished to join in with social activities. The staff we spoke with understood the circumstances when important decisions would need to be made through 'best interests' meetings if people did not have capacity to do so.

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). The registered manager confirmed that she made referrals to the local authority where necessary and notified the local authority if a person's DoLS was due to

expire.

Requires Improvement

Is the service caring?

Our findings

People who used the service and relatives expressed mixed views about whether staff were caring and provided care that promoted their dignity. One person said, "The staff are lovely, I like them all. They have a very, very good attitude. I like [member of staff], she is the best one. They do respect my privacy and dignity, they always knock the door which is very polite. They are very kind. The atmosphere here is very caring." Another person told us "I find the staff caring. They are very helpful and they help me if they can. They respect my privacy and dignity." The person stated that they liked to have privacy when their relatives visited and staff understood this. A third person informed us, "Most of them (staff) are caring. By and large they are very good but it varies. Occasionally some are a bit loudly spoken but mostly they are okay. The night staff you rarely see. They will bring you a tea or coffee and a banana but nobody came this morning. Most of them do respect my privacy and dignity. They have never asked me about my history and my likes or dislikes but yes I do feel the staff have got to know me." Comments from relatives included, "The staff are lovely, friendly and very caring. They call [him/her] by their (preferred) name. They tend to their personal care very well and [he/she] is spotless. [He/she] has transformed since [he/she] came here. [He/she] looks happy …[his/her] quality of life is so much better" and "We find the staff are caring and the care is good. [His/her] dignity is respected."

Other relatives described incidences that had occurred at the service where their family members did not receive care that upheld their entitlement to dignity and respect. One relative told us about occasions when their family member had not received appropriate personal care, which included care to manage their continence needs. A different relative told us they had been spoken to in a patronising manner and staff had not offered an adequate standard of care and support to meet their family member's end of life care needs.

We saw positive interactions between staff and people during the inspection. We observed a member of staff who was extremely patient with a person who used the service when supporting them to the dining room with their zimmer frame. The staff member was very encouraging, supportive and compassionate. We also saw one person walking along the hallway with no shoes on. A staff member noticed this and supported the person to put on socks that had a special grips on the soles to prevent slipping over. One person described how staff had made their birthday feel special, "Last week I was [age]. They made me a cake with candles on. That was nice, they do make an effort." However, we noticed that one person who used the service was wearing a stained top but staff did not take any action to assist the person to change into clean clothing.

One of the care plans we looked at evidenced that a person's relative had been involved in the care planning process. The person was not able to contribute their views due to their cognitive impairment. We had noted that the local authority visit conducted jointly by the contracts monitoring and safeguarding team had identified that care plans did not always evidence that relatives and other representatives were invited to contribute their views, where applicable. Some of the relatives we spoke with during this inspection confirmed that staff had spoken with them about their family member's care plan and they had been given a form to complete about the person's likes, interests and life history.

People were asked if they wished to be supported with their personal care by staff of the same gender. We observed that staff knocked on people's doors before entering and confidential information about people was stored securely. The staff we spoke with confirmed that they had received dignity training and gave us examples of how they maintained people's dignity and confidentiality, for example by ensuring that they did not discuss a person's needs in front of other residents and their visitors. However, we observed that a person who used the service being asked questions in a communal that should have been asked in the privacy of their own room.

People and their representatives were provided with written information about the service, including details about how to make a complaint about any aspect of their care and support. The registered manager confirmed that documents could be produced in different formats if required, for example large print, audio or braille, in accordance with the requirements of the Accessible Information Standard (AIS). Since August 2016 all organisations that provide NHS care and/or publicly funded adult social care are legally required to follow the AIS. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people who use services and their informal carers with a disability, impairment or sensory loss.

Requires Improvement

Is the service responsive?

Our findings

The care plans we looked at contained relevant and up to date information about people's needs. The provider ensured that staff had access to any pre-admission assessments from social services or continuing health care trusts, so that they had accurate information about the person's needs from external health and social care professionals. The service carried out a range of assessments to develop an individual care plan and accompanying risk assessments.

One of the care plans we looked at contained some conflicting information. The monthly dependency assessment stated that the person had limited vision but their most recent falls risk assessment stated that they had no issues with their vision. An optical assessment carried out last year highlighted that they had poor vision and this was confirmed by the person's relative when they contributed to the pre-care planning assessments. We pointed this out to staff, who said they would immediately rectify the discrepancies. This type of finding was not typical of assessments in other care plans.

We found that the care plans provided satisfactory guidance for staff about how to support people with their activities of daily living and information about how to support people with their health care needs. For example, we looked at another care plan for a person with diabetes. Clear information was given that would enable a registered nurse or a care assistant to understand what care and support the person needed. There was information about the person's diet, including how many artificial sweeteners they took in hot beverages. The warning signs to detect low and high blood sugar (hypoglycaemia and hyperglycaemia) were explained and the frequency for carrying out blood sugar monitoring was recorded. The care plans appropriately linked the person's needs, for example the impact of being diabetic was reflected in the risk assessment for skin integrity and the care plan for daily personal care. In terms of the person's social care needs there was information about the activities they enjoyed at the service and satellite channels they watched, which broadcast programmes that met their cultural and linguistic needs and preferences.

We noted that the care plans appropriately explained how to safely support people to have a daily wash, shower or bath, and took account of factors that included their mobility, skin integrity, cognitive and/or sensory impairments, and relevant heath care conditions. Where people were known to have dry skin, there was guidance about applying a moisturising cream. However, limited information was given about people's individual preferences, for example whether they wished to be supported to apply make-up or cologne, preferred toiletries to be used and how they wished to dress. We spoke with the registered manager about the absence of this type of information in care plans that should demonstrate a person-centred approach The registered manager confirmed that changes could be made to further personalise the care plans.

We spoke with people and their representatives about how the service responded to their social care needs. One person told us, "I like word search and I go out to the garden. I sit here on my own but I am quite happy. I don't go to the lounges as I can't be bothered". Another person said, "I do a lot of listening to classical music. I sometime go to the music events and on one occasion we got walked in wheelchairs to a lovely local concert. We have had barbecues here, a Tickled Pink show and Angelica Arts, a charity, came here. Three young people came and danced and threw a ball. For me personally there is enough to do." A relative

remarked, "They (staff) just bring them in and sit them in front of the television and normally there is nothing for them to do. There are two ladies who do activities, both of them are good. We had a farm that came for six weeks but there is no money. No school kids come and no dogs come like they do in other homes."

We met with the two wellbeing coordinators to find out how they supported people who used the service to engage in meaningful activities, either as part of a group or in one to one sessions in accordance with their individual needs and preferences. The wellbeing coordinators were responsible for organising the monthly residents' meetings. The minutes for these meetings showed that the service genuinely wished to seek people's views about the quality of the service and act on their comments. For example, one of the chefs attended these meetings so that they could directly hear people's opinions about the food service and either provide an instant response or report back at the next meeting, depending on the nature of people's queries. The wellbeing coordinators informed us they had also taken over the responsibility for completing 'life story' forms with people who used the service and/or their representatives, to enable staff to understand about people's background, former occupation and interests.

People were offered a range of activities, which included gentle movement and exercises, relaxation sessions in the sensory room, arts and crafts, reminiscence, coffee mornings with staff and volunteers, and manicures by one of the wellbeing coordinators in the service's own salon. This salon was also used for hairdressing appointments which people could book with a visiting hairdresser. One to one activities were provided for people who were not able to or did not wish to join communal activities. The wellbeing coordinators had established links within the local community, for example the local fire brigade had visited the service with an engine for a social event and invited people living at Aspen Court Nursing Home to attend an open day at the fire station. Other community links included project work in the garden with young volunteers from National Citizens Service, visits from the local city farm and weekly visits from a local nun who was well known to some of the people and relatives we spoke with. The entertainment programme included beach themed barbecues, a Harvest festival and a coffee morning held during the inspection to raise funds for Macmillan Cancer Support charity.

The wellbeing coordinators were keen to develop the quality of care for people living with dementia and they attended training forums for activity staff, organised by NHS occupational therapists. They told us that one of these sessions was about how to introduce Namaste. This is a structured programme of sensory activities that aims to improve end of life care for people in care homes who have advanced dementia by giving them pleasure and helping them to connect with others. The wellbeing coordinators stated that the registered manager provided useful guidance in relation to the activities programme and was supportive of their plans to introduce more sensory stimulation for people.

People and their relatives were provided with information about how to make complaints. A person who used the service told us "I would complain to the manageress, she would listen to me." One relative told us they had experienced difficulties when they wished to make a complaint, "There is supposed to be a complaints form but there is no form. We had to [contact head office]. We have been to quite a few relatives' meetings. They are well set up." Another relative told us they felt that staff listened to them and their family member. The complaints log showed that complaints were investigated and complainants were responded to in accordance with the provider's policy and procedure. We also saw where a compliment had been received and staff were acknowledged as having 'gone the extra mile' to support a person to celebrate a special birthday.

Prior to the inspection we were informed by a relative that they had made a complaint in relation to the quality of care received by their family member in the final week of their life. The relative was very concerned by practices they had witnessed which included unprofessional conduct by members of the staff team, for

example the lack of compassionate care, insensitive comments by a senior registered nurse and the falsification of care records. The relative told us they made three attempts to obtain a response to their complaint before receiving a response that failed to address the issues they raised. During the inspection visit the registered manager stated that the complaint was now subject to a thorough investigation by the provider and the relative has subsequently informed us that they have received a more detailed response from the provider.

At this inspection we spoke with four people who were receiving end of life care and we spoke with the relative of a person who had passed away at the service. The relative felt their family member had received good care and treatment, and expressed their gratitude to the staff. We observed that staff acted in a sensitive and discreet manner when speaking with the relative and contacting the funeral director. The staff we spoke with were upset as they had got to know the person well and expressed they felt reassured because a member of the team had been with the person when they died. One staff member told us they had been to the funeral of a person who passed away at the care home as the relatives had specifically asked for their attendance. Staff explained to us about the 'Last Offices' practices they carried out, for example they called religious ministers to attend to people following their death if this was required by their faith.

The four people with end of life care needs told us they were comfortable and they appeared well cared for. Each person had access to drinks and their call buzzer, however the environmental hygiene in two of the rooms was unsatisfactory. The call buzzer in one of the rooms was not clean and there was a stale smell lingering in the carpets in two rooms.

We looked at the documentation for two people, which showed they received monitoring visits every week from nursing and/or medical staff from the local hospice. The specialist staff at the hospice provided advice to staff at the care home about how to support people's relatives, particularly where it was known that relatives were vulnerable due to their own health care needs.

Requires Improvement

Is the service well-led?

Our findings

The registered manager informed us the provider's ethos was to provide kind care, where people who used the service received help and support tailored to their own needs and delivered with kindness and compassion. During the inspection we received comments from some people and their relatives who felt that the service was caring and person-centred. For example, one relative told us "The staff are really nice and helpful. The home has given me my life back because I know [my family member] is safe here." However, other relatives we met at the inspection and relatives who contacted us by telephone described standards of care and support which was not acceptable.

In relation to the complaint about the quality of end of life care, the registered manager confirmed to us that the probation contracts for two staff members were terminated and the performance of two other staff was being monitored. Other measures were due to be implemented, which included retraining for all staff in communication and customer care, and end of life care training and staff competence in this area will be monitored by the home's management team supported by the local hospice. The registered manager informed us that all pre-admission assessments for prospective new people moving into the service would be reviewed by herself or her line manager and care plan review meetings will be held with relatives within the first week of a person's admission. Additionally, all daily documentation, for example positioning charts and fluid balance charts, must now be checked every two hours and this will be monitored by the registered manager and the deputy during their walks around each unit.

However, the provider's own monitoring systems to scrutinise the standard of end of life care did not identify that there were clear deficits in relation to staff knowledge, skills and integrity to provide competent and empathetic care and support to people with end of life care needs and their relatives. The provider's monitoring and auditing systems for the safe management of medicines had not picked up the errors we found during the inspection.

These issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with people who used the service and their relatives as to whether they thought that the service was well managed. Comments from people who used the service included, "I think it is excellent here and it is a well-run home. I would recommend it to others without a shadow of a doubt" and "The managers are absolutely fine. I don't know that we have residents' meetings here but you can always put forward your opinion and they will listen to you. I have never done a survey. I would recommend it to others, everybody who comes to visit me are happy because they can see that I am relaxed here." Comments from relatives included, "The manager is really nice and so is [administrator]. I go to the residents and relatives' meetings. They are very interesting and people can talk about any issues" and "The manager is very polite. She is a very nice person. She is friendly, she has time to talk to you and ask you how you are." A third relative told us they were not satisfied with the approach of the registered manager and felt she addressed them in an insensitive way.

Staff told us they felt supported by the registered manager. One staff member said the registered manager came onto the unit to administer controlled drugs with them, as this medicine required two signatures. The staff member explained to us that the registered manager used this time to check how people who used the service were and whether staff needed any assistance or guidance. Minutes showed that staff attended general meetings so that they could be updated by the registered manager about any new developments at the service and give their views.

Records demonstrated that the registered manager was supported in her role by senior managers within the organisation. The minutes for the provider's national quality governance meetings showed that clinical topics and policies to promote the safety of people living in care homes were discussed, so that improved ways of working could be cascaded to care homes. We noted that the provider carried out their own monitoring visits and recommended improvement actions for the registered manager to undertake. At the time of the inspection the registered manager was carrying out audits of the care plans and we noted where she had identified discrepancies or missing information for the unit staff to address.

Audits were carried out to check the quality of different practices within the service, and make improvements where necessary. The audits we looked at included medicines, infection control, food hygiene and the monthly analysis of accidents, incidents and occurrence of pressure ulcers.

The registered manager ensured that safeguarding alerts were appropriately raised and The Care Quality Commission (CQC) was informed of notifiable events. The provider understood the legal requirement to display their CQC rating in a prominent place at the premises and on the provider's website.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People must be supported to receive their medicines safely and properly. 12(1)(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality checking arrangements did not consistently assess, monitor and improve he quality of experience for people who use the service. 17(1)(2)(a)