Equinox Care

Aspinden Care Home

Inspection report

1 Aspinden Road
London
SE16 2DR

Tel: 02072314303
Website: www.equinoxcare.org.uk

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service caring?	**Inspected but not rated**
Is the service responsive?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

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 21 people living at the service and one person was in hospital. People had their own rooms with shared bathroom facilities. The home supported people who had a history of homelessness and alcohol dependency.

People's experience of using this service and what we found
Medicines were not always managed safely. Risk management plans were not always in place when a specific risk had been identified. Risk management plans provide staff with guidance as to how they could reduce possible risks. The provider did not always have effective processes in place for evidencing Covid 19 testing. We signposted the provider to national guidance. The provider did not have effective systems in place to record incidents and accidents and learning from these had not been embedded into the service. We made a recommendation to the provider regarding staffing levels at the home.

Some people did not have care plans which meant staff did not have important information to respond to people's needs. The provider was not always ensuring information about people's care and support was available in suitable formats to meet their support needs.

After the last inspection, the provider completed an action plan providing a clear time frame on how they would address the breaches of regulations. Some areas had been addressed however we found ongoing actions still needed to be completed to ensure people received safe care and support. We also found some aspects of the provider's quality assurance systems and structures were ineffective because areas identified for improvements in the action plan had not always been completed.

The home was welcoming, and we saw some nice caring interactions between people and staff. People's nutritional needs were being met.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 17 August 2021) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found some improvements but the provider was still in breach of regulations.

Why we inspected
This inspection was prompted by a review of the information we had about this service. This indicated a need to prioritise the service for an inspection to review the quality of care provided. We undertook this targeted inspection to check if the provider was still in breach of regulations. The overall rating for the

service has not changed following this targeted inspection and remains requires improvement.

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.

Enforcement
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so. We have identified breaches in relation to safe care and treatment, person centre care and good governance. We made a recommendation to the provider regarding staffing levels. We served the provider with a regulation 17(3) letter which requires the provider to submit a detailed action plan telling us how they are going to make improvement to the care people receive.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service effective?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service caring?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service responsive?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question

we had specific concerns about.

Aspinden Care Home

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check whether the provider was in breach of regulation 9 (person centred care) 10 (dignity and respect) 12 (safe care and treatment) 14 meeting people's nutritional and hydrational needs and 17 (good governance)

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

Inspection team
The inspection team included one inspector and an inspection manager.

Service and service type
Aspinden wood is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we held about the service which included notifications of significant events. The provider was not asked to return a provider return form. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
We spoke with five members of staff including the nominated individual. The nominated individual is

responsible for supervising the management of the service on behalf of the provider. We looked at two staff files in relation to recruitment and staff supervision. We reviewed a range of records. This included five people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We requested further information from the provider to validate evidence found. We looked at medicines audits, infection control records, quality assurance records and policies.

Inspected but not rated

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. 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.

We have not changed the rating of this key question, as we have only looked at the part of the key question, we had specific concerns about.

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 further 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 associated with people's health, medical and care needs had been assessed but we identified that these were not always comprehensive. For example, one person was diagnosed with a mental health condition but there was no other information recorded to guide staff on how to support them. The lack of detailed information and guidance for staff meant that people may have been placed at risk of possible harm.
● In one person's file we read they had challenging behaviour and staff needed to use de-escalation techniques to support them. There was no behaviour management plan in place or clarity on how staff were to support this person safely.
● The provider did not always have effective arrangements to help protect people from risks associated with the home environment. We found an old fire door stored in the dining room which was broken and a cabinet in need of repair.
● People's care plans and risk assessments were not updated to reflect any changes in support required or identified risk following an accident or incident.
● The provider had systems to log incidents and accidents as they occurred in the service. We could see evidence that accidents had been recorded but we did not see any analysis of themes and trends in relation to the incidents that occurred.

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

● There were individual fire risk assessments in place for people who used the service, and these had been updated after the last inspection. In addition to these, there were individual personal emergency

evacuation plans (PEEPS) in place which considered people's individual needs and how to ensure they could evacuate safely in the event of a fire.

Using medicines safely

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 did not have PRN protocols (when required medicines) in place. This meant there was not a clear record made of the reason for use and the effect that the medicine had on the person. The provider was not always following their medicine policy and staff did not have adequate information to evaluate the effectiveness of the medicines.
● The provider was completing monthly medicine audits, but these were not identifying that people did not have PRN protocols in place.
● In one person's file we read they were at risk of relapse if they did not take their medicine. This person had not taken their medicines for the last three months. We were not assured that staff were taking appropriate action to ensure people and staff were not placed at risk of harm.

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

● Staff had received medicines training and medicines were stored appropriately.

Preventing and controlling infection

At the last inspection we found systems were not in place to ensure risks relating to safe care and treatment were assessed and mitigated. 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.

At this inspection we found improvements had been made and the provider was no longer in breach.

● The home was clean and free from malodour. However domestic staff were not completing a daily cleaning schedule, this meant we were not assured all areas of the home had been cleaned regularly to minimise the spread of infection.
● People using the service, staff and visitors were tested for COVID-19 however the provider was unable to provide us with evidence of how they were recording this information.

During the inspection we signposted the provider to best practice guidelines for managing infection control.

● Since the last inspection the provider had updated their infection prevention and control policies and procedures in line with government guidelines.

Staffing and recruitment

At the last inspection we found staff recruitment procedures were not effectively managed. This was a breach of Regulation 19 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, enough improvement had been made and the provider was no longer breaching Regulation 19.

● Staff were recruited safely. New staff completed their training online and they started their induction at the home where they were meant to shadow more experienced staff. We requested evidence of this part of the induction, but the provider told us they did not record this information. Staff confirmed they had an induction before they started to work with people. We brought this to the attention of the nominated individual who assured us induction records would be recorded going forward.
● The provider carried out checks on the suitability of staff before they started working at the service. These included checks on their identity, eligibility to work in the United Kingdom, checks on any criminal records and references from previous employers.

At our last inspection we recommended the provider further assess 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 as they had deployed staff from another service. The nominated individual told us this was an outstanding issue, and they were planning to introduce a dependency assessment tool in the near future. We will look at this when we next inspect.

We recommend the provider further assess staffing levels at the home to ensure the home has the appropriate levels of staff in place to care for people.

Inspected but not rated

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

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

At the last inspection, the provider was not ensuring people's nutritional needs were met. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had been made and the provider was no longer in breach of Regulation 14.

● People were supported to have enough to eat and drink. There was a planned menu which incorporated people's preferences and provided a balanced diet. People were able to make a choice at mealtimes and alternatives to the main menu were available if needed.
● The provider was recording people's nutritional, and hydration needs which meant staff had the necessary information to care for people. If there were changes in people's food and fluid intake appropriate action was taken. For example, we read in one person's risk assessment that they needed to be encouraged to drink more fluids, we could see evidence of staff supporting this person to have more fluids.

Inspected but not rated

Is the service caring?

Our findings

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

At the last inspection this key question was rated as requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

The provider had not ensured that people were always treated with dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had been made and the provider was no longer in breach of regulation 10.

- Staff were kind, polite when they spoke with people. They had friendly relationships with people, and we observed staff supporting people individually in a caring way.
- Staff spoke positively about trying to change the culture to ensure people were cared for in a kinder way. For example, one staff member spoke about working with one person to clean their room whilst, reflecting in the past this task would not have been carried out. This was because staff would not have been proactive in engaging with this person to ensure their room was well maintained.
- Staff attended a monthly meeting to reflect on their working practice and to discuss specific interactions between staff and people living at the home. This was used as a method to discuss new approaches that could be used to support people. If staff training was required, this was arranged.
- People came at specific times to the reception area to be given their alcohol and tobacco, and we observed much more friendly and engaging conversation. The nominated individual spoke positively about the changes made at the home but also recognised more improvements were needed.

Inspected but not rated

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. This meant people's needs were not always met.

We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

Planning personalised care to ensure people have choice and control and to meet their needs; End of life care and support.

At our last inspection the provider was not providing person centred care to people according to their needs and preferences. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● There had been some improvements since the last inspection. The provider had introduced a new support planning system which was much more detailed and recorded people's likes and dislikes and personal preferences.
● The providers action plan stated that everyone had support plans in place. However, this was not correct as we requested to see four support plans which were not completed. We also requested to see one person's support plan and we were told it was done but later in the day staff told us this person did not have a support plan in place.
● People were meant to have regular one to one key working sessions to review their support needs. This was meant to happen every three months or when significant incidents occurred. We requested to see one person's session notes as there had been an incident with an action recorded that staff should meet with the person. We asked the staff member if this meeting had happened and they told us, " I haven't done anything on it".
● Staff spoke about having informal key working sessions with people but when we requested to see notes of the informal sessions there were no records. We raised this with the nominated individual who recognised the need to keep more accurate records.
●Staff told us the home's model was based on a Psychological Informed Environment (PIE) which considers the psychological makeup of the person and aims to ensure people received person centred care. We asked the nominated individual about this ethos and how it supported people living at the home. They were unable to provide us with any documentation to support this ethos of delivering care to people who had complex needs.
● We asked staff if they had training in PIE's and if they understood the model as a tool to engage with people who had complex needs. Two members of staff told us they had limited training in this model.

The fact that people's care needs had not been fully considered and addressed in their care plans was a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 Regulations 2014.

● Since the last inspection the provider had started to record people's end of life wishes.

Meeting people's communication needs
At the last inspection, the provider was not ensuring people received person-centred care.
This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider to be still in breach of regulation of person centred care.

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

●There were no records of people's communication needs as the provider's support plan did not record this information. We raised this with senior staff and they told us they would update their paperwork accordingly.

The fact that people's care needs had not been fully considered and addressed in their care plans was a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● The provider was reviewing the activities that were held at the home and staff recognised the challenges in trying to engage people in meaningful activities. We will look again at this when we next inspect.

Inspected but not rated

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 the last inspection this key question was rated as 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 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 monitoring the quality of the service had not always been effective and improvements still needed to be made to ensure people received safe care and treatment.
- Since the last inspection the provider had completed an action plan detailing how they were going to address the issues that we found at the last inspection. We found identified actions which had not been completed for example, the implementation of the care plans. Furthermore, there was not enough oversight to confirm if the tasks had been completed and to hold people, who were responsible to complete various actions, into account when these were not completed.
- The home had recently registered as a care home with nursing and the provider was still learning about their regulatory requirements to keep people safe. During the inspection we found issues with care plans and risk assessments, management of medicines, accident and incident procedures and record keeping as detailed in the other sections of the report.
- Accidents and incidents had been recorded and reported to the senior team however there was no analysis of when actions had not been completed to identify what went wrong and to learn lessons. The lack of effective management oversight within the service placed people at risk of receiving care that was not safe, effective and responsive to their needs. This also meant that learning and improvements could not be identified or implemented.
- The ethos of the service was based on a psychologically informed environment however some staff did not have the training and the nominated individual was unable to provide the inspection team with any written information on how this ethos was embedded into the service to ensure people received safe care and treatment.

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

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 9 HSCA RA Regulations 2014 Person-centred care People may not have been receiving appropriate care and support that was responsive to their needs and choices.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always assess risks associated with people's health and care needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Management systems in place were not robust or sufficiently comprehensive to demonstrate adequate oversight of the quality of care at the home.