Twinglobe Care Homes Limited

Aspray House

Inspection report

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19 January 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**

Summary of findings

Overall summary

This focused inspection was prompted by notifications of incidents following the deaths of two people who used the service. These incidents are subject to coroner investigations and as a result this inspection did not examine the circumstances of the incidents. However, the information shared with CQC about the incidents indicated potential concerns about the management of choking. This inspection examined those risks.

The focused inspection of Aspray House was carried out on 19 January 2017. Focused inspections do not look at all five key questions of safe, responsive, caring, effective and well-led, they focus on the areas indicated by the information that triggered the concerns. During this inspection we looked at the key questions of 'safe' and 'effective'.

We last inspected Aspray House on 8 & 10 August 2016. At the time the service was rated as 'Good'.

Aspray House is a nursing and residential home that provides care for up to 64 older people some of whom may be living with dementia. There were 63 people using the service when we visited.

There was a registered manager at the service at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risk assessments did not always consider associated signs and symptoms, specific to the person that could indicate potential or actual risk of choking. Care staff were not always confident what to do in an emergency medical situation.

We observed interactions between staff and people living in the home and staff were kind and respectful to people when supporting them. People were provided with a choice of food and drink and supported to eat healthily. However some staff were not sure of the food they were feeding people.

People had access to health care professionals and were supported to lead healthy lifestyles.

The registered manager had put some safety measures in place to minimise the risks for people at risk of choking.

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. Risk assessments did not address the risks associated with certain medical conditions for some people using the service which put people at risk of harm.

The registered manager had put some safe measures in place to minimise the risks of people at risk of choking.

Is the service effective?

Requires Improvement

The service was not always effective.

Care staff did not always feel confident performing first aid in a emergency situation.

People had choice over what they ate and drank and the service sought support from relevant health care professionals where people were at risk of dehydration and malnutrition.

Aspray House

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.

We undertook a focused inspection of Aspray House on 19 January 2017. This focused inspection was prompted by notifications of incidents following the death of two people who used the service. These incidents are subject to coroner investigations and as a result this inspection did not examine the circumstances of the incidents. However, the information shared with CQC about the incidents indicated potential concerns about the management of the risk of choking. This inspection examined those risks.

Before our inspection, we reviewed the information we held about the service. This included the last inspection report for August 2016. We also contacted the local borough contracts and commissioning team that had placements at the home, and health specialist teams that support the home

We spoke with four people living at Aspray House and one relative. We also spoke with three nurses, five care staff, two activities co-ordinators, the chef, the registered manager, and the head of operations. We observed care and support in communal areas and also looked at some people's bedrooms and bathrooms. 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. We looked at seven care files, staff training records, accidents and incidents, four staff supervision notes, and minutes of meetings.

Requires Improvement

Is the service safe?

Our findings

The provider had assessed risks to people's safety. People's care plans included assessments of risks related to personal safety, falls, nutrition and dehydration, pressure sores and tissue viability, manual handling and challenging behaviour. The staff had recorded detailed observations in each assessment and had updated these monthly. There were plans to minimise the risks and information for the staff about how to keep people safe in different situations.

However, risk assessments for nutrition that identified people at the risk of choking were not always consistent regarding what control measures were in place and how these were recorded. For example, one person had been identified as being at risk of choking however, the control measure in place stated, "[person who used the service] is served pureed meals at lunch and supper." The risk assessment did not consider associated signs and symptoms specific to the person that could indicate potential or actual risk of choking. Another person had been assessed as being at high risk of choking and required assistance with all aspects of nutrition. The control measure in place for this stated the person was given thickened fluids however no guidance was in place that would assist care staff how to manage the risk of choking. The inconsistencies in risk assessments means there was a risk that people did not receive safe support.

Staff we spoke with knew who was at high risk of choking. Printed information was available in people's bedrooms that gave staff information about the risks to that person. For example, one person's bedroom had signs which had the recommendations from speech and language therapy team (SLT). The information on display also included guidance and recommendations on the person's food and drink intake and what to do if the person was choking. However this was not always consistent. People's bedrooms had diet recommendations on display but their was not always warning signs if someone was choking. Each unit had a kitchen which had on display information about people who were supported with eating and drinking. For example, the information included the consistency of the food and drink the person should be having. Staff we spoke with were knowledgeable about people who needed support with eating and drinking and this reflected the information on display.

Nursing staff we spoke with knew how to refer to SLT team. People would be referred to SLT team if they were having eating, drinking and swallowing difficulties. Records showed the SLT team notes and input were clear and staff acted on recommendations promptly. For example, one person had been recommended by the SLT team to have a quiet environment when eating. Observations of this person during the lunch period confirmed this was being done. Before the inspection we contacted the SLT team for feedback about the service. They told us, "Recommendations are typically followed and we receive fairly regular and appropriate referrals. By following recommendations staff are reducing the risk of choking." We also contacted the dietician team for feedback about the service. They told us, "They are efficient with referring patients to our service and include the required information like anthropometry (the scientific study of the measurements and proportions of the human body), weight history and MUST score."

The registered manager told us that after the serious incidents in 2016 that she had put in place safe measures to minimise the risk of further incidents. The registered manager told us and records confirmed

staff had received supervisions looking at these serious incidents. For example, one supervision recorded a discussion about people at risk of aspiration must be monitored at all times, notices to be placed in people's room about the SLT team's recommendations and to monitor food being brought in from friends and family to assess if it is suitable. The service had organised relative meetings to discuss risks of bringing in food to the home and records confirmed this. Records showed the service conducted staff meetings, group supervisions and daily briefings about people at risk of choking in the home. For example, the staff meeting dated 5 October 2016 looked at consistency of food, updating fluid and food records, SLT guidelines to be handed over at each handover, and monitoring any signs of people of choking.

Requires Improvement

Is the service effective?

Our findings

The registered manager and records confirmed that training had been provided by the Speech and Language Team (SLT) in April 2016. The training looked at supporting people with eating and swallowing difficulties. The registered manager also told us staff received online training on nutrition and hydration and records confirmed this. Most care staff told us they had received training on supporting people with eating and drinking difficulties. One staff member said about the training, "Very good and helpful. It brought more knowledge." However another staff member told us, "Training would be good so we know what to do." A third staff member said, "At the moment we don't have training for choking." After the inspection the registered manager confirmed that all staff were booked for training for February 2017 with the SLT team. Records confirmed this.

Records confirmed staff had received first aid training. Nursing staff we spoke with were able to explain what they would do if a person was choking. However, when we spoke to care staff they were not always confident about actions to take when a person was choking. Most care staff advised they would push the emergency call bell and wait for a nurse. One staff member told us, "If I saw a person choking I would sit them up and push the emergency button. We really need training on that." This meant people using the service were potentially at risk of receiving care from staff who were not confident in performing first aid in a medical emergency situation.

The service had a nutrition policy that stated each person would be offered three full meals each day, hot and cold drinks, snacks and that the menus would be changed regularly. We saw that the policy was being adhered to and saw records of the menus and food on offer. On the day of our inspection, we observed people having their lunch. The food was presented well and all blended separately allowing people to experience and taste the different flavours. We observed people eating their lunch in their bedrooms and dining room. People were able to take their time and staff were patient while supporting people. For example, we observed a staff member assisting a person to eat some soup. The person was forgetting to swallow and the staff member reminded the person to do this. However, when we asked the staff member what flavour soup it was they replied, "I'm not sure, mushroom, I think?" We also asked another staff member supporting someone with pureed food what was the person eating. The staff member told us, "Oh I don't know, I didn't check the menu. I think its mash, meat and vegetables." This may have meant people did not always have a positive experience at mealtimes as staff could not have a conversation with people about the food they were eating and this may have been of particular importance to people.

The chef told us that people's choices were listened to and the staff from each unit would tell them the food preferences of the people using the service every morning. One person when asked about the food told us, "Everything is fine. Waited on like a king." A relative said about the food, "Fine, too good."

The kitchen had on a display a list of people's dietary needs, for example if people were on a soft or pureed diet. The chef and records confirmed a folder was kept in the kitchen which had copies of the SLT team's recommendations for people at risk of choking. The chef had a good knowledge of people's dietary requirements. The chef told us they had been on training for people at risk of choking. The chef told us, "Last

year had training around thickeners. Nurses and carers attended."

People's nutritional needs were assessed and regularly monitored. For example, records showed people's weights were monitored to ensure that people remained within a healthy range, and when concerns were identified further action was taken to monitor and improve this. For example, people were supported with their nutrition with referrals to dieticians or speech and language therapists when necessary.