Bupa Care Homes (BNH) Limited

Aspen Court Nursing Home

Inspection report

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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

Overall summary

This unannounced inspection was carried out on the 20 & 21 August 2015.

Aspen Nursing Home provides accommodation and nursing care for up to 40 people living with nursing needs. At the time of the inspection there 35 people living there.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service was last inspected in May 2013. The service was meeting people's needs in all areas inspected.

There were not enough staff to respond to people's needs in a timely manner and people often had to wait too long to have their needs attended to. People in communal areas were left unattended for long periods of time. This meant that people did not always receive care and support that met their needs and reflected their preferences.

Summary of findings

Staff were aware of how to protect people from the risk of abuse. Whistleblowing information was available to staff and they knew how to use it.

Medication was administered, recorded and managed appropriately.

Staff had been appropriately trained to carry out their role, however they were not always supervised and supported. The registered manager understood their role in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People had their nutritional needs recognised and supported. People were not always assisted to eat in a manner that supported their dignity.

People were supported to access health and social care professionals on a regular basis. People were supported in relationships with their family members and friends. However, their hobbies and interests were not always supported.

People or their relatives were involved in the decisions about their care and their care plans provided information on how to assist and support them in meeting their needs.

Staff were knowledgeable about people's needs, however they did not have time to spend with people to ensure their independence was promoted. Most staff were caring, kind and compassionate but we observed occasions where staff provided care in a way that did not promote people's dignity and sense of well-being.

The service was not always managed in an inclusive manner that invited people, their relatives and staff to have an input to how the service was run and managed.

The provider did not have effective systems in place to assess, review and evaluate the quality of service provision. They had not recognised or responded to issues we identified during our inspection that impacted on the quality of care people received.

We found two breaches of the Health and Social Care Act and you can see what actions we told the provider to take at the back of the full version of this report.

Summary of findings

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 were left unattended for long periods of time due to issues with staffing levels.

People and their relatives told us that the home was safe. Staff were recruited safely.

Medicines were managed safely.

Safeguarding and whistleblowing guidance enabled the staff to raise concerns when people were at risk of abuse.

Is the service effective?

Requires improvement

The service was not always effective.

Staff did not always feel supported and they did not have regular supervision.

The registered manager had an understanding of their responsibilities under the Mental Capacity Act 2005 (MCA), and the associated Deprivation of Liberty Safeguards (DoLS).

People had timely access to appropriate health care support.

Is the service caring?

Requires improvement

The service was not always caring.

People's wishes and choices were not always respected. People's independence was not always promoted.

We observed positive and respectful interactions between the staff and people who used the service.

The staff we spoke with demonstrated that they knew the people they supported well and that they understood their needs.

Relatives were encouraged to visit whenever they wanted.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's needs were not always met in a timely manner. People felt unable to ask for their needs to be met. Call bells were not responded to in a manner that ensured people's needs were recognised and met.

Care was not delivered in an individualised manner and people were not supported to follow their interests or hobbies.

Summary of findings

People had to wait too long at the dining room tables before their lunch was served and did not always receive the support they required during mealtimes. People were supported to eat sufficient and nutritious food and drink.

People needs had been assessed and reviewed in a timely manner. Care plans were up to date and contained clear information to assist staff to care for people.

There was a complaints process in place for people to use.

Is the service well-led?

The service was not always well led.

There was no effective management structure in the home and staff were without direction and support.

The quality systems in place were ineffective and did not always recognise or respond to areas for improvement.

The staff were not always well motivated and felt that their views were not always listened to.

Requires improvement

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.

The inspection took place on 20 and 21 August 2015 and was unannounced. It was conducted by one inspector.

We reviewed the inspection history of the service and the information we held including notifications received from the provider. This refers specifically to incidents, events and changes the provider and registered manager are required to notify us about by law.

We spoke with six people who used the service, six relatives, one healthcare professional, three care staff, two nurses and the registered manager.

We used the Short Observational Framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed five people's care records and medication records. We looked at records relating to the recruitment of staff, their support and records relating to how the safety and quality of the service was monitored.

Requires improvement

Is the service safe?

Our findings

People told us that they felt their physical safety was promoted. One person said "Of course I am safe here" another said "It's very secure here." A third person said that they would tell their family if they didn't feel safe." Relatives we spoke with were concerned about the staffing levels and one person said "Sometimes especially on the weekend you can't find staff for love or money." Another said "We have to help other people who have no visitors." A third said "I have no concerns about [relative] actual safety it's the quality of life I worry about."

The registered manager told us that the provider used a tool to determine the staffing levels but couldn't give details of how it worked or pertained to the staffing levels in the home.

The registered manager had recently reduced staff levels because there were three fewer rooms occupied they were unable to tell us the impact of this reduction on people and staff. Staff told us that the reduction made caring for people very difficult. For example getting people to bed at night at a time that suited them, was now rushed and staff felt that this could compromise safety.

People were left unattended for long periods of time. We observed two occasions when the sitting room had up to 12 people there and no staff presence for 26 minutes. Staff and visitors confirmed that this was usual. During our observation people were not at risk of falling. However some people were unable to call for assistance and needed monitoring to ensure their wellbeing. The registered manager said that this shouldn't happen but accepted that it did. This lack of a consistent approach to staffing put people at risk of injury and neglect.

All people had a personalised risk assessment. These included information for staff on how to keep people safe and to prevent injury. For example people who had a pressure area or were at risk of developing a pressure area were turned on a regular basis. This aided recovery by ensuring the affected area was not exposed to constant pressure. People who needed assistance to move had the appropriate equipment in place. These included hoists and walking aids.

We saw that there was a current safeguarding policy in place, and information about keeping people safe from harm or abuse was available to staff. The staff we spoke with told us that they had received training on safeguarding procedures and were able to explain these to us, as well as describe the types of abuse that people might suffer. One member of staff said, "Some people only have us so you have to make sure you know what to do." Records showed that the staff had made relevant safeguarding referrals to the local authority and had appropriately notified CQC of these when required. This meant that staff were aware of their duty of care to protect people from abuse.

People were protected by the provider having thorough procedures in place to recruit staff. Discussions with staff and a review of six records showed that staff identity and security checks had been carried out before they stared working in the home. This included checks of their previous work and employment history. Disclosure and Barring Service (DBS) certificates had been obtained for all staff prior to starting to work in the home. Staff confirmed that they did not take up their employment at the home until the appropriate checks such as, proof of identity, references and satisfactory Disclosure and Barring Service (DBS) certificates had been obtained. This helped to ensure that only staff who were safe to work with vulnerable people were appointed

People's medicines were administered safely and as prescribed and by staff that had been trained to do so. The registered manager told us that there was always a member of staff that had been trained to administer medicines on duty each day. We observed that people were offered drinks to assist them to take their medicines. Medicines were stored appropriately. We looked at the medicines administration record (MAR) for two people and found that these had been completed correctly with no unexplained gaps. There was a system in place to return unused medicines to the pharmacy. Protocols were in place for people to receive medicines that had been prescribed on an 'as when needed' basis (PRN). People had their medicines reviewed once a year to ensure they were receiving optimum medicines to promote their health. This meant that people were offered their medicines as prescribed by their GP to support their health and welfare.

People were protected from risk in the environment because the provider had carried out assessments to identify and address any risks posed to people by the environment. These included checks of window restrictors, hot water and fire systems. Staff told us that there were

Requires improvement

Is the service safe?

formal emergency plans with contact number available for emergencies to do with the building, such as a gas or water leak and information as to where to find the necessary taps to switch the supplies of gas, electricity or water off.

Each person had a personal emergency evacuation plan that was reviewed regularly to ensure that the information contained within it remained current. These enabled staff to know how to keep people safe should an emergency occur.

Requires improvement

Is the service effective?

Our findings

People told us they thought the staff were trained to care for them and always "Knew exactly what they were doing." Staff had received training in how to care for people. This included assisting people to move safely, infection control, health and safety and food hygiene. Some people were living with dementia and staff did not have training on caring for people with memory loss or living with dementia. Staff we spoke with said that they would like to understand more about dementia so they could assist people, where possible, to live well. They said that they did not always some people's behaviour, for example when they always called out or seemed 'somewhere else'. The manager said that this training would be arranged.

Staff told us that they were due to have received regular supervision but that this did not always happen. This meant that the managers and supervisors in the home missed the opportunity to capture the concerns, opinions and knowledge of the staff. The registered manager was aware of this and told us they were making plans to address the issue.

Staff had received training on the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves to their care, or make specific decisions about this. This meant that people who no longer had mental capacity were protected.

Staff were not always able to demonstrate a good understanding of the requirements of the MCA or DoLS. They were not always aware of who was subjected to a DoLS. This means that people are deprived of their liberty to keep them safe. However they were able to explain how decisions would be made in people's best interests if they lacked the ability to make decisions themselves. This included holding meetings with the person, their relatives and other professionals to decide the best action necessary to ensure that the person's needs are met. Staff told us, and we saw records that showed that DoLS applications had been made to local authorities for people who lived at the home as they were not allowed to leave unless supervised by relatives or staff. The registered manager understood their responsibilities under the MCA. Two people who use the service were subjected to a DoLS. The process for this had been appropriately completed.

People chose what they wanted for lunch the previous day. We saw that staff did not ensure they were happy with or remember their choice. Lunch was served in a haphazard manner. One person was seated at the dining room table at 11.55 and had their lunch served at 1.20. They had nothing to engage them in that time and staff did not engage in any way with them. This left them isolated.

Drinks were available, however we saw that people's drinks were sometimes left out of their reach and there were no staff around to assist and encourage them to drink. This could have put people at risk of dehydration.

People who were at risk of poor nutrition had their food and fluid monitored. A review of records and discussions with staff showed that staff were diligent in recording people's nutritional input. Where people continued to lose weight referrals were made to appropriate professionals such as dieticians for assessment and guidance. This helped ensure people had good nutrition intake.

People's relatives were invited to eat with them. Relatives told us that they really appreciated this as they could encourage [relative] to eat and drink as much as possible. They also said it made, "Life more pleasant and normal."

People were supported to maintain their physical and mental health and well-being. Tissue viability nursed visited people who had a pressure area to ensure staff were offering optimum treatment. People had access to their health care professional such as their GP, optician and chiropodist. People were offered the opportunity for a dental check up on an annual basis. Those people who were close to the end of their lives had input from Mc Millan nurses. This approach to care ensured the physical and mental well-being of people was promoted and their health needs were responded to in a timely manner.

Requires improvement

Is the service caring?

Our findings

People and their relatives said the staff were caring. One person said, “They are good girls, and would do anything for you.” Their relative told us staff were, “Caring and committed.” They went on to say, “The staff are kind and caring it’s a pity they don’t have more time.”

People’s dignity was not always promoted because staff focused on tasks to be completed rather than on the person they were caring for. One staff member said, “It is really hard to focus completely on the person you are caring for as you are thinking and worrying about the next person and hoping they are ok.”

Some staff assisted people to eat in a manner that promoted their dignity and independence. However we saw one staff member try to assist someone to eat when they were clearly asleep. Other staff assisted more than one person to eat at a time and frequently walked away from the person they were assisting without excusing themselves. Providing care and support in this manner did not promote people’s dignity and self-esteem.

People were not always encouraged to be as independent as possible. They were left sitting for long periods without staff input. This meant that they could get stiff and loose mobility and confidence.

People were not always involved in deciding how they spent their day. They did not always have choice about when to get up and go to bed. However they did have choice on what they wanted to wear and where within the home they wanted to spend their day.

Most staff interacted with people in a caring way and positive manner. One member of staff told us, “It’s about respecting people.” Another said, “Once you get to know people they become important to you, so you really look after them and sometimes worry about them.”

We saw that staff promoted people’s privacy, care was delivered behind closed doors and staff always knocked and asked permission before entering people’s rooms. Staff were able to describe ways in which they protected people’s dignity when supporting them, such as ensuring that if someone was having a shower the door to their bathroom was kept closed, or if someone was getting dressed, the curtains in their room were drawn.

People and relatives we spoke with told us that friends and relatives could visit at any time. The person told us, “I’ve got my [relative] coming on Wednesday to take me out.” The relative told us, “There is no restriction on visiting. We can come any time during the day or evening.” This meant the provider supported people to maintain relationships that were important to them.

Requires improvement

Is the service responsive?

Our findings

People told us that they had to wait too long for their call bells to be answered. All the people we spoke with and their relatives confirmed this. Staff were upset that they could not get to people in a timely manner to take them to the toilet and told us this led to 'accidents.' Two people told us that staff had told them in the past to 'use their pad' as they were attending to other people who couldn't be left. Relatives told us that they often found their relative in wet clothing. They said, "This was particularly worrying when the person was recovering from a pressure area." Another relative said, "You can't get a member of staff to do something at the weekend for love or money."

The registered manager reviewed the call bell system and had information on how long people had to wait for their bells to be answered. However, staff, relatives and people confirmed that staff come and switch off the call bell and then return later to attend to the peoples' needs. Therefore the registered manager and the provider had no way of knowing how long people waited for their needs to be met. On the day of our inspection, one person had some of their needs met and then had been forgotten and had waited a further 25 minutes for their care to be completed.

People told us that they often do not ask for their needs to be met as staff are so busy. For example a person asked us for assistance and we said we will call a staff member. They then became visibly upset and said they would manage as they staff were too busy. People said on average it takes 25 to 30 minutes for their request to be met. They said unfortunately this was, "Sometimes too long." Staff told us that they had recently 'accidently' bathed the wrong person. When they found out there was no time to bathe the person whose 'day' it was for a bath. This meant that people's needs were not met in a manner that suited them.

People did not always have their choice respected. Staff told us that they respected people's decisions as to their daily care and support needs, such as the time they get up, what they wear or how they spend their time. However we were told that people did not have a choice on when to bath or shower and usually this was only offered once a week. Some of the people we spoke with were happy with this arrangement others would have liked a daily choice. Staff and people told us that choice was limited due to the pressure of work.

Staff said that they found it upsetting not to be able to meet people's needs particularly when they went back some time later and they had an 'accident.' One relative said this was particularly upsetting as [relative] "Was always so particular about their cleanliness." Another said that it was "Totally unacceptable."

People were not stimulated and they did not have the opportunity to pursue their interests or hobbies. There was one activity staff member on duty. They offered a manicure to people. However this left other people in the sitting room, this varied between 10 and 13 unoccupied and unstimulated for the morning.

People did not always receive care that met their needs and reflected their preferences. This was a breach of **Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Care plans were drawn up with the person or their representative. They were updated on a regular basis and they reflected the needs of the people. All the care plans were personalised and contained good information for staff on how to meet people's needs. However staff told us that they did not have time to read the care plans and got their information from hand overs. This meant that they did not have a full picture of the person or their overall needs and wishes. For example staff were unable to tell us who would like a daily shower.

The provider had a complaints system in place and details on how to use it was available throughout the home. People and visitors knew about it and how to use it. However relatives told us that they had complained about the staffing levels on many occasions. They said that this had no effect and said the registered manager regularly told them that the staffing levels were right for the service. They said they no longer, "Bother complaining as nothing happens."

The registered manager had followed the provider's complaints procedure in responding to and investigating complaints. The registered manager reviewed the complaints to ensure the service learned from any mistake and put systems in place to avoid a re-occurrence. For example a recent complaint identified the need to have information that was usually kept in the registered manager's office available to night staff. The registered manager put this in place.

Requires improvement

Is the service well-led?

Our findings

There was no consistent approach to managing and leading the service. Staff said the registered manager never left the office and therefore was not available for guidance. The management structure was haphazard and ineffective. For example, the provider had two senior carers to manage the care staff. This was not enough to ensure the care staff had direction and guidance on shift or on a daily basis. Nursing staff were unsure of their role in managing or supervising care staff. This meant that nursing staff were not sure how to address bad practice when they saw it. For example, they are not sure what to do when people were left unattended by care staff.

The registered manager told us that nurses had responsibility for managing the care staff. However they were not empowered or trained to do this. The care workers said that they did not feel supported in their role. They said that none of the management group understood their work load. When call bells went unanswered they were 'blamed' despite them saying they were 'already not managing.' The registered manager acknowledged they spent a long time in the office due to the amount of paperwork they had to complete. However they said that they had an 'open door' policy. Evidence supported this. However this approach to management depended on staff having time and confidence to take problems to the registered manager. This lack of clear management structure and staff support in the home meant that staff were without direction and support and did not always know what was expected of them.

People, their relatives and staff said that the registered manager and the provider did not listen to their concerns regarding staffing. The registered manager said that the staffing levels were determined by the provider and that recently they had to reduce the staffing levels as there were three vacant rooms. This was done by asking some staff for the least busy time rather than using a recognised staffing tool that determined staffing levels based on people's needs and wishes. This meant that the provider could not be sure people's needs and wishes were recognised and met and had led to task based care.

The provider had systems in place to audit the service. These included quality of care, quality of life, leadership and management, hotel services and discussions with relatives. None had identified and addressed the problems staff had in responding to people's needs in a timely manner. The subsequent effect on the quality of life for people living at the home had therefore not been recognised and addressed. For example, the registered manager had relied on data from the call bell system to determine how long call bells rang for, rather than reviewing and observing the actual practices within the home to see whether staff met people's needs in a timely manner. Quality assurance systems were ineffective because they had failed to identify this as an issue and as a result the quality of service people were receiving had not been improved.

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

Audits on people's health care included wound care, medicines and monitoring nutrition. These identified and addressed appropriately when additional input was needed to promote people's physical health and welfare.

Environmental audits were carried out. These included ensuring all fire equipment was serviced on a regular basis. Checks were carried out on all electrical equipment and water checks were carried out to protect against the risk of Legionella disease.

The service held meetings for people and their relatives. People and their relatives told us that, "It was very hard to get past the staffing levels." We saw that meetings were held on a regular basis and that menu choices were discussed.

Staff told us that sometimes morale was low and they did not feel listened to or their knowledge of people respected. However, they said that some senior staff were brilliant and they could go to them for guidance and support but that this was not consistent. Many did not feel able to raise their concerns with the registered manager or provider. This meant that an open and transparent culture had not been promoted.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People who use services were not having their needs recognised and met in a timely manner.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **We found that the registered person had not protected people against the risks of inappropriate or unsafe care, as there was no effective system in place to assess and monitor the quality of the service provided.**