Opal Care Homes Limited

Aspen Grange Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Aspen Grange Care Home is a residential care home providing personal and nursing care to 35 people aged 65 and over at the time of the inspection. The service accommodates up to 49 people in one adapted building. At the time of the inspection 37 people were living at the service.

People's experience of using this service and what we found
Aspen Grange has been through a difficult period since our last inspection, and whilst we found some improvements had been made to recruit new staff and work better with other professionals, frequent changes of manager have led to a lack of leadership, management and oversight of the service. This has impacted on the quality of the service provided and has resulted in risks to people's safety not being identified and managed effectively. People's relatives and staff told us the changes in management had impacted on the culture in the service and the quality of the care people received.

At the time of this inspection there was no registered manager in post, the service was being managed by the area manager and deputy during a transitioning period until a newly recruited manager commenced in post on 20 January 2020.

Our previous inspection in January 2019 identified the providers governance arrangements needed to improve. At this inspection we found the frequent changes in management had failed to drive the required improvements. Governance systems had not been used effectively to address previous issues regarding staffing levels and staff knowledge or identify improvements needed, such as cleanliness of the premises. Neither had they been used to analyse information to identify trends and look at ways of reducing risks to people, such as deployment of staff to manage people's behaviours and repeated falls. This is a continued breach of regulation 17 (Good governance) Health and Social Care (Regulated Activities) Regulations 2014 from the previous inspection in January 2019.

People's relatives and staff told us there were not enough staff to meet their family members care needs, provide meaningful engagement and keep them safe. Both days of the inspection people's anxieties and agitation manifested in arguments whenever staff were not present, resulting in people becoming verbally aggressive towards each other.

Systems, processes and practices to safeguard people from abuse were not effective. Staff were not clear of when to raise incidents that constituted as abuse, which meant there were times when people's safety had not been protected. Improvements were needed to ensure the environment was clean to prevent the spread of infection and free from unpleasant odours.

We have made recommendation about improving infection control and hygiene.

Although the provider had a training programme in place, this did not ensure all staff had the skills and

knowledge to carry out their roles effectively and keep people safe. Additionally, not all training was up to date. Staff had completed challenging behaviour training, but this had not included techniques to keep themselves and others safe where people become physically aggressive. There were no systems in place to test staff understanding of training delivered and minimal testing of their competence to ensure they delivered safe and effective care.

The induction process for agency staff was not robust, 21 agency staff were used between December 2019 and January 2020. 16 of these agency staff had no record of induction to the service to ensure they were familiar with the premises, safety matters and had the skills and knowledge to carry out their roles. Staff recruitment checks, including agency needed to improve to ensure employees were suitable to work with people using the service.

Staff were mixed in their views about the support they received from managers. Staff supervision had not routinely taken place, with some staff not having had a supervision meeting to discuss their performance and professional development. The area manager assured us a supervision programme had been implemented for all staff in 2020.

Care plans needed to improve to ensure they accurately reflected people's needs and provided guidance to staff on how to meet those needs. Further work was needed to ensure people's care plans contained information about their preferences at the end of their life.

We have made a recommendation about improving end of life care.

People's personal hygiene needs were not always being met, which meant people were not always treated with dignity and respect. Complaints were not always actioned and responded to.

Systems in place ensured people received their prescribed medicines. The service was working the Clinical Commissioning Group (CCG) Medicines Management Team, the GP surgery and pharmacy to improve communication.

People's relatives were positive about the caring attitude of staff. Staff treated people with kindness and demonstrated a caring attitude. People had developed good relationships with staff and looked comfortable in their company. A new activity organiser had been recruited. People and their relatives told us there had been an improvement in the activities provided.

People had access to enough food and drink to maintain a balanced diet. People and their relatives were complimentary about the food provided. Peoples healthcare needs were being met. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 February 2019) and they were in breach of regulation 17, good governance.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, not enough improvement had been made and the provider was still in breach of regulation 17, good governance.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

Why we inspected
This was a planned inspection based on the previous rating. The inspection was prompted in part due to concerns received about poor falls management, safeguarding concerns not being reported and management of people's behaviours. A decision was made for us to inspect and examine those risks.

Enforcement
We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well led sections of this full report. We have identified breaches in relation to good governance, staffing, staff recruitment, staff training and failure to safeguard people from the risk of abuse at this inspection.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.
If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Aspen Grange Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The team consisted of an inspection manager, one inspector, an assistant inspector, a specialist advisor who was an occupational therapist and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Aspen Grange Care Home 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 did not have a manager registered with the Care Quality Commission. A registered manager like 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 had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. 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. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service, and ten relatives about their experience of the care provided. We spoke with representatives of the provider, which included the area manager. We also spoke with the deputy manager, as well as eleven staff including two nurses, seniors, care assistants, an activities coordinator, kitchen assistant and the chef. 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 a range of records. This included seven people's care records and multiple medication records. We looked at five staff files in relation to recruitment and supervision and 21 agency records. We also looked at a variety of records relating to the management of the service, including policies and procedures.

Inadequate

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 deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
• Safeguarding policies and procedures were not fully imbedded in the service to protect people from the risk of harm.
• Staff had not recognised incidents between people using the service as abuse and failed to report these to the management team. For example, staff had recorded in a person's daily records three separate incidents of inappropriate sexual behaviour towards another person using the service. A record had been made that the person had 'invaded the other persons personal space.' As a result, this behaviour had gone undetected, which had exposed other people using the service to a significant risk of sexual abuse occurring.
• We brought these incidents to the area manager's attention, who responded immediately reporting all three separate incidents to the local authority safeguarding team and arranged for the person to have one to one staff support, at all times to minimise the risk of this happening again.

Systems and processes in place to safeguard people from the risk of abuse and improper treatment were not effective. This placed people at risk of harm. This is breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
• People's care records did not always reflect their current needs, and associated risks. Care plans contained information about the person but did not guide staff on the practical steps to provide the support they needed to keep safe. Therefore, risks to people's safety were not consistently identified or addressed quickly enough. For example, one person's care plan showed a change from low to a high risk or falls, with no rationale or what additional measures were needed to minimise the risk of further falls.
• People's complex needs meant they often behaved in ways that challenged others. Where people had known triggers, control measures to reduce the cause of their distress and manage their behaviour were vague. Failure to have guidance for staff on how to support people to manage their behaviours had placed, and continued to place, people at risk of harm.
• Behaviour charts used to record incidents of challenging behaviour contained minimal detail. There was no analysis of incidents to identify triggers, or how to mitigate the risks of such incidents happening again.
• Systems were in place to ensure that equipment was safe to use and well maintained. Regular fire safety checks were undertaken to reduce the risks to people if there was a fire. People had individual personalised evacuation plans in place which guided staff on how to support them to evacuate the premises in the event of fire.

Staffing and recruitment
• People told us they felt safe, however their relatives said there was not enough staff, which compromised people's safety. Comments included, "My [Person] has had a few falls but no one has seen them actually fall. I feel they are often too short of staff," and "We come at least once a week, we think staffing levels are poor at weekends. My [Person] fell and was found in the corridor."
• The area manager told us, staffing levels on weekends were the same as week days. They carried out a monthly assessment to review staffing levels, and numbers were adjusted accordingly. They told us in December 2019 an additional member of staff had been added to the morning and afternoon shifts due to the increase in occupancy. However, of the 11 staff spoken with, two considered there to be enough staff. The other nine staff told us staffing levels were not enough to meet people's needs. One member of staff told us, "From the minute we come in, to the minute we go home, we will be nonstop. People that are in bed and need a hoist to transfer often have to wait and we do not have enough time to chat with people." Other staff comments included, "There's not enough staff, residents are not safe, they don't get the care and support they are supposed to," and "I think at times there could be more staff, it depends what floor you're on. Downstairs there's a lot more people to keep an eye on and there are a lot more people who need help from two staff."

Failure to have sufficient staff deployed across the service has placed and continues to place people using the service at risk of harm. This is a breach of regulation 18 Health and Social Care (Regulated Activities) Regulations 2014

• Recruitment checks to ensure staff were suitable to work at the service, such as Disclosure and Barring Service (DBS) (a national agency that keeps records of criminal convictions), were in place. However, a review of staff files found, some information missing, such as explanations for gaps in employment history and the reason for leaving their previous jobs.
• The service used agency staff on a regular basis. Improvements were needed to ensure information about agency staff was obtained to ensure they were safe to work at service. Out of 21 agency files, we found 12 had no profile in place to reflect they were up to date with relevant training, their right to work in the UK and a DBS check.

The lack of provider and managerial oversight has failed to ensure staff, including agency staff are of good character and safe to work with vulnerable people using the service. This is a breach of regulation 19 Health and Social Care (Regulated Activities) Regulations 2014

Preventing and controlling infection
• The provider's infection control policies and procedures reflected relevant national guidance to keep the premises clean and prevent the spread of infection, however we found areas of the service were not clean. This included staining in toilet basins, grime around the taps on wash basins and sinks in the mini kitchens were stained and poorly cleaned.
• There were strong odours throughout the home, both days of the inspection. One relative told us, "We had terrible problems in [Person's] room with smells, there was a persistent smell for ages." Other comments included, "We think they could turn the hygiene here up a notch or two, sometimes my [Person's]' room really smells," and "I suppose you can't get rid of that smell it must be impossible."
• Monthly infection control audits were being carried out but were not effective in identifying poor cleanliness and odours. These consistently referred to 'communal areas visibly clean'.
• The kitchens were located on the top floor of the premises. We observed a member of the catering team transport kitchen waste via a central lift and through a communal lounge/dining area on the ground floor, to the garden and rear of the building where the bins were located. Although this practice was not ideal, the provider had assessed the risk of spreading infection, and measures had been implemented to reduce the

risk.

We recommend the service refers to national guidance such as the Health and Social Care Act 2008 Code of Practice on prevention and control of infections to ensure the cleanliness and hygiene in the service is maintained to a high standard.

Learning lessons when things go wrong
• Since our inspection in January 2019 we received a high level of whistle-blowing, safeguarding concerns and complaints in relation to poor falls management, safeguarding issues not being reported and staff not managing incidents of violence, aggression, and sexualised behaviours. Although some action had been taken to review incidents where things had gone wrong, at this inspection we continued to find incidents, such as sexualised behaviours that had not been identified and acted on.
• The area manager told us processes to analyse information and identify themes and trends had been implemented, however they acknowledged these needed to improve. For example, records for people assessed as high risk of falls showed 'loss of balance' without any explanation of the type of fall, or the activity they were involved in prior to the fall. There was no analysis of these falls or falls reduction planning, and no medical follow up to ascertain possible causes, such as low blood sugars, or if linked to their medication.

Using medicines safely
• People's medicines, including controlled drugs were ordered, stored, administered and disposed of safely and in accordance with relevant best practice guidance. Random sampling of people's routine medicines tallied with records confirming they were receiving their medicines as prescribed by their GP.
• Medication Administration Records (MAR) records were completed in full. However, where people's medicines were administered by a community nurse there was no was no record of this on the MAR, or a tally of how many medicines were in stock. The management team told us they would ensure arrangements were put in place to reflect medicines given by other professionals.
• We observed two nursing staff administer medicines both in the morning and afternoon. They followed best practice guidelines for administering medicines and we saw they interacted with people well. They explained what the medication was for and why it was needed.
• Where medicines were prescribed on an 'as required' (PRN) basis, clear protocols were in place to guide staff when these should be administered. For example, regular use of pain relief included prompts for staff to look at signs of constipation. Where people were at risk, staff were promoted to consult with the GP to consider if they should discontinue or change the prescribed pain killers.
• Staff responsible for administering medicines had received the appropriate training. Systems were in place to check their practice and competency.
• Medicine audits were carried out on a regular basis and any discrepancies were investigated appropriately.

Requires Improvement

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: At this inspection this key question has remained the same.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• The providers website states the service specialises in Alzheimer's and challenging behaviour, however we found staff were not always working in line with national guidance and best practice. Staff told us they had completed dementia training, but not all staff were aware of the different types of dementia, and how this may impact on people's health and behaviours, such as Lewy Body Dementia, often linked with Parkinson's, and challenging behaviour. One relative told us, "I think the staff are trained in care, but maybe not enough in dementia care."
• Staff told us they had completed computer-based learning about challenging behaviour, but this did not include how to manage physical aggression. One member of staff commented, "We have not been taught 'breakaway' techniques and staff are expected to manage physical aggression the best way they can." The area manager told us positive behaviour support training was planned for 06 March 2020.
• Where people had specific health conditions, such as epilepsy, a care plan in line with the National Institute for Health and Care Excellence (NICE) guidance was in place. These plans contained general information about the condition, with no information on how staff were to manage the risks to the individual, or what to do if they had a seizure. However, the area manager told us there were two qualified nurses on each shift trained in dealing with seizures and 87% of staff had received training in basic life support, including epilepsy and how do deal with a seizure.

Staff support: induction, training, skills and experience
• Staff told us they had received training to ensure they had the skills and knowledge to meet people's specific needs. However, the training matrix showed not all staff were up to date with training, including manual handling. Eight out of 16 staff's manual handling training was out of date, with two staff new to care not having had this training before working with people needing assistance to move. The area manager told us dates for manual handling training was planned for 12 February 2020.
• There was no system in place to assess the quality of training, staff's knowledge and understanding of training delivered, and their competency to deliver safe and effective care. For example, staff told us they had completed safeguarding training, but had failed to recognise and report incidents of abuse.
• Inductions of agency staff needed to improve to ensure they were familiar with the premises, safety matters and had the skills and knowledge to carry out their roles. Records showed 21 agency staff were used between December 2019 and January 2020, 16 of these agency staff had no record of induction to the service.

Failure to properly induct agency staff and ensure permanent staff have the knowledge, skills and competence to carry out their roles has placed and continues to place people who use the service at risk of harm. This is breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• New staff told us they completed an induction when they joined the service, which included shadowing experienced staff. Comments included, "This is my first job in care, I have found it challenging, it's definitely an experience, but I do like it here. Everyone's been helpful, I love it a lot".

Staff working with other agencies to provide consistent, effective, timely care
• Staff understood people's health care needs and supported them to access other health professionals, such as the GP, tissue viability nurse and the Speech and Language Therapist (SALT). However, advice from professionals was not always updated in people's care records. For example, where a person had been referred to the SALT due to swallowing difficulties, recommendations to minimise the risk of choking had not been updated in their nutrition and hydration plan. Therefore, staff unfamiliar with the person, such as agency did not have the most up to date guidance to follow, which continued to place the person at risk of choking.
• The service worked well with Medication Optimisation Team (MOT) and local GP surgery to ensure people received the right support and medicines to ensure best health outcomes.
• Nurses also described positive working relationships with the tissue viability nurses to understand and meet people's needs in relation to pressure wound management.

Adapting service, design, decoration to meet people's needs
• Aspen Grange is a purpose-built home arranged over two floors providing safe and comfortable accommodation for people needing residential, nursing and dementia care.
• The premises were accessible and suitable for the needs of the people living there, with aids and adaptations to encourage independence.
• Assistive technology and equipment were provided to meet people's needs and ensure risks to their safety were minimised. One relative told us, "My [Person] goes walk about at night, but they have a sensor mat now, so staff know when that happens' and they can be settled back down again."

Supporting people to eat and drink enough to maintain a balanced diet
• People and their relatives were complimentary about the food provided. Food looked appealing and appetising. One relative told us, "The foods very good here."
• People were provided with the support they needed to eat and drink. Drinks including, water, juices, tea and coffee were readily available and offered by staff throughout the day, reducing the risk of dehydration.
• People's preferences, including vegetarian options were catered for. Staff offered people plated meal options to help them make a choice of what they wanted to eat. Fresh fruit and snacks were available in lounges and dining areas and easily accessible to people.
• A record was completed daily of what people had eaten and the amount to ensure they were having enough to eat or drink and maintain a healthy balanced diet.

Supporting people to live healthier lives, access healthcare services and support
• Where required prompt referrals to the appropriate health services, such as the falls team and community psychiatric nurse had been made.
• People were supported to see their GP, and health professionals when needed. Relatives commented, "My [Person] had a fall and broke their arm. Staff were very good and called us a soon as it happened", and "We can phone up and ask questions about [Person] and if they need hospitalisation staff will take them straight in, they always phone, so we know they are safe and being looked after.''

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• Peoples care records contained information on how staff supported them to make day to day decisions. Staff understood the importance of gaining consent before providing support and were observed doing this consistently during the inspection.
• Management and staff knew what they needed to do to make sure decisions were taken in people's best interests.
• Where people had been deemed to lack capacity to make significant decisions about their care, health, welfare and finances, relevant people including their Lasting Power of Attorney and health professionals had been involved.
• DoLS applications had been made where needed and approvals were monitored to ensure any conditions on authorisations were being met.

Requires Improvement

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. At this inspection this key question has now remained the same.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
• People did not always receive a service which was caring as they were not always protected from potential risk, as documented in the safe area of this report. We saw people constantly pacing corridors, banging on doors, and shouting, with minimal input from staff. People's anxieties and agitation manifested in arguments whenever staff were not present, resulting in people swearing and shouting at each other.
• People's relatives and staff told us there was not enough staff deployed to provide meaningful engagement and keep their family members safe. Staff comments included, "I do try to make time to sit and talk with people, I'd love to sit and play dominoes, but it's difficult to fit this in between tasks, and paperwork," and "People are lacking stimulation, and screaming out for attention, it's very frustrating for staff."
• However, we did observe some positive interactions between people and staff. Staff treated people with kindness and demonstrated a caring attitude. People had developed good relationships with staff and looked comfortable in their company.
• People's relatives were positive about the caring attitude of staff. Comments included, "The staff at Aspen Grange, work extremely hard, to keep people, clean, happy, comfortable, well fed and as far as possible engaged. They give excellent care to people who can be extremely challenging, they always stay calm and are very patient", and "We've found the carers really kind and very patient with my [Person]."

Respecting and promoting people's privacy, dignity and independence
• People's relatives had nothing but praise for the care their family member received. For example, one relative told us, "The staff are always happy, and cheerful. Nothing is too much trouble. They try so hard and work extremely hard."
• Staff understood the need to respect people's privacy and were observed knocking on people's doors before entry and then closing it behind them when delivering tasks such as personal care.
• People were supported to maintain relationships with those who were important to them. People could visit at any time and were welcomed by the staff team.

Supporting people to express their views and be involved in making decisions about their care
• Care plans outlined family involvement in planning their relatives care, including consenting to care and treatment where their relative was deemed not to have capacity to make those decisions.
• People's relatives told us staff kept them informed about changes in their family member's health. One relative said, 'The communications with staff are very good indeed' they keep us informed on our [Person's] progress, we are very satisfied with the home, the staff are so helpful and kind.'

• People were encouraged to make day to day decisions about their care, support and where required treatment. For example, we saw a member of staff have a conversation with a person complaining of pain. The staff offered them a choice of one or two pain killers to help manage the pain.
• Where people refused care, this was respected. For example, a person refused their medication. This was clearly documented, and attempts were made to try again later in the day. The nurse on duty explained they would seek advice from the person's GP if they continued to refuse.

Requires Improvement

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. At this inspection this key question has now remained the same.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• People, their families and health professionals had been involved in completion of pre-admission assessments to determine the person's needs, however these initial assessments had not always carried information over in to their care plans. For example, one member of staff listed a person's main needs as migraines and reduced mobility, but there was no record of this in their care plan.

• Although people's care plans contained detailed information about their health conditions these did not always provide practical steps for staff on how to meet the persons specific needs. For example, one person's pressure care prevention plan provided a lot of generic detail about pressure wounds and potential risks but did not clearly state what the risks to the individual were, or what actions staff needed to take to minimise these.

• Care plans were not always updated when people's needs changed. For example, a person's care plan talked about their ability to independently mobilise, but there was information from a physiotherapist stating they needed support to use a walking frame.

• People's protected characteristics, such as age, gender, and sexuality had been assessed and recorded in the equality, and diversity section of their care plan, however there was no guidance for staff to support people's choices around their sexuality or manage inappropriate sexual behaviours.

• Care plans had been developed using a framework with a four-stage approach to interpreting people's communication and responding appropriately. The deputy manager told us this approach was designed to understand and engage well with people who have dementia. They commented, "People with dementia don't always understand or listen to reasoning but do understand how they feel." Although this was a good initiative to ensure people were listened to and valued, staff had not been trained on how to use this approach, and we saw limited use of this approach during the inspection.

The failure to develop clear personalised care or treatment plans placed people at risk of receiving inappropriate care and treatment. This is breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

• Systems were in place for people to report compliments, raise concerns, or make complaints. However, people's relatives told us they were reluctant to complain, or had complained but nothing had happened. One relative told us, "My [Person] had a few falls and caught themselves on the edge of the foot board. The edge of the board is very sharp, I have covered it in foam, but a different bed would solve the problem. I

contacted the management team about this and wrote a letter. I was told the bed would be raised higher, but nothing's happened." Another relative commented, "I'm reluctant to address problems as I don't want to make a fuss and I don't know who the manager is anyway."
• The complaints folder contained four complaints which had been made since our last inspection. The PIR stated the main trend of these complaints was identified as failings in the care and welfare of people due to the number of agency staff being used. Records seen confirmed this and showed these complaints had been investigated and responded to appropriately.

Meeting people's communication needs
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.
• The provider had implemented some processes to meet these requirements, such as providing information about the service and how to complain in an easy read format and large type for people with sensory loss.
• Notice boards contained information about activities, the date and meals using a variety of graphics and text, however we found the information was not always accurate or related to the right days.

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 service had an activity organiser; however, they were not on duty on the first day of the inspection and we saw people had very little to do. Most people sat in the same chair asleep, all day, (except for lunch time) with minimal engagement from staff. There was minimal activity or engagement taking place to give people meaning to their day, and people became restless and verbally aggressive.
• In contrast the activity organiser was present on the second day of the inspection, and we saw an improvement in the activities provided. This was confirmed in discussion with relatives, who told us, "They have got a new activities person, they are lovely, [Person] has done some great things, like making Pizzas, and fruit kebabs," and "One of the staff brings their dog in, the residents love that and once a month they have an exercise session, all that's great too."
• The activity organiser described in detail a range of activities they provided on a weekly basis, which included one on one activities, group activities and booking external entertainers. They commented, "I ask individuals what they would like to do, 'residents' choice. They give me some ideas, but I roughly know what I'm going to do the week before. This week is cooking, movement to music, and remembrance (reminiscing). I will change whatever I have planned if people aren't enjoying it. When I'm not here, I put out boxes containing dominoes, books, puzzles and cards, so that staff can interact with the residents."
• The activity organiser told us, "I encourage people to engage in activities, based on previous life experiences, for example, one person used to be a secretary, so I got them a type writer and they help me with book work."

End of life care and support
• At the time of this inspection no one using the service was being supported with end of life care. The management team told us they were experiencing problems where hospitals were discharging people for palliative care, but finding they were not actually at end of life. For example, a nurse explained a person had been admitted two weeks ago, however it was felt they were not on end of life, and their health had improved.
• A review of people's care plans showed advanced care planning was in varying stages. One person's records contained a PEACE (Proactive Elderly Advance Care) advanced care plan, completed in hospital. Other people either had plans in development, or no information about their end of life wishes, including decisions about whether they would wish to be resuscitated if they suffered cardiac arrest or died suddenly.

• The clinical lead advised arrangements for when people were dying were managed as and when they were deemed to be end of life. They told us there was no specific pathway used at the service, but if a person became end of life, they completed an advanced care plan. This reactive approach meant people's preferences at the end of their life to have a comfortable, dignified and pain-free death may not be met.

We recommend that the service consults with a reputable source, such as the National Institute for Health and Clinical Excellence and /or the Gold Standard Framework (GSF) to develop end of life plans ensuring people receive appropriate care at the end of life.

Inadequate

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. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed to have effective systems in place to monitor the quality and safety of the service They had not identified the areas of concern in relation to staffing levels, staff knowledge, maintenance of the building and equipment. This was a breach of regulation 17 (Good Governance) 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 17.

• The service does not currently have a registered manager in post. The previous manager resigned in March/April 2019. A new manager had been recruited and was due to commence in post on 20 January 2020.
• Although interim managers had been appointed by the provider to manage the service in the absence of a registered manager, the lack of continuous provider oversight and leadership has resulted in an increase in whistle blowing and safeguarding concerns not being identified and addressed in a timely way, and low staff morale. One member of staff told us, "We have a new manager starting next week, each and every one of the carers have a good heart, they just need leadership."
• The management team acknowledged there had been failings in the service, and knew what needed to improve, however frequent changes in management team has seen improvements made, but not sustained. For example, initiatives such as PROSPER, (a programme to improve safety and reduce harm to people using services) and the dementia Butterfly scheme were commenced but were not fully implemented. If used, these initiatives could help to improve the quality of the care people receive.
• The provider had systems in place to monitor the quality and safety of the service however, these were not robust nor effective because they had failed to identify and address safeguarding issues, staff deployment, staff knowledge and understanding and the lack of cleanliness we found during this inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility.

• People, their relatives and staff told us the constant change of managers and high agency use has impacted on the culture in the service and the quality of the care people received. A relative commented, "The staff are really kind to my [Person] they really help them, but they don't have enough time for the residents. There's a high proportion of agency staff here, because staff are leaving. The other thing is, there seems to be too many changes of managers here."
• In the last year, the PIR reflects 36 staff had left the service, resulting in high levels of agency staff being used. Although efforts had been made to ensure the same agency staff were used to provide continuity, the level of demand to safely staff the service meant using agency staff who did not know people's needs which had led to incidents of poor care and complaints about the service.
• Staff were divided in their opinion of the culture and morale in the service. Of the eight nursing and care staff spoken with, two felt supported by the management team. Comments included, "Very supportive management, I can go to the deputy with any problem and they always try to help," and "All staff are really nice, we all help each other out."
• The other six staff told us, staff morale was low, they didn't feel supported by the managers, felt frustrated as they didn't have time to fully meet people's needs and didn't feel appreciated, which resulted in high staff sickness. Comments included, "It's not little things that need to be changed, it's the culture. There's no trust between staff or the management. Management pave over cracks," and "I like working here, but it's management that's the problem. Sometimes I can talk to them, other times, I get very little response. It's like that all the time."
• Staff supervision to support professional development was inconsistent. Staff commented, "I am supposed to have supervision every three months, but I can't remember when my last one was," and "I haven't had supervision since I've started." The area manager confirmed supervision had been lacking and showed us a planned programme for 2020.

Engaging and involving people using the service, the public and staff.
• The minutes provided reflect the last relatives' meetings were held in March 2019 and May 2019. One relative told us, "It's the first relatives and resident meeting for ages this week." Another commented, "There's are relatives meeting, but these haven't happened much recently were hoping the new manager will get these going again soon."
• The minutes provided of staff meetings showed these had taken place, each time a new manager was in post. The last meeting was held on 30 October 2019 but was not well attended. Other meetings were taking place, including 11 at 11, health and safety and heads of department meetings to improve communication in the service, however records of these meetings contained minimal detail of discussions and agreed actions.

Continuous learning and improving care.
• Audits had not identified shortcomings in the deployment of staff. The clinical lead told us a trial to increase an extra member of staff in the evening and change the deployment of nurses had not shown any advantages, and this had been stopped. There was no analysis or clear rationale to support this decision. The management team acknowledged this was something they have not developed enough and wanted to improve.
• There was no formal system in place to ensure incidents occurring in the service were reviewed and monitored. For example, people's care records contained information where they had been involved in physical altercations with other people. Incident and accident records did not include this information. Neither was there a record of action taken to remedy the situation, protect people, prevent further occurrences and make sure improvements were made as a result.
• The area manager told us the biggest challenge at Aspen Grange had been reducing the amount of agency staff and recruiting permanent staff. Recruitment of new staff was ongoing, and we saw at inspection several new staff had been recruited.

• The area manager told us to improve the quality of the care people received, specific staff had been designated as champions in areas such as dementia, infection control, end of life and pressure wound care. These champions were responsible for training, inspiring and motivating other staff to ensure people received better care.

Working in partnership with others.
• Representatives of the local authority and Mid Essex Clinical Commissioning Group (CCG) told us the service had worked well with them in an open and honest way to improve the service.
• Feedback from the CCG, Medicines Management Team reflected there have been communication issues between the surgery, pharmacy and Aspen Grange which they are working to resolve.
• Where previously safeguarding incidents had not been reported to the appropriate authorities, such as the Local Authority (LA) safeguarding team or the Commission in accordance with current legislation and regulations, the service has been more open and transparent when raising safeguarding concerns, and sharing lessons learnt within the teams.