Bupa Care Homes (BNH) Limited

Aspen Court Care Home

Inspection report

Aspen Drive
Spondon
Derby
Derbyshire
DE21 7SG

Tel: 01332672289

Date of inspection visit:
20 September 2017

Date of publication:
05 January 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 20 September 2017 and was unannounced. Aspen Court Care Home provides long term and respite care for adults with a range of physical and nursing needs. This includes palliative and end of life care. The service is registered to accommodate 40 people. At the time of our inspection 38 people were using the service.

The last inspection took place in November 2016 before BUPA (the provider) changed their legal identity to BUPA Care Homes Limited. This was the first inspection of the service since the legal entity changed on 31 January 2017.

A registered manager was 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.

People did not always receive their prescribed medicines at the right time. We found gaps in the records that showed the systems to manage and store medicines, was not safe.

The provider was mostly meeting their regulatory responsibilities. The provider's governance system was not used effectively. A range of quality audits were carried out. Shortfalls were not always identified and any improvements made were not always sustained. System to support and manage staff was fragmented. Opportunities to make comment about the service were limited. The registered manager acted on complaints and feedback from surveys. We found the registered manager was responsive and had acted on some of our feedback immediately. That showed they were committed to improving all aspects of Aspen Court Care Home.

People had a choice of food, drinks and snack which were available throughout the day and night. Catering staff were knowledgeable about people's dietary requirements and planned menus that were nutritious and balanced. Despite this, some people's nutritional needs were not always met due to inconsistences found in the records used to monitor the nutritional needs.

People had access to a range of health care services but recommendations made by health care professionals were not followed and not always included in the care plans. The registered manager was responsive and took action to ensure people's health needs were met.

Comments from people, their relatives and staff; and our observations found that staffing levels were not always sufficient to consistently meet the needs of people who used the service. We identified this was an area of improvement as to how staffing levels were determined in the detailed findings within this report.

Staff knew how to keep people safe and understood their responsibility to protect people from the risk of

abuse. People's safety was promoted and protected from avoidable harm. Risks were assessed, managed and reviewed regularly. Measures were put in place including the use of equipment to support people safely and promote their independence.

People lived in a clean environment. Regular checks were carried out on the premises and equipment used in the delivery of care.

Staff recruitment procedures were robust. Staff received appropriate induction and training for their role. Staff felt confident to approach the registered manager when required.

People were supported to have maximum choice and control of their lives. Staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People developed positive relationships with the staff. They found staff to be kind and caring. Staff knew people who used the service well and respected their wishes with regards to their care and support needs. People's dignity and privacy was promoted and maintained by staff. Records showed that people and in some instances, their relatives, had been involved in the development and review of their care plan. This enabled staff to provide care and support that respected people's preferences.

People mostly received personalised and responsive care when they needed it. Care plans contained information about people's preferences and how staff should support them to meet their individual needs. Care plans were reviewed regularly.

People maintained contact with family and friends. People's religious needs were met. People had opportunity to take part in a range of social events, activities and accessed the wider community. This enhanced people's health and wellbeing and protected them from the risk of social isolation and loneliness.

People knew how to make a complaint and were mostly confident that action would be taken. A complaints process was in place and records showed complaints were handled appropriately. Advocacy information was made available to people.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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 consistently safe.

Medicines were not always managed and administered at the right time. Feedback from people and staff and our observations found that staff were not consistently able to support people when required. We have made a recommendation as to how staffing levels are calculated within the report.

Risks associated to people's needs were managed safely. People's safety was promoted through the robust recruitment process for staff. Staff understood how to keep people safe. They were trained to recognise abuse and respond to allegations or incidents. People lived in a clean environment that was maintained. Staff followed the infection control procedures.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had the skills and experience they needed to meet the needs of those in their care. System's to supervise, support and improve communication with staff team were not used fully.

People made daily choices and decisions. Staff obtained people's consent before supporting them. People's rights and liberties were protected in line with the Mental Capacity Act 2005.

People's nutritional and health needs were not always met. External health care professionals were involved in people's care as appropriate, but their recommendations were not always followed. There were inconsistencies found in care records used to monitor health. Despite this, some people's health conditions had improved.

Is the service caring?

Good

The service was caring.

People were cared for by kind and compassionate staff. They knew people they cared for well and communicated with them respectfully and in a way they would understand.

People were encouraged to make decisions about their daily lives and the support they received. People and in some instances, their relatives were involved in decisions about their care. People received care that respected their privacy and promoted their independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care needs had been assessed and were involved in the development and review of their care plan. People mostly received personalised care albeit with some delay. Care plans were reviewed regularly but there were inconsistences in the care plans and records used to monitor people's health.

People's preferences, interests and hobbies were taken into account when planning social events and activities. The activity organiser was proactive and adapted activities to ensure people were not excluded.

People were confident to make a complaint. A complaints process was in place and staff knew how to respond to complaints but improvements were not sustained. Advocacy information was made available to people.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The registered manager understood their role and responsibilities. Staff felt supported by the registered manager despite a fragmented system to support staff and manage staff. People had limited opportunities to make comment about the service. There were limited opportunities for people to make comments or influence the development of the service.

The provider's governance system to assess and monitor the quality of service and drive improvements was not used effectively. Lessons were not always learnt as improvements made were not always sustained.

Aspen Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 20 September 2017 and was unannounced. The inspection team comprised of two inspectors, a Specialist Professional Advisor and an Expert by Experience. The Specialist Professional Advisor had experience of working and caring for people within health care and managed care services. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in older people living with dementia.

Before the inspection we reviewed all the information we held about the service. This included concerns received about the management of medicines and staffing levels. We reviewed notifications we had received from the provider. A notification is information about important events and the provider is required to send us this by law. We reviewed the provider's statement of purpose. A statement of purpose is a document which includes the aims and objectives of the service.

We contacted commissioners for social care, responsible for funding some of the people that use the service and Healthwatch Derby and asked for their views. This was used to inform our judgements.

We spoke with 10 people who used the service and five family members who were visiting their relative. We spoke with the regional manager, registered manager, deputy two registered nurses and six care assistants. We also spoke with the chef manager, house-keeper and the activity organiser. We used the Short Observational Framework for Inspection (SOFI), which is a way of observing care to help us understand the experience of people who used the service and we made direct observations of staff's interaction with people who used the service.

We looked at the records of 10 people, which included their risk assessments, care plans and the daily care records. We looked at a sample of people's medicine and three people's medicines records. We also looked at the recruitment records for four members of staff, staff training records, meeting minutes and a range of

quality assurance audits and records. We reviewed the information sent to us by the registered manager following our inspection visit.

Requires Improvement

Is the service safe?

Our findings

People's medicines were not consistently managed and administered to people as prescribed. During the staff handover meeting the nurse from the night shift reported that two people had not had their early morning medicines. There were two medicine rounds; early morning [before breakfast or at 6am] and morning. The nurse administering the morning medicines was not aware of this information despite being in the handover meeting. When they checked medicines for those people who had the early morning medicines, they found the medicines had not been dispensed. The medicines were administered three hours later than prescribed. It raised concerns that people were at risk of not receiving their medicines at the right time because staff did not routinely check at the start of the morning medicine round that the early morning medicines had been given, even though it was reported at the staff handover meeting.

A person told us that they did not receive their medicines they needed before breakfast to manage their health condition. When they complained, it was arranged that the night staff left the medicines in their room at 6am so that they could take it when they woke up. The medication administration records (MAR) had been signed to confirm the medicines were taken but was not witnessed by staff.

We found people who were prescribed topical creams did not always have these applied to manage their specific skin conditions. For example, two people with pressure sores were prescribed barrier cream to be applied to the affected area. The MAR was not always completed and there was no other record to confirm that the topical cream had been applied.

We found a third person's daily records completed by staff made reference to topical prescribed creams being applied. Although a topical MAR chart was in place it was not completed. Another person had no topical MAR chart in place even though they had been prescribed creams to treat their skin condition. Again no other record was found to confirm the creams had been applied.

We found medicines were stored securely. We found gaps in the room and fridge temperate records for the month of September 2017. This meant the risk of medicines not stored within the manufacturers recommended temperature range to ensure they were safe to use.

We shared our findings and concerns about the management of medicines with the registered manager to address.

This was a breach of breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people's medicines were always stored, managed and administered safely.

Throughout our inspection visit we observed there were busy times in the day. Staff's ability to respond to people's needs depended upon the support they required and the needs of others. We observed a number of instances whereby some people's requests were responded to within minutes whilst others had to wait for more than 10 minutes before staff were able to support them.

People's views about there being enough staff to respond and meet their needs were mixed; "I sometimes have to wait for 20 minutes. They sometimes respond within minutes but longer when they are very busy. My longest wait was for an hour" "When I ring the buzzer they should be here within 15 minutes. They eventually come. But it's not good enough" and I have to wait quite a while. Sometimes more than half an hour."

Relatives also had mixed views about the staffing levels and staff's ability to respond. A relative told us that staff regularly checked on their family member who was nursed in bed and was unable to use the call bell. Another relative said, "I know they are understaffed, especially at weekends. My [family member] visited this Saturday and no staff were visible. Nobody had midday drinks. They were very short staffed."

Staff told us there had been staffing issues and felt that this had improved. At a staff meeting ideas were shared as to how staffing could be improved. As a result staff were allocated specific areas of the home and were responsible in providing care and support for those people.

We shared some of our observation and feedback we received with the registered manager. They used the provider's staffing tool to determine the number of staff required and the staff rota showed staffing levels were being managed. They acknowledged there had been changes in the staffing and unplanned staff absences were covered by existing staff or agency staff, if possible.

We recommended that the service re-evaluates the current dependency tool used and monitor how staff are deployed. This would ensure there were consistently sufficient numbers of staff available, to safely meet people's needs and to respond to requests to keep them safe.

We asked people if they felt safe and why. A person said, "Because the staff are kind and caring which gives me assurance." Another person said, "The security is very good and I have had no falls." A relative said, "A carer spoke inappropriately to my [relative]. I mentioned it to the manager and this behaviour stopped." Information about how the service handled any alleged abuse was included within the information given to people when they moved to the service.

Staff had received training on a range of topics related to safeguarding procedures and health to promote and maintain people's safety. A new member of staff told us they had received safeguarding training and were confident to report concerns or use the provider's whistle-blowing procedures. When we asked another staff member about their understanding of safeguarding, they said, "To protect service users, to make sure they're not abused such as financial, institutional, physical, neglect."

Staff were aware of safeguarding procedures and the signs of abuse. A staff member said, "There is different types of abuse, like physical, financial, verbal like shouting and emotional. I've not seen anything like this but if I did I'd go straight to the manager with it." Staff were confident to report concerns to the management team and the external agencies such as the local authority, Age UK and Care Quality Commission. This assured people that they were protected from avoidable harm.

The provider's recruitment procedure ensured the staff employed were safe to work with the people using the service. Recruitment records contained relevant checks including an enhanced Disclosure and Barring Service (DBS) check. A DBS is carried out on an individual to find out if they have a criminal record which may impact on the safety of those using the service. A further check was carried out of nursing staff to ensure they were registered with the appropriate professional body, which meant they were registered to provide nursing care safely.

Potential risks to people had been assessed, identified and measure put in place to manage them. These

covered a variety of subjects including, moving and handling and falls. Care plans provided staff with guidance as to how they were to support people to stay safe and where assessed the equipment used to maintain people's safety such hoist used to move people. Staff told us, and records showed risks were reviewed on a regular basis and updated when required. This showed the people's freedom and human rights were supported and respected.

Upon our arrival at Aspen Court Care Home at 6am, we found the premises were secure, but the external lighting leading the entrance to the service was not working. There were potential risks of falls to people and visitors when entering or leaving the service and no deterrent for unwanted intruders. Maintenance staff had ordered the replacement light when the fault had been reported at the weekend. The replacement light was being fitted on the day of our visit.

A person sat in the dining room comments that another person appeared uncomfortable. They noticed that the person was not seated on a pressure cushion. When it was mentioned to a staff member they promptly fetched an appropriate cushion and supported the person to stand whilst the cushion was put into place.

We observed staff supported people to move around safely. Two staff assisted a person to move from their wheelchair into an armchair using the equipment correctly. Staff member's communicated clearly what they were doing and checked the person was seated comfortably.

People told us they lived in a safe environment and staff followed the infection control procedures. The premises were clean and regular safety checks were carried out. Records showed that visual safety checks on equipment such as blood pressure machines were not always completed. Inaccurate reading or malfunctioning equipment could affect the care and treatment people received. The registered manager assured us that they would address this.

There were plans in place for emergency situations such as an outbreak of fire and personal emergency evacuation plans (PEEP) were in place for all people using the service. This meant that staff would have sufficient guidance on how to support people to evacuate the premises in the event of an emergency.

Staff knew what action to take in the event of an accident. Records showed all incidents were documented and action was taken to prevent further risks. The provider had an extensive business continuity plan covering potential situations and events, such as a power failure, flood or fire. This, if activated, would mean the registered manager and staff would follow the emergency procedures that would enable them to provide support and care to people to keep them safe.

Requires Improvement

Is the service effective?

Our findings

We found some inconsistencies to ensure people's nutritional needs were met to sustain good health. Staff had sought advice from health care professionals to manage risks associated to people's eating and drinking. A care plan for a person at risk of poor nutrition and weight loss reflected the speech and language therapist (SALT) recommendation. Records showed the person had their food and drink fortified using full fat cream and milk. This was not the case for everyone. For example, a person was prescribed nutritional supplements due to weight loss. A fluid target had been set but there was no guidance for staff to follow as to the action to take should the target not be reached. The target had not been reached and no evidence of the action taken by staff.

Another care plan we reviewed had no nutritional or health needs identified. However, a letter from the hospital showed the person had an appointment for diabetic screening. Care plan contained no information about the person's dietary needs.

We found care records were not always accurate to reflect guidance provided by SALT and dietician for a person who received their nutrition via a feeding tube. SALT had recommended that the fluid consistency should be 'custard thick' but in the care plan it stated the consistency should be 'syrup'. Feedback from staff as to the consistency of fluid also differed. The dietician had recommended that fluid intake should be between 2500mls to 3000mls but there was no record found that showed how much the person had consumed. The lack of adequate supply of food and drink could result in further health risks.

We shared our findings with the registered manager. They assured us that they would review people's eating and drinking care plans and seek advice from healthcare professionals.

We saw menu cards and picture menus were available in the dining area. There was a choice of breakfast, lunches, tea-time meals and light snacks and drinks available throughout the day and night.

People arrived in the dining room for breakfast at different times. Each person was asked what they would like to eat. People had a choice from cereals, toast to cooked breakfast. One person chose toast with preserves and another had scrambled eggs and bacon.

People spoke positively about the meals. "The food is lovely, yesterday we had roast lamb, it was so tender it melted in your mouth," "I get a choice of food. There's plenty to eat", "You can get snacks if you need them," and "The food is ok. I'm on a partially restricted diet and can only eat small mouthfuls. I get enough to drink. Sometimes the food is cut up for me. But usually I can cut it up myself."

A relative said, "The food is excellent. Mum gets mashed up food. Her fluids are being monitored." Another relative said, "There is plenty to eat and drink. She gets snacks in the morning. There is cake and fruit. When she was losing weight before, [catering staff] put more butter in [the food]. If she doesn't feel like eating in the dining room then they bring food to her bedroom."

The chef had a good knowledge of people's dietary needs and preferences. They said, "I make a point of speak with the person or their relative about the meals they like to eat." The chef had received training on how to meet people's dietary requirement and prepared meals that were nutritious. They sought feedback on the meals individually and through meetings. The feedback was used to influence the menu choices and ensure preferred snacks and sandwich fillings were always available.

People were not consistently supported to maintain good health. A relative shared instances where their family member's health was put at risk because the breathing mask had not been placed over the mouth securely.

Some care records we looked at were not accurate or reflective of the support provided. Inconsistent record keeping contributed to people's health needs not being met. For example, a care plan stated the person should be re-positioned every two hours to prevent further risks of developing skin damage. Entries documented in the re-positioning chart ranged from 30 minutes to over eight hours. A staff member told us that they had re-positioned another person at regular intervals and despite the recoding issue, the person's wound had reduced in size. We shared our findings with the registered manager. They assured us that the issue of re-positioning and record keeping would be raised with the staff team immediately and monitored.

People told us staff were prompt to support them to access to health care services when they required it. They said, "I go to the hospital for check-ups," "I still have my own GP. The home also has a GP attached to it. I see the doctor occasionally" and "I'm going to the dentist today." Records showed people had access to a wide range of external healthcare services and their ongoing health needs were met. Monthly evaluation of people's care plans took account of healthcare professional's visits and treatment and where required care plans had been updated. For one person it meant they had regained their independence and mobility following a fall with the support of staff.

Most people told us that they received good care and that the staff who supported them had the necessary skills and knowledge to meet their needs. One person said, "Staff are not as good as they used to be. I get washed and changed alright. The communications could be better and one member of staff could be more polite." A relative said, "There are always two staff when they are moving or cleaning mum" and added that they were confident that staff had been trained to support people.

An experienced member of staff told us that their role included mentoring new staff. They said, "To ensure new staff are settled and confident, and that they are aware of whistle blowing [procedure] for example." A relatively new staff member described their induction as, "The first week I did training completing booklets in the kitchen, fire safety, and hoisting which included practical training." They found the training was adequate and felt by working with experienced staff they learnt how people liked to be supported with regards to their personal care needs.

Nurses told us they were supported to undertake the revalidation process for their qualifications. Staff member's explained how training had enabled them to provide good quality care. They referred to the end of life training provided by MacMillan. They now understood more about people in receipt of end of life care and the negative impact eating and drinking had on their physical health. Another staff member felt they would benefit from training in Parkinson's disease. The insight would enable them to support people with this condition. We shared this with the registered manager.

Training records showed staff received ongoing training in a range of topics to ensure they had the knowledge and skills required to meet people's needs. Staff were supported to attain a professional qualification such as the care certificate, a nationally recognised introduction to care and specialist training

such as dementia care to support people living with dementia.

Staff comments as to the frequency of supervisions and staff meetings were mixed. One staff member had received one supervision meeting in the last 12 months and another was supervised six weeks ago. Staff meetings were ad hoc and did not always take place monthly as set out by the provider's policy and procedures. We shared our findings with the registered manager. They had already identified this was an area that needed to be improved. One improvement introduced was the 'mentor system' for all new staff to support them during their induction. A staff supervision schedule had been developed so that staff would be made aware of their supervision meeting dates in advance. We will continue to monitor this.

The registered manager and staff we spoke with understood their responsibility under the Mental Capacity Act 2005 (MCA). Records we viewed showed that staff had received training on these subjects. The 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. The application procedures for this in care homes and hospitals are called 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 were being met. Eight people had an authorised DoLS in place One person had a condition attached to their DoLS and had a best interest decision in place should they decline to take their medicine. Their care plans provided staff with clear guidance as to how to support the person with their medicine. Records showed that the person had not declined their medicines to date. Another person's records included a Lasting Power of Attorney (LPA) agreement. It detailed the person who had the legal authority to make decisions on behalf of the person with regards to their health needs or their financial affairs.

All records containing information about people's care and support were reflective of the principles of the Mental Capacity Act 2005. That meant the principles of the MCA were followed.

A system was in place monitor the authorisations to ensure they were renewed as necessary. These included the new DoLS referrals sent to the local authority.

Some people had made advanced decisions about their care with regards to emergency treatment and resuscitation. This meant they had a DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) in place. This was put in place with the person's involvement, their relative and healthcare professionals. Decisions made had been documented, which assured the person that their wishes would be acted upon when needed as agreed by all parties involved.

A person said, "There are no restrictions on me" and added that they went on outings with their relative regularly. We observed staff sought consent before they assisted people. A staff member said, "Would you like to go through to the lounge" (having had their breakfast)," "Would you like to join us in reading today's newspaper and "Where would you like to sit to have your breakfast." That showed staff were aware of the need to seek consent, provide information and choices to enable people to make decisions.

Good

Is the service caring?

Our findings

People complimented the caring attitudes of staff involved in the delivery of care, management and staff with other responsibilities. A person described their experience of care had been positive. They said, "I couldn't praise [staff] anymore. I've never found any fault. They help me with anything." Other people said, "The staff here are lovely. They are so friendly and really look after me" and "The staff know my story. I'm a talker. Outside the bedroom is a frame with something [information] about me" and "Staff are excellent. Kind and pleasant. A few can be sharp. People are different."

Relatives told us they were welcome to visit at any time. A relative told us staff built positive relationships with their family member. Another relative said, "The staff are very polite. They know me by name now. [My relative] had an appointment and I couldn't go and so one of the carer's went. They went in a taxi." The relative felt this was an example of staff's caring quality.

Staff felt they provided a caring service. They knew the people well and had built positive caring relationships with people and their relatives. A staff member said, "You get to learn about the person by reading their care plan and more importantly spending time with them."

Throughout the visit we observed staff interacted with people in a warm and compassionate way. They supported people at a pace that suited them. We saw a person seated in the lounge became distressed when the staff member left them to support someone else. No other staff member was present so we offered some assurance by talking with them. After some time, the staff member returned to the person, whose mood positively changed as a result.

Staff communicated with people effectively and used different styles of communication. For example, communication was enhanced with touch; at the same eye level with people who were seated and staff altered the tone of their voice appropriately. There was good humour exchanged and staff showed an interest in what the person had to say. We saw a staff member knelt down so they were at the same level when they listened, and spoke clearly and allowed the person time to process the information before they replied.

People we spoke with were aware of their care plans. A person said, "Yes, my care plan is in the office. Staff bring it up and I get a chance to review it." A relative told us they were aware of their family member's care plan and would be involved in the review meeting if their family member wanted their support.

Care plans indicated people or their relatives were involved in the development of their care plans and in their review. Care records contained information regarding people's life history, individual preferences as to their daily routines, choice of food and past times. Care records showed that people had signed to confirm they were happy with the agreed care and support to be provided. A person's care records showed that they preferred the bedroom door to be closed at night and that the call bell was kept within reach. Records showed where relatives, in some instances, where appropriate, had been involved in the best interest decision-making process.

Staff treated people's information confidentially and care records were stored securely. The language and descriptions used in care plans and care records showed people and their needs were referred to in a dignified and respectful manner.

The service user guide emphasised that the service would not discriminate on the basis of relevant issues such as race, religion and sexual orientation. This message assured people and staff that they would be treated with fairness and respect.

People told us that staff respected and promoted their privacy and dignity. A person said, "Everyone knocks on the door. They sometimes close my curtains. My room is private." Another person said, "I can stay where I want. Downstairs most people go to sleep in the lounge. I prefer to read in my room."

We saw staff knocked on bedroom doors before they entered. Staff member's respected people's dignity by closing the doors and curtains before personal care needs were met.

Throughout the inspection visit we saw people looked clean and were dressed in clothing of their choice. People's nails were clean which showed that staff paid attention to their appearance. Staff maintained people's dignity when they were supported to move and adjusted their clothing accordingly. A person told us they continued to use their own hairdresser who visited the service regularly. For them it meant they were in control of their life and had a sense of wellbeing.

Aspen Court Care Home looked after people who received palliative and end of life care. Staff worked closely with health care professionals to support people towards the end of their lives. A staff member said, "We make sure the person is comfortable, free from pain and maintain their dignity because that's important." Staff had access to care plans where people had made an advanced decision about their care with regards to emergency treatment and resuscitation. This showed that people's choices and decisions were supported and would be acted upon when needed as agreed by all parties involved.

Two visitors we spoke with had had family member who used the service. They were happy with the care provided to their loved ones at the end of their lives and continued to visit the service to socialise with people who they had befriended.

Requires Improvement

Is the service responsive?

Our findings

People's care records showed that their needs had been assessed prior to their admission to Aspen Court Care Home. This process assured people how their needs would be met. Records showed people had been involved in the development of their initial care plans. Staff were given an overview of people's care needs when they moved to the service. We observed this to be the case during the morning handover meeting. This helped to assure people that staff would provide the care and support they needed.

People told us that staff had a good understanding of their needs but did not always respond promptly. This was partly because staff were not always available when required. Some relatives felt the care provided was personalised and promoted people's wellbeing. A relative said, "[My relative] looks well cared for. It's a lovely room. It feels like home from home." At lunch time we saw staff supported people with their meals in a sensitive and respectful manner. We saw a person had been provided with special cutlery which enabled them to eat independently.

A number of people and relatives we spoke with felt communication between the staff team could be improved. Staff acknowledged there were busy times in the day when they could not respond in good time but felt people's needs were met albeit with some delay at times.

A staff member described handover meetings as 'hap-hazard' and felt there was no clear system to update staff as to people's changing needs. Although the staff handover meeting on the morning of our visit was in depth, it was evident that not all staff took account of what was shared and followed instructions to ensure people received support when they needed it. When we shared the feedback with the registered manager they told us that that communication had improved but would continue to monitor as they and the deputy manager regularly worked alongside staff in the delivery of care.

We spoke with two staff members, one was relatively new and the other had worked at the service for many years. Both were able to describe how they supported two people with differing health conditions and the care and support provided. One staff member when describing a person's needs was considerate as to the phrases used so to maintain the person's dignity. The second member of staff explained that the person they supported would tire when walking short distances. A wheelchair was kept close by so when this happened the person was able to use it. This showed the person's independence was promoted with the support of staff.

A care plan was in place to support a person with sensory difficulties and included how staff should communicate. For example, 'staff to provide clear and concise instructions and advice when conversing'. This enabled the person to remain in control of their care and be assured staff communicated with them appropriately. Another person's care plan showed that they had been referred to and continued to receive support from a counselling service following a family bereavement. Staff we spoke with knew how to support the person when they became tearful.

The service had an activity organiser. They understood their role and were aware that social isolation and

loneliness is known to have a detrimental effect on people's health and wellbeing. They planned events and activities based on people's interests. They took account of people's ability to participate in activities; adapted activities to ensure people were not excluded and provided information in ways that people could understand. There were regular events held which included the monthly Communion service, cake baking, external entertainers including visits from the local school children and trips.

Our observations and discussions showed different sensory experiences were used to support people in engaging in activities. The activity organiser told us that if people could not visit the place of interest then they brought the place to the person through books, photographs and newspaper articles. This was an example of people protected from the risk of isolation. In the afternoon we saw people read books, magazines, completed jigsaw puzzles and played board games with the support of the activity organiser. One person told us about the different activities they had enjoyed and said, "Yesterday we were making masks."

Photographs displayed showed people had taken part in a range of social activities, hobbies and events. They had celebrated festivals within the year including Burns Night, Shrove Tuesday, The Chelsea Flower Show and summer picnics. The current event was the European Express. This was a way of visiting different countries each week, during a six week period in August and September to explore different foods and cultures. On the day of our inspection visit the country being visited was Italy. Events and outings were organised for people to access the wider community. These included links with the local schools and places of worship. A person told us a monthly service there held at the home but they preferred to attend a service at the Derby Cathedral with their relative. Another person told us that they had been on holiday.

Care records had information about people's personal histories and preferences to help staff ensure that people's individual needs were responded to. For example, in one care plan it included a person's interests in group activities and the outdoors. The notes completed by the activity organiser showed the person took part in board games, walked around the garden, arts and crafts, chair exercises and bingo. Another person's records showed that they had enjoyed visits by 'Ringo' the PAT dog and a trip to Derby Silk Mill. This showed how people's interests, hobbies and access to community resources meant the quality of people's life at Aspen Court Care Home had been enhanced because people had opportunity to socialise and pursue their interests.

The complaint policy and procedure was clearly displayed on the notice board along with information and contact details for the local authority and advocacy services. An advocate is a trained professional who supports, enables and empowers people to speak up. When we asked staff what they would do if people or their relative had any concerns about their care. They all said they would try to address any minor issues where possible or report it to the management team.

People and relatives we spoke with were confident to make a complaint. They said, "I've got no complaints; believe me I'm not shy in coming forward if there was someone wrong. I would be the first to say" and, "I am aware of the complaint procedure. We can fill in a form. At first I would talk to the manager. I had a concern about my morning tablet and that has been sort out."

A relative told us that they had seen the complaint procedure at the entrance of the service and would speak with a member of the management team and another had noted a suggestion box at the entrance should they wish to make comments about the service. Another relative shared some concerns about the care of their family member. These related to staff not being aware of how to support their relative, personal hygiene, cleanliness and regular wellbeing and safety checks not carried out. They told us that since they complained to the registered manager there had been some improvement.

Records showed the service had received six complaints in the last 12 months. These related to the quality of care provided, medicine and staffing. This included a relative's concern we received, which was referred to the provider to investigate. Records showed outcomes had been provided for each complaint and action taken to improve the quality of care people received. However, based on our inspection findings the improvements had not been sustained.

Requires Improvement

Is the service well-led?

Our findings

Aspen Court Care Home had a registered manager. They were 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.

People's views about the management and the registered manager were mixed. They said, "The place is well managed and kept clean. I don't know who the manager is" and "Managing this place could be improved. Staff do not respond quickly though it has improved a bit." Relatives said, "We go to the manager when we need to. She is not here on nights or weekends. The deputy is here on weekends" and "She [registered manager] is easy to talk to. The communications could be better especially by carers. Verbal messages don't always get through."

The provider had sought people's views about the service prior to changes to the provider's legal entity in January 2017. The registered manager told us that although people were satisfied in the service they received there were areas that needed to improve in relation to staff retention and some aspects of care. They were supported by the regional manager to improve staff recruitment and retention to improve continuity of care.

Opportunities to promote a positive culture or empower people and staff to be involved in the development of the service could be improved. People's comments about 'resident meetings' were mixed. One person said, "I am not aware of residents meetings." Relatives said, "Every two months there are meetings. You can say things to the manager. A carer comes to take minutes but their presence stops people speaking openly." Another relative was aware of the residents meeting and told us they had not received a satisfaction survey.

A resident meeting had been held on 1 February 2017 involving people using the service and their relatives. This had identified that a staff member would be based in the lounge / dining area at all times. It had been noted that this had a negative impact on staff's availability to answer and respond to call bells. This was supported by our observations. No other residents meeting were held which meant people were unable to influence how the service could be improved.

We found improvements were to ensure staff were supervised, supported and the communication between staff was effective. Despite the provider's expectation of quarterly staff meetings to be held, the most recent staff meeting for the day and night care staff took place on 10 and 17 May 2017. A number of issues had been identified and the date for the next meetings had been confirmed to review the progress. However, neither took place. A senior care staff meeting was last held in 24 January 2017. The next meeting planned for 28 February 2017 had not taken place. We noted that there had been no meeting for the nurses.

Inaccurate and inconsistent record keeping with regards to monitoring people's health and staff communication needed to improve. Whilst the staff handover meeting we had observed was in depth it was evident that there was no process in place to assure the management team that staff had acted on

information to ensure people's needs were met. An example of this related two people who would have missed their morning medicines if we had not enquired about them. Lack of staff accountability, ineffective communication and inconsistency in record keeping had a detrimental effect on how people's care and support needs were managed.

A staff member told us that they had attended one staff meeting since their appointment. They said ad-hoc meetings took place where they had discussed specific concerns and identified ways to improve which had a positive impact on people. For example, they had discussed specific concerns about people's weight loss and the positive impact made as snacks and drinks were now made available at supper time and were actively offered by staff. They added, "All staff are great here. I've felt very welcomed. It's a great place to work."

Staff had access to the provider's policies and procedures, which were stored electronically and included key policies on medicines, safeguarding and moving and handling. These were updated at the provider level, which meant the most up to date copies were available to staff at all times. Despite this we found medicines were not always managed safely and showed staff did not follow procedures consistently.

The registered manager demonstrated enthusiasm and commitment to driving improvements. Examples of some of the improvements already made included the refurbishment of the walk in wet room, decor and furnishing. They told us that improved nutrition and monitoring had improved people's health and weight as a result. Despite this they acknowledged that the management of people's medicines, and record keeping still needed to improve.

Throughout our inspection visit we shared concerns about people's care and care records with the registered manager. They were disappointed with some of the issues that we found but were open, transparent and responsive as to the actions they had already taken or had planned to take.

The provider's governance system was used to assess the quality and effectiveness of service. The provider had a monitoring system called 'operational essentials', linked to specific areas of auditing and monitoring. The registered manager told us that they continued to monitor the management of medicines as the improvements required had not been sustained. We looked at a sample of audits and action plans used to monitor improvements to bring about change. The reports only partly identified the issues we found on the day. We were shown the monthly training report which they used to identify training due for staff. This enabled the registered manager to manage and plan staff training however, further action was needed to assure people staff followed procedures and instructions correctly.

This was a breach of breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the governance system to monitor the quality of care people received and the management of the service was not used effectively.

The registered manager and deputy manager completed daily clinical 'walk arounds.' This enabled them to observe the provision of care and speak with people who used the service. They documented any areas of risk in relation to the environment and looked at people with clinical concerns such a falls, safeguarding concerns and those who were nursed in bed. They checked that the 'resident of the day', process was completed to ensure the named person's care and supporting records were up to date and staff from each department, such as the chef and house-keeping staff, ensured that all aspects of the individual's care and residency were appropriate.

Staff spoke positively about the registered manager. They told us that the registered manager had a 'hands

on' approach, provided leadership and managed the service well with the support of the deputy manager. One staff member told us that since the appointment of the registered manager they had been informed of the rota in advance. They found the registered manager was approachable and 'hands on' as they worked alongside in the delivery of people's care and support if required. Another staff member said, "It's more organised on the floor since [registered manager] appointment. She interacts with all the residents. She's very supportive and hands-on." They added that the staff worked well as a team.

The service received a number of compliments and thank you cards from people and relatives whose family member had used the service. These were taken into account in the monthly compliance visits that were carried out by the regional manager. These covered a range of areas of the service and included feedback from people who used the service, observations and review of records. Actions plans were developed from the audits and showed the action being taken by the registered manager to improve the service. For example, improvements made to the environment and the ongoing plans to address the management of medicines.

Audits carried out by external stakeholders showed no significant concerns and the service was compliant with the food hygiene, and health and safety regulations. Derby City Council who fund the care of some people who used the service found most people were satisfied with the care and support provided. They also reported similar concerns about the management of medicines and continued to monitor this area.

Following our inspection visit the registered manager confirmed that issues found in some people's care plans had been reviewed and their care plans were amended to reflect the current needs. Monitoring records and charts had been put in place for staff to document the support provided. A staff meeting had been planned to share with the staff team some of the issues found in relation to care provided, care records and communication between staff, and to identify solutions collectively. This showed that registered manger involved staff to make the required improvements.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not stored, managed and administered safely. Regulation 12 (2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance system was not used effectively to identify shortfalls and ensure improvements made had been sustained. People's views about the service were not sought consistently and acted on. System to support staff, communication and information shared was fragmented. Accurate records were not kept and the lack of accountability meant that ongoing risks relating to people's care could not be managed effectively. Regulation 17