Mrs D Roussel

Aspen House Care Home

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

We inspected Aspen House Care Home on the 6 and 8 May 2015. Aspen House Care Home is a residential care home that provides care and support for up to 15 older people. On the days of the inspection, 12 people were living at the home. Aspen House Care Home provides support for people living with varying stages of dementia along with healthcare needs such as diabetes, epilepsy and sensory impairment. The age range of people living at the home varied from 60 – 90 years old.

Accommodation was arranged over two floors with stairs and a stair lift connecting both levels. Some consideration had been given to the environment, making it dementia friendly. This included the use of signs and pictures to help orient people around the home.

A registered manager was in post, who was also the provider/owner. 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 and associated Regulations about how the service is run.

Staffing levels were stretched and staff commented they were often under pressure. People received the care they

Summary of findings

needed, however, poor staffing levels meant staff did not have the time to take people out for walks, to the local shops or provide one to one activities and stimulation. We have identified this as an area of practice that requires improvement.

A musical entertainer visited the home three days a week which people enjoyed. However, consideration had not been given on how to provide activities the remaining four days a week. Staff had a firm understanding of the individual activities people enjoyed doing such as painting. However, people were not consistently supported and encouraged to undertake these meaningful activities and keep their minds occupied and stimulated. We have made a recommendation for improvement in this area.

Staff understood the principles of consent to care and treatment and respected people's right to refuse consent. However, not all staff had received training on the Mental Capacity Act 2005 (MCA) and mental capacity assessments were not consistently recorded in line with legal requirements. We have identified this as an area of practice that requires improvement.

Deprivation of Liberty Safeguards (DoLS) had been submitted for everyone living at the home. Restrictive practice was used within Aspen House Care Home, such as stair gates and locked front door. Although DoLS application had been made. Little consideration had been given to the care planning process on how to enable people to have as much choice and control within their lives as possible. We have made a recommendation for improvement in this area.

Risks to people were assessed and risk assessments implemented. However, each person had a generic risk assessment in place which was not specific or individual to them and their specific needs. We have identified this as an area of practice that requires improvement.

Incident and accidents were consistently recorded; however, they were not reviewed on a regular basis to monitor for any emerging trends or patterns. We have identified this as an area of practice that requires improvement.

People were treated with respect and dignity by staff. People were called by their preferred name and staff had clearly spent time building rapports with people. Staff members respected people's privacy and always knocked on their door before entering. Staff understood the importance of monitoring people's mental health and well-being on a daily basis. Staff worked closely with healthcare professionals and was responsive to people's changing needs.

Everyone we spoke with was happy with the food provided and people were supported to eat and drink enough to meet their nutrition and hydration needs.

People told us the manager and staff were approachable. Relatives said they could speak with the manager or staff at any time. The provider operated an open door policy and welcomed feedback on any aspect of the service. Regular meetings took place with staff which provided staff with the forum to discuss any ideas or practice issues.

We found two 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 the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Aspen House Care Home was not consistently safe. Risks to people were assessed and risk assessments developed. However, risk assessments were often generic and not individual to the person.

Staffing levels required improvement and feedback from staff reflected staff did not have the time to spend with people and the delivery of care was very much task oriented. For people who required the use of covert medicine, documentation was not in place which demonstrated it was in their best interest.

People told us they felt safe at the home and with the staff who supported them. Staff had a firm understanding of how to support people and manage behaviour that challenged.

Is the service effective?

Requires Improvement

Aspen House Care Home was not consistently effective. Mental capacity assessments were not completed in line with legal and best practice guidelines. Restrictive practices, such as stair gates were present throughout the home. Consideration had not been given on how to empower people to have choice and control and lessen the restrictions imposed on them.

Staff received training on how to provide effective dementia care. However, training schedules failed to reflect the training staff had received.

People were supported to have sufficient to eat and drink and maintain a balanced diet. Staff recognised that people's healthcare needs could change rapidly and mechanisms were in place to maintain people's health and wellbeing.

Is the service caring?

Good

Aspen House Care Home was caring. Staff communicated clearly with people in a caring and supportive manner. Staff knew people well and had good relationships with them. People were treated with respect and dignity.

People were supported to dress in accordance with their personalities and lifestyle choice. Care staff were observed speaking about the personal care needs of people sensitively and discretely.

People's friends and family were welcomed at the home and staff supported and encouraged these relationships.

Is the service responsive?

Requires Improvement

Aspen House Care Home was not consistently responsive. The opportunity for meaningful activities was limited. Call bells to summon assistance were not consistently working.

Summary of findings

Care plans were personalised to each person. Systems were in place for the monitoring of people's wellbeing which enabled responsive action to be taken when required.

There was a complaints procedure in place and people felt comfortable raising any concerns or making a complaint.

Is the service well-led?

Requires Improvement 

Aspen House Care Home was not consistently well-led. Incidents and accidents were not monitored for any emerging trends or themes. The home's quality assurance framework needed improvement to demonstrate how the provider was striving to improve and develop.

The provider took an active role in the running of the home and staff spoke highly of their management style. Systems were in place to gain feedback from people and their relatives.

Aspen House 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 checked 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 home, and to provide a rating for the home under the Care Act 2014.

We visited the home on the 6 and 8 May 2015. This was an unannounced inspection. The inspection team consisted of two inspectors. On this occasion we did not ask the provider to complete a Provider Information Return (PIR), this was because the inspection was carried out at short notice. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority, looked at safeguarding concerns that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the home. We last inspected Aspen House Care Home in April 2014 where we had no concerns.

During the inspection, we spoke with five people who lived at the home, three visiting relatives, five care staff, the deputy manager and the provider. We looked at areas of the home, including people's bedrooms, the kitchen, bathrooms, communal lounge and dining room. Some people were unable to talk to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during lunchtime. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we reviewed the records of the home. These included staff training records and policies and procedures. We looked at six care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at Aspen House Care Home. This is when we looked at their care documentation in depth and obtained their views on how they found living at Aspen House Care Home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Aspen House Care Home. One person told us, "I feel happy living here and I'm very safe." Visiting relatives confirmed they felt confident leaving their loved ones in the care of Aspen House Care Home. Although people told us they felt safe, we have found areas of practice which were not consistently safe.

For people living with dementia, positive risk taking is integral in providing care that promotes people's independence and autonomy. Positive risk taking involves measuring the balance of the benefits gained from taking risk against the negative effects of attempting to avoid risk altogether. Throughout the inspection, we saw people walking throughout the home, coming and going from their bedroom, to the lounge and dining room. The provider recognised the importance of enabling people to do the things they wanted to do and allowing people to live their lives as they so choose despite living in a care home. The provider told us, "If people want to go out for walks, to the local shops or coffee shops, we try and facilitate this." Although the provider recognised the importance of positive risk taking, we could not see this embedded into every day practice. We asked staff whether staffing levels would allow them to take people out for walks or to the local shops. Staff members confirmed they could not recall the last time they took someone outside or spent one on one time with people.

Enabling people living with dementia to take risks and live autonomous lives entails sufficient staffing levels whereby staff have the time to spend with people, build their confidence and independence with risk taking. Staffing levels were stretched and staff members commented that staffing numbers required improving. One staff member told us, "Two staff members to 12 residents living with dementia, administering medicine, providing personal care, drinks, breakfast, paperwork and supervising them, it's too much." Another member of staff told us, "Staffing levels are not good enough; we don't have enough time to spend with the residents and get everything done." Between 07.00am to 08.00am, four members of staff were available. After 08.00am, two members of staff provided support along with the cleaner and chef. The provider or deputy manager also provided support after 09.00am. The afternoon shift consisted of three care staff and the night shift was one waking care staff and one sleeping care staff. The provider and deputy manager provided support throughout the day and on-call support at night.

Formal mechanisms were not in place for determining how many staff were required to safely meet the needs of people. The provider told us, "If we admit more residents, we increase staffing numbers, or if we have residents that present with challenging behaviour we would increase staffing levels." However, no system was in place which demonstrated people's needs had been assessed to determine the number of hours of care they required to safely meet their needs. The provider acknowledged a key challenge for Aspen House Care Home was the recruitment of care staff. The provider told us, "We advertise on-line, through recruitment agencies, but we cannot recruit any staff, we are continually trying, this therefore makes it hard to increase staffing numbers especially as we are reluctant to use agency staff."

Throughout the inspection, it was clear that two staff members to 12 people put a strain on staff members. Staff members were seen continually undertaking one task followed by another. People received the care they required and call bells were answered in a timely manner. However, the impact of insufficient staffing levels meant people were left without staff interaction or stimulation. We queried what would happen if someone in the morning requested to go outside or for a walk. We were informed by staff and the provider; they would have to wait until the afternoon when another member of staff arrived on duty and whether they would have time. For people living with dementia, this may cause them agitation as they may not understand why they cannot go outside or go for a walk when they so wish. We have therefore identified this as a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people were assessed and risk assessments developed. These included diabetes, epilepsy and falls. Where people suffered with epilepsy, detailed risk assessments were in place which included information on the actions to take when the person experienced a seizure, what to do after the seizure and when the paramedics should be called. Seizure monitoring charts were in place which recorded the time of each seizure and where the

Is the service safe?

person experienced the seizure. Staff members had a firm understanding of the actions required to safely manage people's seizures and clearly conveyed the signs of when a person would be about to experience a seizure.

Each person had a service user risk assessment which considered various activities. These includes going outside without an escort, walking indoors, stairs, declining medical treatment and handling own medication. However, each risk assessment was generic for each person. Information recorded was not specific or personalised to the individual. One person had recently experienced a fall which resulted in their attendance to hospital. Their falls risk assessment from 2014 identified they were at high risk of falls and their care plan reflected their sensory impairment added to their risk of falls. This information was not detailed in their risk assessment and the risk assessment reflected the same information as recorded in everyone else's risk assessment. Staff members could clearly tell us the actions required to minimise the risk of harm to people. One staff member told us, "Some people forget to mobilise with their mobility aid, therefore we prompt them and remind them to use the aid, stay close behind them and make sure the pathway is clear." The provider and deputy manager recognised that risk assessments needed revising and improving. The deputy manager told us, "We have specific risk assessments in place, such as epilepsy but yes we also have the generic risk assessments and these need to be individual to the person." This is not a breach of regulation, but we have identified this as an area of practice that needs improvement.

Due to people's diagnosis of dementia, they were not able to consistently tell us if they received their medicines on time. However, visiting relatives commented they felt assured in staff managing their relative's medicine regime. Medicines were stored safely and ordered in a timely fashion from the local pharmacy and Medication Administration Records (MAR charts) indicated that medicines were administered appropriately. MAR charts are a document to record when people received their medicines. Records confirmed medicines were received, disposed of, and administered correctly.

The use of covert medicine was used within Aspen House Care Home. Covert is the term used when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in a drink. Covert medicine is sometimes necessary and justified, but should never be given to people who are capable of deciding about their medical treatment. Giving medication by deception is potentially an assault. The covert administration of medicines should only take place within the context of existing legal and best practice frameworks to protect the person receiving the medicines and the care staff involved in giving the medicines. Where people were administered covert medicine, a letter from the GP was available confirming agreement with the practice of covert administration of medicine. This letter was dated 17 April 2014. We could not locate any documentation to confirm this decision had been reviewed by the GP. We could also not locate any underpinning mental capacity assessment (MCA 2005) to confirm that the individual lacked capacity to consent to the administration of covert medicine. Documentation of the best interest decision was also not available to demonstrate that the person's family had been involved in the decision and the person's wishes and feelings had been considered. We asked the provider whether they had asked the GP to undertake a mental capacity assessment. The provider confirmed the GP had not visited the individual nor had they assessed the person under the Mental Capacity Act 2005.

All information pertaining to the covert administration of medicine must include Mental Capacity Assessments, Best Interest decisions and suitability of administering the medicine with food and drink and must be documented in people's care plan and contemporaneous care record. We have therefore identified this as an area of practice that needs improvement.

Staff had spent time getting to know people and were knowledgeable about the people they supported and specifically how to support people with behaviour which might challenge. One staff member told us, "We have one person who can be aggressive and agitated but we know that if they are agitated to leave them alone and give them space." Another staff member told us, "If people become aggressive with one another, we will diffuse the situation, separate them and talk to them about why they become aggressive or upset." During the inspection, we observed one person becoming increasingly anxious and agitated when being supported to move and transfer with the support of staff. Staff provided reassurance; spoke to the person calmly throughout the transfer and eased their anxiety.

Requires Improvement

Is the service safe?

Staff were aware of how to protect people and the action to take if they had any suspicion of abuse. Staff were able to tell us about the signs of abuse and what they would do if they had any concerns such as contacting the local safeguarding team. One member of staff told us, "I would initially raise my concerns with the provider but if they didn't do anything, I would contact the local authority." Staff had received training in protecting people, so their knowledge of how to keep people safe was up to date.

Where safeguarding concerns had been raised, the provider had worked in partnership with the Local Authority to ensure protection plans were in place for people and any risk of future harm was minimised.

Safe recruitment systems were in place. Staff confirmed that checks had been completed before they were allowed to start work. This included the obtaining of references and checks with the Disclosure and Barring Service (DBS). The DBS check would show if prospective staff member had a criminal record or had been barred from working with adults due to abuse or other concern.

Requires Improvement

Is the service effective?

Our findings

People and visiting relatives expressed confidence in the skills of care staff. One visiting relative told, "The staff are very good and they have a good understanding." People spoke highly of the food and the meal choice. One person told us, "I'm looking forward to lunch, it's roast dinner." However, we found Aspen House Care Home did not provide care that was consistently effective.

The Mental Capacity Act (2005) provides a statutory framework to empower and protect people who are not able to make their own decisions at a specific time. The provider and deputy manager had considered people's ability to make specific decisions, such as what to wear, ability to choose own meals, attending GP and hospital visits and retaining information for long enough to make informed decisions. However, documentation failed to record the person's ability to communicate, retain, weigh up and understand the decision or the steps taken to empower the person to make the decision. The deputy manager could clearly describe the steps they had taken to assess whether someone had the ability to make a specific decision about attending a hospital appointment. Such as providing the individual with all the information required. Returning throughout the day to see if they had retained the information and whether they could weigh up the pros and cons. However, documentation failed to reflect these steps taken. We have therefore identified this as an area of practice that needs improvement.

Good dementia care involves a clear and robust understanding of the MCA and paid staff who provide care and support are legally required to work within the framework of the MCA and have regard to the MCA Code of Practice. Staff's understanding of the MCA 2005 varied. Training schedules confirmed training on the MCA 2005 had been provided in February 2015, but not all staff had attended. One staff member told us, "I can't recall MCA, I don't think I've had any training here." Other staff members had a firm understanding of the principles of the MCA 2005. We have therefore identified this as an area of practice that needs improvement.

Despite the above concerns, staff understood the principles of gaining consent from people and recognised that people had the right to refuse consent. One member of staff told us, "This morning, one person refused one of their tablets. I accepted their refusal and went back later when they agreed to take the tablet." Staff clearly understood the principles of gaining consent from people before delivering care.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Restrictive practice was used throughout Aspen House Care Home. This included the use of a locked front door whereby key code entry was required to exit the home. A stair gate was in situ to prevent people from accessing the kitchen and was also at the top of one set of stairs within the home. The provider had made DoLS applications for everyone living in the home as it was assessed that everyone was under continuous supervision and control and not free to leave. However, consideration had not been given on increasing people's liberty and empowering people to have choice and control within their lives. Care plans made reference to the use of restrictive practice; however, we could not see how alternative ways of providing care had been explored or how the restrictions could be lessened. For example, incorporating into people's daily care the opportunity to go outside, access the local shops, go for walks or enabling them to undertake tasks which promoted their well-being and sense of identity.

We recommend that the service considers the National Institute for Health and Social Care Excellence: Supporting people to live well with dementia guidance.

Staff received training that was essential in providing safe and effective dementia care. This included dementia awareness and mental health awareness. Staff demonstrated a good awareness of how to provide effective dementia care. This included maintaining eye contact with the person, providing information in a manner in which the person could understand and awareness of how to approach the individual. However, training schedules confirmed that one member of staff had not received any training since commencing at employment at Aspen House Care Home. They told us, "I've been working here since August 2014 and I haven't received any training, I worked at another care home and had training there." However, the staff member confirmed they had not

Is the service effective?

received moving and handling training but were booked onto a training course in August 2015. On the day of the inspection, we were informed of one person who could require the support of a hoist (mobility aid) now and then. We therefore questioned, what would happen if the person required the support of a hoist when they were working. We were informed the provider or deputy manager would support. However, the provider had not identified the risk of the staff member working weekends or night shifts when they or the deputy manager would not be available to provide support. The need for trained and competent care staff is essential in providing safe and effective care. We have therefore identified this as an area of practice that needs improvement.

Other training schedules failed to reflect when staff members had received updated (refresher training) to ensure their skill and knowledge base remained up to date. For example, one staff member had received manual handling training in 2007 but documentation did not reflect if/when they had received updated training. This member of staff confirmed they had received updated manual handling training in 2014. The deputy manager acknowledged that staff's training records were inaccurate and they were in the process of implementing a staff training schedule which would record all staff's training, when they required refresher training and when that had been updated. We have therefore identified this as an area of practice that needs improvement.

The provider recognised the importance of supporting staff and encouraged staff to progress with their career and staff were offered the opportunities to obtaining a National Vocational Qualification (NVQ) (now care diploma). Staff commented they felt able to approach the provider and deputy manager if they had any questions or queries. One member of staff told us, "I learn a lot from the provider." Through the forum of ad hoc supervision, staff received regular support from management. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed. Although staff did not receive regular, staff commented on how they found the forums of staff meetings and handovers helpful and provided them with the opportunity to raise any concerns, discuss practice issues and encouraged them to reflect on their own practice.

People and visiting relatives spoke highly of the food. One visiting relative told us, "The food always looks really good and Dad never complains about the food." One person told us, "Get immaculate food, and choose what we want."

We spent time observing lunchtime in the communal dining area. Most people attended the dining room for lunch, however, some people chose to remain in their bedrooms and this decision was respected by staff. Tables were laid for people, with napkins, condiments and the cutlery was of a good standard. People were offered refreshments of their choice and the atmosphere was calm and relaxing for people. People were encouraged to be independent throughout the meal and adapted cutlery and plates were made available for people to promote their independence with eating and drinking. Staff were attentive and provided support where required.

People were involved in making their own decisions about the food they ate. For breakfast, lunch and supper, people were provided with options of what they would like to eat. A daily menu was displayed in the dining room and if people did not like the options available, alternative meals could be offered. Information was readily available on people's dietary likes and dislikes and the chef had a firm understanding of people's dietary requirements. Where a need for a specialist diet had been identified we saw that this was provided. For example, a diabetic diet.

People's food and fluid intake was monitored on a daily basis, this helped to monitor for any signs or symptoms of weight loss or dehydration. Staff recognised that if someone was refusing food or suffering weight loss, it may be associated be a swallowing problem or a deterioration in the person's mental health. Where required, input had been sourced from the dietician and speech and language therapist. On the days of the inspection, no one was requiring a soft or puree diet.

Effective management of people's healthcare needs means people can live long healthy, autonomous and fulfilling lives. The provider and staff recognised that for people living with dementia, they may not be able to communicate they are unwell or experiencing pain. One member of staff told us, "People's facial expressions, behaviour and mannerism and can indicate to us whether they may be unwell or in pain." The provider told us, "If people present as more confused, this may be an indicator they are unwell

Is the service effective?

or suffering from a urinary tract infection (UTI). We would therefore test their urine." The provider and staff regularly sought the advice of the GP and district nursing team if they suspected someone had a UTI.

The provider worked in partnership with the older people's mental health team, district nurses and GPs to help promote people's health and wellbeing as far as possible. Where people experienced heightened levels of anxiety, agitation or presented as more aggressive, prompt input was sourced from the mental health team to ascertain if any triggers had caused the change in the person's behaviour and presentation. For example, one person had been physically aggressive towards care staff. The psychiatrist was contacted who undertook a home visit and amended the person's medicine which resulted in the person's presenting as much calmer and less aggressive.

Good

Is the service caring?

Our findings

People and visiting relatives were complimentary about the care, treatment and support they received. One person told us, "It's lovely here and I like my bedroom here." Another person told us, "I like living here, it's nice." Visiting relatives felt their loved ones were treated with dignity and respect.

The atmosphere in the home was calm and relaxing for people. When we arrived people were seated in the communal lounge, dining room and some people remained in bed, preferring to have a lie in. Music was playing in the background of the communal lounge and people were seen sitting talking to one another. Staff adopted a warm and mutually supportive approach when supporting people. Staff addressed people respectfully and called people by their preferred name.

Staff relationships with people were strong, supportive and caring. Staff had gained a firm understanding of people's needs, likes, dislikes, life history and personality traits. One staff member told us, "I enjoy looking after the people here. I know people's routine, such as who likes to get up early and late." Where people had difficulty communicating verbally staff recognised changes in body language and demeanour. On the inspection, one person's arm was a sling. This was causing them distress. Staff clearly recognised their signs of distress and altered the sling to make it more comfortable for the person. The use of language, verbal and non-verbal, was considered a key element of good quality dementia care and was significant for how it impacted upon the person's perception of self-worth.

We spent time sitting with people in the communal lounge. People looked comfortable in the care of Aspen House Care Home and in the company of care staff. One lady was seen relaxing in the communal lounge in her dressing gown with a cup of tea interacting with another resident. Creating a homely atmosphere whereby people treated Aspen House Care Home as their own home. Staff members had spent time building rapports with people and this was underpinned through their interactions with people.

Staff provided emotional support and were respectful of people's dignity. For people living with dementia, they may not be oriented to time or place and may often think they are much younger, or their understanding of time/ place may vary on a day to day basis. The inspection team spent time talking and sitting with people, however, due to people's level of dementia, they often spoke about past events and were not oriented to time. Staff members recognised and understood this. One person was walking about waiting for their Mother to go shopping. Staff members did not orient the person to time or place. They provided emotional support and distraction techniques suggesting the person come into the communal lounge and wait with other residents. Staff provided care and support that was emotionally supportive of the person whilst being compassionate and understanding.

People's privacy and dignity was respected. One person told us, "They always respect me." Assistance with care was offered discreetly. We observed staff knocking on people's doors and waiting before entering. Staff members had a firm understanding of the principles of privacy and dignity. One staff member told us, "We always knock before entering, close the curtains and always explain what we are doing to the person." Another staff member told us, "When providing personal care, making sure the person is covered and not exposed." For people in shared rooms, screens were available to help provide privacy. The provider commented that for people who have shared rooms, they always discussed and deliberated whether the people would get on and enjoy sharing a room. If a person was moving into a shared room, they would allow the people to spend time together initially to see if they got on and would suit sharing a room.

For people living with dementia, incontinence can greatly impact upon a person's feeling of self-worth and dignity. Good continence care involves robust toileting regimes and recognising non-verbal cues of when the person may need the toilet. Staff members recognised the importance of ensuring people received regular support to meet their toileting needs and reduce the risk of any toileting accidents. Throughout the inspection, staff members were seen assisting people to the toilet and discreetly asking people if they needed the toilet.

People were supported to maintain their personal and physical appearance. People were dressed in the clothes they preferred and in the way they wanted. Where required, people were supported with their hair and make-up. Ladies had their handbags to hand which provided them with reassurance. The provider promoted people to decorate

Good

Is the service caring?

and make their room their own. People were encouraged to bring in personal possessions from home. Rooms were personalised and contained personal possessions that people treasured, including photographs and ornaments

Visiting times were flexible and staff confirmed people's relatives and friends were able to visit without restrictions.

People could see their visitors in the communal lounges or in their own bedroom. One visiting relative told us they could visit at any time and were always made to feel welcome.

Requires Improvement

Is the service responsive?

Our findings

People and visiting relatives spoke highly of the care and felt that the care was personalised and responsive to people's needs. One visiting relative told us, "The quality of the care is good and very individual." However, we identified areas of practice which were not consistently responsive.

For people living with dementia, engagement in meaningful activities is important. It can help people to maintain a level of independence and functional ability, and improve people's quality of life. As with other aspects of caring for people living with dementia, understanding personal preferences and abilities will help to provide truly meaningful engagement and activities. The provider told us, "We have an external activities entertainer come in three days a week and provides musical entertainment, arts and crafts and movement to music. We are looking at increasing this to five days a week and to include discussions on news topics and world events." On the day of the inspection, the entertainer provided an hour of musical entertainment in the afternoon which people enjoyed and sang along to. However, we raised concerns what stimulation was provided at weekends or throughout the rest of the day.

The provider demonstrated a firm understanding of the activities people liked to do. One person enjoyed painting and their paintings were on display in the dining room. Another person likes word searches and crosswords while another person enjoyed music and singing along to music. The provider told us, "We try and keep people's minds stimulated using the things they like." One person told us, "I like that I still get to paint here." The provider and staff had a clear understanding of the activities that were meaningful to people. However, during both days of the inspection, we did not see staff encourage or support people to undertake meaningful activities. On the second day of the inspection, people were sitting in the communal lounge, the radio and television was off and there were no interactions or stimulation for people. Staff commented that they tried to find the time to support people to do activities but staffing levels impacted upon their ability do this. One staff member told us, "There isn't always enough staff for us to do the things we want to do, like one to one activities."

Each person had a daily log where staff would record what activities they had undertaken. A common theme was 'resting in their room' or 'watching television'. Keeping occupied is an integral aspect of good quality dementia care alongside supporting people to maintain their identity and feel valued. For example, some people living with dementia, like to be involved with the running of the home such as folding laundry or laying tables. Throughout the inspection, we could not see how people were supported to feel valued and stimulated.

Despite the above concerns, people did not appear agitated or distressed by the lack of activities and visiting relatives did not raise any concerns. However, consideration had not been given to the lack of stimulation and the impact this would have on people's cognitive functioning.

We recommend that the service considers the National Institute for Health and Care Excellence quality standard for mental wellbeing of older people in care homes.

Staff demonstrated a good knowledge of people and their care needs. One member of staff told us, "One resident has taken to their bedroom today which is very unlike them." Due to the care needs of people living at Aspen House Care Home, staff members undertook hourly checks of people to ascertain their wellbeing. Assessments were also made of people's ability to use call bells to summon help from staff members. Some people had been assessed as able to use the call bell facility while some people were not able to summon assistance through the mechanism of the call bell. The inspection team tested a sample of call bells on the first day of the inspection. Three were found to be not working. On the second day of the inspection, the call bells remained not working. Records demonstrated staff had also identified the call bells were not working through daily testing, however responsive action had not been taken. The provider confirmed an electrician would be called; however, alternative action had not been taken to ensure people could summon assistance in the interim. We have therefore identified this as an area of practice that needs improvement.

Each person had their own care plan. We saw that each person's needs had been assessed before they were offered accommodation at the home. Each section of the plan covered a different aspect of the person's life, for example physical care, communication, personal safety, medical history mobility and dexterity, religious needs, mental health and wellbeing. Care plans were personalised to the individual and information was readily available on how

Requires Improvement

Is the service responsive?

the individual preferred to be supported. Care plans included information on the support required along with the aim of how the support should be provided. One person was partially blind but their care plan reflected they required support from staff to choose their clothes but could dress themselves independently.

Staff kept daily progress notes about each person which enabled them to record what people had done and meant there was an easy way to monitor their health and well-being and take responsive action when needed. Staff were kept aware of any changes in people's needs on a daily basis. This was supported by systems of daily verbal handovers between staff shifts and daily notes. Staff commented that there was good communication within the home.

Visiting relatives told us they would feel confident raising any concerns with the deputy manager or provider. One visiting relative told us, "I would not hesitate in raising any concerns." People commented they felt able to talk to the provider. One person told us, "I would go to the boss lady." A copy of the complaints procedure was on display in the entrance hall of the home. The provider's complaints policy and procedure contained the contact details of relevant outside agencies and the timeframe of when complaints would be responded to. The provider had not received any formal complaints in over a year. The provider told us, "If I did receive any complaints, they would be investigated and taken seriously."

Requires Improvement

Is the service well-led?

Our findings

People, visiting relatives and staff spoke highly of the provider and deputy manager. One staff member told us, "She's a very hands on owner." The provider had a firm understanding of each person's individual need, likes, dislikes and personality traits. Staff commented they felt able to approach the provider and deputy manager with any questions or queries. However, despite people's high praise for manager, we found Aspen House Care Home was not consistently well-led.

Following any incidents or accidents, documentation was completed by staff. Documentation included where the accident/incident occurred, the date and time, person involved and nature of the injury/accident. 12 accidents were recorded since the beginning of 2015, of which 11 were falls. A high percent of the falls experienced were un-witnessed. Mechanisms were not in place for the reviewing of incidents and accidents to monitor for any emerging trends, themes or patterns. There is a strong emphasis on providers and registered managers having systems and mechanisms in place to enable them to identify patterns or cumulative incidents as identified in the Care Act 2014. We asked the provider, what action was being taken to reduce the likelihood of un-witnessed falls and documentation failed to record what follow up action had been taken following each fall. The provider and deputy manager acknowledged systems were not in place and this required improvement.

Effective systems were not in place for the monitoring of the running of the home. The provider and deputy manager completed monthly audits of all aspects of the home. Audits are a quality improvement process that involves review of the effectiveness of practice against agreed standards. Audits help drive improvement and promote better outcomes for people who live at the home. Audits included care plans, staff files, medication and supervision. However, each audit just recorded the month, a tick to confirm the audit had taken place and who by. Documentation did not record what was looked at as part of the audit, any concerns identified during the audit and any action points. It was also not demonstrated how the provider used the audit process to drive continual improvement.

Robust mechanisms and systems were not in place to assess, monitor, mitigate risks and drive improvement; we have therefore identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A yearly development plan was in place for 2015. The provider had identified improvements which were required to be made. Actions included for all care plans to be changed to a clearer format, new carpet in one bedroom and for the encouragement of more staff to obtain further qualifications such as National Vocational Qualification (NVQ). The provider was committed to the on-going improvements of the home and throughout the inspection was open and responsive to our concerns.

The running of Aspen House Care Home was governed by its statement of purpose which reflected its aims and objectives. This included the resident's right which documented, 'The rights of the residents at Aspen House are placed at the forefront of our philosophy for care. We seek to advance their rights in all aspects of the environment and the service we provide and to encourage the residents to exercise their rights.' Although staff were not familiar with the aims and objectives of the home, they demonstrated a strong commitment to providing good care. One staff member told us, "We look after people well."

The key challenge faced by Aspen House Care Home was staffing levels. One member of staff told us, "The main challenge is staffing levels." Another staff member told us, "Staffing levels do put us under pressure." The provider and deputy manager recognised the impact of the staffing levels and acknowledged the main hindrance to improving staffing levels was recruitment. Despite concerns with staffing, staff members described the morale as positive within the home. One staff member told us, "We work together and are a good team."

Systems and processes were in place to consult with people and relatives. This included regular satisfaction surveys being sent out to relatives and people. This enabled management to monitor people's satisfaction with the service provided. Results from the April 2015 survey found that people and relatives were happy with the quality of care delivered. Feedback from relatives included, 'The staff at Aspen House are always so caring and considerate about the feelings of relatives. They go out of their way to help and it's so appreciated.' Feedback from people included, 'I'm very happy.' Staff meetings were held

Requires Improvement

Is the service well-led?

on a regular basis, these enabled staff to express any ideas, discuss practice issues or make suggestions. Minutes held from the last meeting reflected staffing levels had been discussed alongside health and safety. Staff commented they found the forum of staff meetings helpful and felt they contributed to the running of the home.

There was a management structure in the home which provided clear lines of responsibility and accountability. Staff members were aware of the line of accountability and who to contact in the event of any emergencies or concerns. Staff members spoke positively about the leadership and management style of the provider. One member of staff told us, "I would describe her as approachable and operates an open door policy." The provider has owned Aspen House Care Home since 1994 and took an active role in the running of the home. People appeared very comfortable and relaxed with the provider and deputy manager.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing** **18(1) – The registered person had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance** **17(2) (a) – The registered person had not assessed, monitored and improved the quality and safety of the services provided in the carrying on of the regulated activity.** **17(2)(b) – The registered person had not assessed, monitored and mitigated the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.**