HC-One Limited

Aspen Court Nursing Home

Inspection report

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15 February 2016

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 10, 11 and 15 February 2016. The first day of the inspection was unannounced; the provider knew that we would be returning for the subsequent days. Aspen Court Nursing Home provides residential and nursing care for up to 72 older people, many of whom also have dementia. At the time of the inspection there were 59 people living at the service.

Our last inspection was completed on 14, 15, and 17 April 2015 and breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to medicines management, staffing, risk management, infection control, good governance and consent. We checked whether the provider had followed their plan during this inspection to confirm that they now meet legal requirements.

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

A new registered manager had been appointed since our last inspection and driven forward a series of improvements at the service. Robust monitoring procedures had been developed to ensure the care was of high quality. The team morale had improved and there was a positive and open culture at the service.

The provider had not done all that was reasonable to prevent the spread of infection because a sluice we observed was not clean and staff did not always wear gloves and aprons as appropriate.

People were protected from other risks related to their health and well-being because risk assessments were adequately detailed and updated to provide effective guidance to staff about how to mitigate such risks. People were kept safe from the risk of abuse by well trained staff who felt confident to raise concerns about poor practice.

The provider had used a robust recruitment procedure to employ staff suitable to work in the caring profession. The provider had appointed staff to newly created roles and had assured there were enough staff to meet people's needs.

Staff developed caring relationships with people who used the service. People were supported to raise any concerns they held.

Medicines were stored, administered and disposed of safely. Medicines that were administered covertly or on an as required basis were well managed. People were supported to get enough to eat and drink and people had access to healthcare professionals as required.

The provider followed the latest guidance and legal developments about obtaining consent to care. Staff used a range of communication methods to support people to express their views about their care. There was evidence that people and their relatives were involved in planning their care and care records included information about people's likes and dislikes. Records were updated in response to people's changing needs.

We have made two recommendations about infection control and communicating with people for whom English is not their first language.

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

Aspects of the service were not safe because the prevention and control of infections was not adequately managed and the provider had not done all that was reasonable to protect people from environmental risks.

Medicines were well managed.

There were enough staff to meet people's needs and they had been recruited safely.

People were kept safe from the risk of abuse by trained staff who understood their responsibilities.

Is the service effective?

Good

The service was effective. Staff were knowledgeable and supported to carry out their roles.

The registered manager and staff understood the legal requirements of the
Mental Capacity Act 2005 and the associated Deprivation of Liberty
Safeguards.

Staff supported people to eat and drink enough and to receive care from health and social care professionals.

Is the service caring?

Good

The service was caring. Steps had been taken to meet people's diverse needs.

Staff had developed compassionate relationships with people.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive. Care records included information about people's likes and dislikes and were regularly reviewed and updated following changes in people's needs.

A range of activities was being developed for people to take part in.

People and relatives felt able to raise complaints.

Is the service well-led?

Good

The service was well led. There was a clear management structure and staff felt well supported by the leadership team. Staff morale had improved since our last inspection.

The service had an open and collaborative culture.

The registered manager monitored the service to ensure the care delivered was of a high quality.

Aspen Court Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 10, 11 and 15 February 2016. The first day of the inspection was unannounced; the provider knew that we would be returning for the subsequent days. The inspection was conducted by three inspectors, a pharmacist inspector and two specialist advisors who had experience of nursing care provided for people living with dementia.

Before the inspection we reviewed the information we held about the service and statutory notifications received. During the inspection we used a number of different methods to help us understand the experiences of people supported by the service. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with three people who used the service and nine relatives of people using the service and one visitor and we made general observations.

We spoke with the registered manager, the deputy manager, three registered nurses, three Senior care workers, 10 care workers, two housekeepers, two activity coordinators and one administrator. We looked at 23 people's care records, and nine staff files, as well as records relating to the management of the service.

Subsequent to the inspection we made telephone calls and corresponded via email with three health and social care professionals.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 14, 15, and 17 April 2015 we found a breach of the Regulations in relation to Infection control. At this inspection we found that the provider had taken action to address our concerns but further improvements were needed. Relatives did not have any concerns in this area. One relative told us, "The place looks much more bright and clean." The provider had recruited additional housekeepers to carry out cleaning tasks. Care staff had a good understanding around how to prevent the spread of infections. We noted the importance of cleanliness had been discussed in team meetings. However, the sluice on the nursing floor was unlocked and visibly dirty. The sink was unclean and buckets of dirty water were left on the floor for over an hour. Furthermore, we observed that a housekeeper did not use personal protective equipment such as gloves and an apron while undertaking cleaning tasks.

At our last inspection on 14, 15, and 17 April 2015 we found a breach of the Regulations in relation to risk management. At this inspection we found that the provider had taken action to address our concerns but further improvements were needed in relation to the management of environmental risks. People were protected from risks to their health and wellbeing because staff were aware of the risks people faced and how to mitigate them. Relatives told us they thought risks to their family members were well managed. We saw a wide range of comprehensive and up-to-date risk assessments in people's care files such as those relating to nutrition, falls and moving and handling. Specific risks had been identified for each person and the associated risk assessments and care plans provided staff with clear and detailed guidance and direction on how the person should be supported. For example care plans for supporting people with diabetes guided staff about how to monitor for signs of changes in people's blood sugar levels and what action must be taken in such eventualities. Furthermore, the assessment and management plans for wound care for those people at risk of developing pressure ulcers were comprehensive and there was evidence that staff took prompt action where necessary. Repositioning charts were kept accurately so that staff knew which position to move a person into to help prevent pressure ulcers.

People were protected from environmental risks. For example, staff were adequately guided in the event of a fire. People's care records contained personal emergency evacuation plans (PEEPs). It was noted that practical fire drills were conducted and related action plans had been drawn up and followed. An up to date fire risk assessment, an electrical installation, a gas safety and a legionella assessment were in place.

People were protected from the risk of harm and potential abuse. People and relatives told us they felt it was safe to live at the service. A relative told us, "I do find it safe here, the people who live here also find it safe, they are made to feel this is their home." People felt confident that they could raise ill treatment to staff, "I would know who to talk to if I needed to report anything that I did not like." People were asked if they had any concerns about their safety at regular team meetings.

Staff had received training in safeguarding adults and all of the staff we spoke with were able to explain how the principles of safeguarding applied to their roles. Staff knew how to report safeguarding incidents and told us they could approach the registered manager if they had concerns about the way people were treated. The registered manager had a good understanding of her responsibilities in reporting allegations of

abuse to the appropriate authorities. Following safeguarding concerns the registered manager had taken steps to embed safe practice. For example, discussing the topic with all staff at individual supervision sessions and performance reviews and holding team meetings where best practice was discussed. Staff were supported by an appropriate policy. People were protected from the risk of poor practice because staff we spoke with were fully briefed about the provider's whistleblowing policy and said that they could escalate concerns to appropriate outside agencies.

At our last inspection on 14, 15, and 17 April 2015 we found a breach of the Regulations in relation to staffing. At this inspection we found that the provider had taken action to address our concerns. There were adequate staffing levels to meet people's needs. People told us, "The staff are there when you need them but not in the way all the time", "The staff always have time for you, especially when I have my bath, they never rush" and "The staff always have time to talk and listen". A relative told us, "There is enough of a staff force here." Since our last inspection the provider had recruited people to different staff posts across the service to meet people's assessed dependency levels. The position of senior carer had been created on the nursing floor to provide support to the registered nurses with their high clinical workload so that all tasks could be carried out more promptly, such as medicine administration. A registered nurse told us, "Since the introduction of the nursing assistant it's helped us so much. They are medicines trained so we can do dressings and catheters. They are getting the right support." Three registered nurse positions were filled by non-permanent members of staff but we saw evidence that the registered manager was working on a development plan with the provider to employ permanent staff. We observed that the numbers of staff working at the service during our inspection matched the rota and levels stated by the registered manager. We observed that people were provided with support when needed, for example, there was always a member of staff in the lounge areas we viewed. There were enough staff to support people with their lunch, this was also highlighted in a recent Health Watch visit report.

At our last inspection on 14, 15, and 17 April 2015 we found a breach of the Regulations in relation to medicines. At this inspection we found that the provider had taken action to address our concerns. Medicines were well managed. A person told us, "I do not have to worry; I get my tablets at the right time." Medicines administration records (MAR) were clear and accurate. Medicines received from the pharmacy were recorded in the MAR charts and the quantities were reconcilable with the administration record. Medicines were dispensed in original containers, and stored in individually labelled boxes in the medicines trolleys. Medicines, including controlled drugs, were stored safely and securely. There were records of daily room and fridge temperatures monitoring.

There were medicine plans for staff to follow for medicines administered only when needed. Staff told us how they carried out regular pain assessment for people prescribed pain tablets as they were needed using the pain thermometer tool and Abbey pain scale. People who were not able to communicate or for whom English was not their first language were also regularly assessed by touch and observation of facial expressions. There was evidence of best interests meetings for people whose medicines were administered covertly and staff told us how they rotated the sites used for administering medicines supplied in patch form. We observed that staff administered the lunch time medicines appropriately. We saw evidence that staff who administered medicines were trained. Medicines were managed safely; we saw documentation on MAR charts of people's allergies and precautions for people with swallowing difficulties.

The service undertook monthly medicines audits. Results of these audits were discussed in staff meetings and action plans implemented. Staff told us that the GP visited twice weekly as well as when needed, and undertook three monthly medicines reviews. We saw documented evidence of these reviews in care plans.

We recommend that the service seeks guidance from a reputable source about measures to prevent and

control the spread of infection.

Good

Is the service effective?

Our findings

At our last inspection on 14, 15, and 17 April 2015 we found a breach of the Regulations in relation to consent. At this inspection we found that the provider had taken action to address our concerns. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and found that the manager and staff had a good understanding of people's mental capacity and involved relevant parties in decisions about what was in people's best interests. The majority of people were subject to a DoLS authorisation and the manager and staff were aware of how to work within this context. We undertook discussions around consent and choice with registered nurses and care staff were very knowledgeable regarding seeking consent.

Staff were knowledgeable and well trained to meet people's care and support needs. The provider supported staff to undergo mandatory training, such as safeguarding adults and infection control via an online system called Touchstone. We noted that completion rates were routinely monitored by the registered manager. Staff told us they felt the standard of training was good and were also given opportunities to attend additional training that would help them to better carry out their roles. For example, person centred dementia care training that was run by an occupational therapist.

Newly appointed staff were given an effective induction about how to carry out their roles. All staff we spoke with were positive about their experiences. One member of care staff said, "I had a great first few months here. The induction was thorough and the initial training was excellent. I shadowed an experienced [care staff member] for three days, which included time on each floor of the home." Care staff were supported to work with all people using the service so that they knew how to provide support wherever it was required. A member of care staff told us they were rostered to work on one floor of the service per week. They said this helped them to provide consistent levels of care. Care staff had worked at least one night shift as part of their training to help them see how the service worked at all times of the day and night. One member of care staff told us this had been a "very positive" experience and helped them to understand the needs of people out of hours.

There was evidence seen of regular staff supervision and support structures in staff files, from induction to annual appraisals. Care staff told us they received regular supervision from the manager, a senior care worker or a registered nurse, and they felt recognised for good practice. We noted that the provider's policy

had changed and supervisions would only be offered on a biannual basis unless there was a need to hold one sooner which may mean staff receive less support in future.

People were supported to eat and drink enough. People and relatives spoke positively about the food on offer. A person told us, "I have a different diet, but always eat a good meal.'. Relatives told us, "I know the food is excellent", "The dining room area is very presentable, the food is excellent" and "The food is very nice." We saw a lounge on the first floor of the building had a selection of juices and whole fresh fruit available for people throughout the day. Staff offered lunch at an appropriate pace and people were able to eat in their own time. We saw staff had a kind and personalised manner with each individual and knew the needs of each person well. For example, staff knew what each person usually preferred to drink and offered them this. Each person was offered a choice of hot meals and where someone did not like either option, staff were able to obtain an alternative for them. Staff encouraged people to enjoy lunch as a social experience and helped them to sit next to their friends. We saw people responded with delight when staff were happy to see them and greeted them warmly when they came to the dining room. The levels of need of people during lunch were high and staff worked hard to encourage people to sit and relax during lunch, especially when people became anxious and started to walk around. Where people found it difficult to eat themselves, staff offered them an appropriate level of assistance whilst maintaining their dignity. For example, staff asked if a person wanted help before providing it and told the person what they could do to support them.

Staff were guided by effective and up to date assessments in care records and there was evidence of input from professionals such as speech and language therapists and dietitians. As such, staff were knowledgeable about people's dietary requirements and recorded people's intake of food and fluid and their weights accurately where required. These were monitored and action taken where anomalies were found. We noted that the importance of such recording had been discussed at a recent team meeting.

People were supported to maintain optimum health because they had good access to healthcare services for ongoing support and people and relatives confirmed this. A person told us, "They always get a GP or doctor in if I feel ill." Relatives told us, "My [family member's] illness was responded to very well", "When [my family member] is ill they are really prompt. They noticed [they] had come down with something so they just said they put him down to see the GP in the afternoon" and "The people here always get help from other health professionals." There was evidence in people's care records that the provider worked collaboratively with healthcare professionals such as dentists, tissue viability nurses, and opticians. A GP visited the service twice weekly. Staff had a good understanding of the health needs of the people they supported and followed guidance from these professionals. Staff were aware of how to monitor people's behaviour to detect deterioration in their health. For example staff told us, "We always observe the residents and if there is a change report it to a senior or the manager" and "Any signs or changes in walking or eating could be telling me that they are becoming ill."

Good

Is the service caring?

Our findings

The provider took steps to respect people's diversity by supporting people for whom English was not their first language. Staff had worked to maintain their dignity by finding ways to communicate with them. For example, a list of simple phrases was available in the care plan of a person whose first language was Spanish and a member of staff was also Spanish speaking.

We noted that there were visits from leaders of the religion that the majority of people using the service followed. However, there was not a connection with other places of worship for people who practiced a different faith. Care records did not routinely capture whether people would prefer their support to be provided by a member of staff of a particular gender. Records demonstrated that people were provided with food appropriate to their culture if they requested it.

Staff developed caring relationships with people using the service. People told us, "The staff all are very good" and "They are always friendly and helpful." Relatives were positive about the staff working with their family members. Typical comments included, "People here are so caring", "They are gentle", "The staff treatment is very good" and "They are really nice people". Staff spoke kindly about the people they supported, "I treat them like my parents" and "The residents really matter to us."

We spent some time in communal areas and observed the care provided to people and their interactions with staff. We saw that staff were respectful and spoke with people kindly. People felt that there were times when staff were not rushing to finish tasks and were able to sit with them and talk. We observed that staff engaged with people about things they found meaningful. We saw staff trying to help people when they became anxious or distressed by using touch. The provider ensured consistency in senior care staff on each floor so that people were aware who to go to when they required help and support.

Staff supported people to express their views and involved them in day to day decisions about their daily lives and support. Care records gave guidance about how to communicate with people to give people effective choices and people told us they were given options about how tasks were to be completed. We saw that staff spoke to people with respect and, lowered themselves to their level and made eye contact, which helped people with dementia to understand what was being said. We observed different options being offered, for example, a choice of daily newspapers and different settings for meals being provided. Staff took the time to tell people about what they were going to do before they did it. A relative told us, "Everything they do, they speak to him even though he doesn't respond."

People and relatives told us that staff respected people's privacy and dignity. Staff recorded the personal care of each person on a daily basis. This helped to ensure people were supported to maintain their dignity through cleanliness and maintaining an appearance that was important to them. We observed that people were asked whether they would like support before it was provided and staff knocked on people's doors and awaited a response before entering their rooms.

People were well supported at the end of their life. A relative told us, "There have been absolutely no

problems. This place has been wonderful. Very kind." We reviewed end of life care documentation that clearly indicated a person's choices about the end of their life, including where they would like to die and who they would like to be with them. The service worked in partnership with a local hospice to provide support and we saw evidence that Age UK had been invited to support staff during such times although this had not yet begun at the time of our inspection.

Good

Is the service responsive?

Our findings

People were involved in planning their own care. The provider carried out pre-admission assessments before people began using the service. These documents were comprehensive and informative tools for staff to refer to when the person first arrived. Complete care documentation was then drafted with input from people and/or their relatives and health and social care professionals. Each person's care plan had a document to be used to indicate who had been involved in the preparation of the plan and who had given consent for the planned care. Relatives told us, "Yes, I am involved in planning the care" and "We got a leaflet going through what [they] like and don't like. A history."

Care plans we reviewed were well written and easy to follow. They were updated on a monthly basis accompanied by a note explaining any change in the person's presentation. Care plans were also updated in response to a change in someone's needs or wellbeing such as a change in their medicines or a change of manual handling requirements.

The care provided was reviewed on a three to six monthly basis which the registered manager tracked using a review matrix to ensure the majority of reviews occurred on time. The reviews we saw involved family members, senior care workers or registered nurses and social workers. Action plans were compiled following the review and discussed at meetings with senior care staff.

The care provided was tailored to each individual because staff were guided by personalised care plans and responded to people's requests. A person told us, "The staff always listen to what I need." Staff told us, "We take into account the needs of each individual resident" and "We use the care plans to make sure we are all singing from the same song sheet." The provider was working with community occupational therapists on a person centred care project and were in the process of completing and updating life histories for every person. Most of the care records we reviewed included people's likes and dislikes. For each person there were sections with the headings 'What people like and admire about me', 'Important things about my life'. Staff had identified how to ensure people felt looked after and supported, such as by providing kind verbal reassurance during personal care. This process was ongoing so not all people had a completed personal history or biography completed.

People's preferences had been taken into account. For example, each person had a personalised sleeping and waking section in their care plan, which staff had used to ensure each person was able to go to bed and wake up according to their preferred routine.

We saw each person had a key worker notice in their bedroom. This included a photograph of their key worker as well as a list of things this member of staff could help them with. We spoke with a person's key worker who told us they had been able to personalise the level of care the person received to help the person feel at home. For example, their relative worked late hours and so the member of staff had facilitated later visiting, from 20.00 each day. This took place within a robust framework that ensured the relative did not disturb people who were sleeping or getting ready for bed.

People's rooms that we observed were personalised. Several of the rooms observed had TVs and radios and were clean and tidy with beds made. One person told us, "I never worry when I need anything, my room has everything I need and I love my own pictures and bits and bobs." This personalisation was also found in a recent visit conducted by Healthwatch Tower Hamlets.

People were supported to maintain their hobbies and interests. Care plans included a section called, 'During the day I enjoy…' Hobbies such as singing, dancing and dress-making had been described and an activities log for each person was kept by the two activity coordinators. From our observations and from speaking with staff it was clear they had a good understanding of people's interests. For example, one member of care staff was able to tell us in detail about how important following updates on the Royal family was to one person, whom they helped to read newspapers to find this information. The activity coordinators had produced a schedule of group activities for the year. We saw evidence of recent events such as cultural celebrations for Chinese New Year and Valentine's day. We observed an arts and crafts session and a sing-along session during the inspection. The provider had recently received a minibus so that people could partake in activities outside the service and this is an area that would benefit from ongoing development.

The provider gave opportunities for people to feedback about the service. Relatives told us they knew who to speak to if they had concerns and felt confident that they would be addressed. Relatives told us, "If I have any complaints I have no problem going to [the registered manager] and things have been addressed. There are more team meetings so people take responsibility", "I had two complaints and went to [the senior care worker]. They took it very seriously and it seems resolved", and "I know how to make a complaint, I have raised a concern in the past and it was dealt with immediately." We reviewed the provider's complaints monitoring system and found that all issues were monitored and action plans were drafted and followed through, such as discussing the issue at supervisions with staff. We found an audit trail of complaints on the floors linking outcomes to change in practice.

Good

Is the service well-led?

Our findings

At our last inspection on 14, 15, and 17 April 2015 we found a breach of the Regulations in relation to good governance.

At this inspection we found that the provider had taken action to address our concerns. There was an open and positive culture at the service. Since our last inspection a new registered manager and deputy manager had been appointed. The deputy manager was a registered nurse who was allocated time each week to conduct managerial duties. Senior care staff worked consistently on their allocated floor so that people and relatives knew who they could speak to about any issues. Feedback about the new registered manager and leadership at the service was overwhelmingly positive. Relatives told us, "It's just lovely, everything is running smoothly", "The staff feel more relaxed and positive", "There is a higher staff morale", "The staff are much happier now. They used to be terrified", and "There's nothing in here I can fault." All staff we spoke with said they had a positive working relationship with the new management team. Typical comments included, "She's an excellent manager. She's very proactive and doing a lot of improvements" and "Our new manager is wonderful. Things work really well and I look forward to coming to work every day."

Staff across all levels reported that they felt well supported by the management team. For example, one member of staff told us, "I always feel as though I am listened to." There was a pervading impression from the staff that they felt well regarded and valued and could raise concerns if needed. The provider enabled such support and communication by holding effective and regular team meetings, supervision sessions and handovers.

The service was organised in a way that promoted safe care through effective quality monitoring. The service was undergoing a period of improvement as evidenced by such things as the increased quality of care documentation. The registered manager implemented an effective auditing system to drive forward such improvements. For example, medicine audits, care documentation audits and falls management. We noted that action plans were drafted and followed to increase good practice in these areas. Trends in incidents were also mapped monthly so that any action could be taken when necessary. The provider sought feedback from people and their relatives in order to improve the quality of care provided. Relative and resident meetings were held on a regular basis. We noted that other professionals and interested parties were invited such as a GP and members of a befriending service who provide volunteers to support people with their interests. This meant that relatives got an opportunity to get up to date information about different aspects of the service and share their views about the direction of the service. There was a feedback machine in the lobby for relatives and visitors to raise their views, however, this was behind a sofa so hard to access and would benefit from being moved to a different location.