N. Notaro Homes Limited

Aspen Court

Inspection report

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Date of inspection visit:
19 February 2019
20 February 2019

Date of publication:
26 March 2019

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection on the 19 and 20 February 2019.

Aspen Court is a care home with nursing for up to 42 people. On the day of our inspection there were 39 people using the service. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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.

At the last inspection in August 2016, the service was rated Good. At this inspection we found the evidence continued to support the rating of Good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Why the service remains Good:

Risks to people were reduced because there were care records in place which provided guidance to staff on how to keep people safe. Staff were trained on safeguarding adults from abuse and knew the procedures to follow to report abuse and to protect people. There were sufficient staff to meet people's needs and recruitment checks were conducted before new staff were employed. A few employment records did not explain what staff were doing between jobs.

People or their relatives gave consent to the care and support they received. The service complied with the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Relatives and healthcare professionals were involved in making decisions for people but the records did not show how staff had arrived at best interests decisions.

People and their relatives were very complimentary about the staff and their caring attitude. People were observed to be treated with kindness and compassion by the staff. However, we also saw incidences where the staff were carrying out their duties in supporting people to meet their needs rather than using a person-centred approach.

Care records were updated and reviewed to reflect people's changing needs. Staff we spoke with demonstrated a good understanding of people's needs.

Activities and events were organised to make them meaningful for people using the service. Staff worked

with individual people or in groups and there were a range of events outside the home. Concerns and complaints were managed effectively with a clear process in place.

Clear leadership and monitoring systems enabled the service to identify good practices and areas for improvement. People, relatives and staff said the registered manager was approachable and made themselves available to speak with them. The service collected people's and relative's views on their experiences of the care provided so that further improvements could be made. The registered manager was developing new ways of linking the service with their local community.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

People enjoyed their food but for some people mealtimes was not always a good experience.

People were receiving care and support from staff who were trained; although a few staff needed their fire training updated.

The service understood the requirements of the Mental Capacity [MCA] Act and Deprivation of Liberty Safeguards [DoLS], which helped ensure people's rights were upheld but could not always evidence how they arrived to these decisions.

Staff supported people to access advice and treatment from a range of healthcare services.

Is the service caring?

Good

The service was caring

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive

Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well-led

Details are in our Well-Led findings below.

Aspen Court

Detailed findings

Background to this inspection

We carried out this comprehensive 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 service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 19 and 20 February 2019 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information the provider sent to us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service which included notifications of events and incidents at the service. We planned the inspection using this information.

During the inspection we spoke with eight people, seven relatives and met with a further six who were attending a monthly relatives meeting. We also spoke with two registered nurses, three care workers, the activities coordinator, the registered manager, the company's compliance manager, the chef and a member of the domestic staff.

We looked at four people's care records and people's medicines administration records. We also reviewed five staff employment records and other records relating to the management of the service including complaints records, health and safety information, and the provider's quality assurance systems. We carried out a specific observation of people's experiences at mealtimes, general observation of how staff provided care to people and looked at most parts of the premises.

Good

Is the service safe?

Our findings

The service continued to provide safe care. People told us they felt safe with the staff who supported them. Some people who lived in the service were unable to fully express themselves due to living with dementia. People were observed to be comfortable and relaxed with the staff who supported them. One person said, "I am safe here, they keep me safe by looking after me" and a relative said, "She is very safe here, the staff make sure of that, they pop in to check up on her all of the time, around the clock."

People had sufficient numbers of staff around to keep them safe and ensure their needs were met. All staff we spoke with said they felt there was enough of them on duty. One member of staff said, "Usually, we have really, really good staffing levels" and one person said, "Staff come when I call them."

People were protected against the employment of unsuitable staff because recruitment procedures were followed. Checks had been made on relevant previous employment as well as identity and health checks. Disclosure and barring service (DBS) checks had also been carried out. DBS checks are a way that a provider can make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Two of the records we looked at did not provide an explanation for a gap in employment, the registered manager agreed to follow this up with the staff concerned.

People continued to be protected from abuse because staff understood what action they needed to take should they suspect someone was being abused, mistreated or neglected. Staff were confident the provider and registered manager would act on any concerns. Staff also knew how to 'whistle blow' and raise concerns outside of the organisation. We saw posters displayed and guidance for staff to follow on how to raise concerns.

Care plans contained risk assessments for areas such as mobility, falls, skin integrity and malnutrition. When risks were identified, plans provided clear guidance for staff. We saw staff using equipment safely when assisting people to move around the home. Staff knew when people were putting themselves at risk and requiring extra support; for example, if people became confused, or trying to move on their own, staff would join them and keep them safe.

Medicines were managed safely. The electronic recording system provided a clear audit trail of stock balances and times when medicines were administered. There was a safe system in place for disposing of medicines that were no longer required and controlled medicines were stored safely. Some people were having their medicines administered covertly. In these cases, there was documentation in place which showed who had been involved in the decision, including the GP and pharmacist.

People were prescribed additional medicines on an 'as required' (PRN) basis. Although there were PRN protocols in place, these were not personalised. We discussed this with the deputy manager during the inspection and they said they would ensure the protocols were rewritten in a more person-centred way. Topical administration charts had been filled in which indicated people had their creams applied as prescribed. Also, the prescribed topical creams or lotions had clear instructions in place for staff to know

when and where to apply them.

The health and safety of the environment continued to be safe and well maintained. There was a fire risk assessment to identify fire hazards. Regular fire drills took place so staff could practice evacuation procedures. We saw valid certificates for Legionella, gas safety and electrical maintenance checks. Portable appliances were tested annually and these checks were up to date. Fire equipment and systems such as fire extinguishers, smoke detectors and alarms were checked weekly and serviced annually to ensure they were functioning properly.

People had personal emergency evacuation plans in place which identified their needs, their ability to respond in the event of a fire, and the support they may require to evacuate the building.

People were protected from the spread of infections. Staff understood what action to take to minimise the risk of cross infection, such as the use of gloves and aprons and good hand hygiene to protect people.

The registered manager had systems in place to learn from risks, significant incidents or accidents at the service. Incidents were investigated, improvements made and learning points were discussed at staff meetings.

Requires Improvement

Is the service effective?

Our findings

The service did not always provide effective care and support to people. Staff were competent in their roles and had a good knowledge of the individuals they supported. One person said, "I couldn't be happier, the staff are wonderful" and a relative said, "The staff are brilliant, they care a lot about everyone, they are very kind people."

The training records showed that most staff were up to date with their training and the registered manager was making arrangements for the two staff who needed updating on their fire training. Nurses said they had access to training and development to meet their professional registration requirements. One nurse told us, "We get mandatory training and we also have access to extra training and I've just done my NVQ Level 5 as well." A member of care staff said, "We get lots of training. I've started my NVQ Level 2." Records showed that staff were supported through regular one-to-one supervision and observations made by their supervisor.

People were supported to have enough to eat and drink. People said the food was good, one person said, "Food is very good, you get a good choice of food here, I eat well." A relative told us, "They get a really good choice of food here, I have eaten here quite often it is very nice" but another said, "The food looks horrible, she has to have a very soft diet, but it all gets eaten." Good practice is for the soft diets to have the different foods separated on a meal plate. We noted that for some people all the different tasting foods were mixed into one before being served. We pointed this out to the registered manager who was going to look into it and improve the staff's practice.

People's nutritional needs were assessed and their weights were monitored. The food and drinks people liked and disliked had been documented. When people lost weight, advice was sought and people were provided with food supplements. However, we saw that people did not always have access to drinks when they wanted them. For example, we saw a member of staff ask one person if they wanted a drink. The person replied, "Tea", and the member of staff said, "Would you like some squash?" We asked why the person couldn't have a cup of tea and were informed the trolley would be round in half an hour. When we asked why this meant the person couldn't have a cup of tea now, the member of staff did go and get them a cup of tea.

We observed lunch on the ground floor. The dining room was busy, and many people were sat at the dining tables. There was also a table of three people in an annexe where we saw a member of staff assist one person at this table with their meal. They did not inform the other people how long they would have to wait for their meals; instead the other people watched as one person had their lunch. Seven minutes later, staff gave a meal to one of the other people who ate their lunch independently. After the staff member finished assisting the first person they began assisting the third person with their meal without an apology for making them wait for 15 minutes. We discussed this with the deputy manager who said the majority of people needed assistance with their meals, which meant some people had to wait. We advised that this arrangement needed to be reviewed. We also saw that a few staff stood over people while assisting them with their meal rather than sat beside them and engaging in conversation. On arrival we observed a member of staff stood over someone whilst assisting them with their breakfast saying "Open…eat…open… keep

eating" without any other conversation taking place.

The Mental Capacity Act (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the 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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider ensured all staff had been trained in the MCA.

Although people's capacity to consent to aspects of their care had been assessed, it was not always clear how best interest decisions had been reached when people lacked capacity. For example, in one person's plan it was documented, "All personal care needs with 3 carers and 2 carers to make a minimal restraint (holding hands to prevent bruises)." However, the person's capacity to consent to this had not been assessed and there was no documented evidence of a best interest decision meeting. We discussed this with the deputy manager during the inspection. They said the decision had been reached in conjunction with other health professionals and the person's family, but were unable to locate records of this arrangement. They said they would address this issue with immediate effect. Some people had bedrails in place, but the documentation in relation to the use of these did not detail if any less restrictive options had been considered or why they had been rejected. We also discussed this with the deputy manager during the inspection and again we were told they would address the lack of written information.

People's healthcare needs continued to be met by a range of healthcare services such as GP's, psychiatrists, physiotherapists, dentists, dieticians and chiropodists. Records confirmed relevant healthcare professionals were involved in ensuring people were receiving care and treatment when they needed it.

The home was purpose built, the environment had adequate adaptations and was suitable for people. People could relax and spend time with visitors in communal areas. Toilets and bathrooms had equipment such as grab rails to assist people in maintaining their independence. People had showers in their en-suite bathrooms and the service also offered people assisted baths if they chose to use them.

Good

Is the service caring?

Our findings

Staff continued to provide a caring service to people. One person told us, "The staff are very nice and kind, they take time to talk to me, they are very nice people" and another said, "Everyone is nice to me and are caring." A relative said, "The staff are brilliant, they care a lot about everyone, they are very kind people" whilst another said, "This is a very homely place, the staff are lovely, kind, caring people, you could not ask for a better bunch of people to look after your loved one."

Staff were mostly attentive to people's needs and understood when people needed reassurance, praise or guidance. We observed some positive exchanges between staff and people. For example, on one occasion we saw a member of staff respond swiftly when one person said they felt cold. We heard another person tell a member of staff they were going to the shops to buy some tea and coffee. The staff member said, "Oh, you don't need to go, I bought some yesterday." The person said, "Well, that's good then, I can save my money. I'll stay here instead."

However, there were occasions when staff interacted in a less positive way. On one occasion we saw a person stand up in the lounge and take a few steps, a member of staff looked up and said, "Sit down please [person's name.]" On another occasion, the same person walked into the hallway and another member of staff said, "Come on [person's name]. I don't mind you wandering as long as you do it in the lounge." We also observed a member of staff drawing whilst being surrounded by 5 people and not engaging with them. A few minutes later another member of staff took over, getting one person involved in a puzzle game whilst complimenting another person in the group, with two others listening.

People told us their privacy and dignity was maintained and respected. Staff knocked on people's bedroom doors and asked the people what help and support they wanted. People told us they could make choices about how they spent their time and were able to remain in their rooms if they wished. Staff were able to tell us how they maintained people's privacy and dignity, in particular when assisting people with personal care.

The service continued to encourage people's independence. Care plans stated what people could do for themselves and what they needed support with. Staff were also able to tell us how they prompted people to try and help themselves. One relative said "The previous home gave up on her. Here staff got to know her and gave her back her dignity. They are so kind and supportive, she's such a different person now. They are getting her to do things which I thought was no longer possible and they talk to her properly, not like to a two year old."

People's equality and diversity needs were acknowledged and respected. Care records documented relevant information regarding their ethnicity, religious and cultural beliefs. One person was supported in participating in a weekly religious service. The service had a multicultural team and through speaking with staff and the management team, we were satisfied the culture at the home was non-discriminatory and the rights of people were respected.

People and their relatives told us the service involved them in decisions regarding the care and support

provided. One relative told us, "I'm always kept informed about what's going on." Care plans reflected that people and their relative, where appropriate, were involved in decisions around the care.

Records relating to people's personal information and staff personnel were confidentially stored appropriately in the office and only accessed by staff.

Good

Is the service responsive?

Our findings

People received support from a staff team who responded to and understood their individual needs. People had a pre-admission assessment completed before they moved into the home. The registered manager confirmed this enabled them to determine if they could meet and respond to people's individual needs.

People's care records were person-centred and held detailed information on how each person wanted their needs to be met in line with their wishes and preferences. Care plans included people's preferred routines but some required further information on how to provide the care. For example; one plan did not detail if a person preferred a wet or dry shave or their preferred choice of clothes. People's records held information on their social and medical history, as well as any cultural, religious and spiritual needs. Staff monitored and responded to changes in people's needs and we saw that care plans were regularly reviewed.

We discussed people's support needs with staff who were able to demonstrated a good understanding. One member of staff said, "I find out about people by reading the care plans and all the paperwork. We need to learn everything we can about the person. Day to day we learn more. It's really important." Staff said some people were given verbal choices while others were shown visual clues to make choices from. One person told us, "I get offered choices and feel involved in my care" and a relative said, "I have Power of Attorney to act on their behalf, I am fully involved in every aspect of the care planning process, I attend regular reviews as required."

People were given information in formats they understood in line with the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information they can easily read or understand. There was a poster on display informing people of the home's commitment to working with people using a communication method which suited them. The service was decorated to assist people in recognising rooms by themselves. Also, staff were learning some signs and gesture to visually communicate with people.

People continued to be supported to participate in various activities, organised by an activities coordinator and assistants, seven days a week. The activities on offer catered for both individuals and groups to meet people's preferences. A weekly programme of activities was developed. Twice a week an outside entertainer came into the home; this ranged from singers and visits by various animal charities. A local vicar visited the home on a regular basis to provide church services. The home had begun to develop contacts with the local nursery where the children visited the home and currently played in the garden. In time the children would enter the home and interact with people using the service. The activities team also facilitated 1-1 interventions with people in the privacy of their bedroom. People told us of the various activities they had participated in which included, singalongs, celebrations of festivals, feasts and events such as birthday celebrations.

One person said, "We do have activities going on here, I don't always go. I have a copy of the activities plan, sometimes I go to the singing as I like music. In the summer I like to sit outside" and a relative said, "She does not really take part in the activities due to her dementia, but the staff try and involve them as much as

possible."

Complaints and concerns were managed effectively. The complainant received a response to their concerns in a timely manner, in keeping with the provider's complaints procedure. People and their relatives knew how to make a complaint but they mainly used informal methods such as the residents' meetings, feedback surveys or speaking directly with staff or the registered manager. All the relatives we spoke with said they knew how to raise complaints if the need ever arose.

The service was accredited with the 'Gold Standards Framework in Care Homes' which is a programme to improve end-of-life care in nursing homes. There were advanced plans in place which enabled people and their families to inform staff of any special wishes around how they want to be cared for at the end of their lives. This included information such as whether people wished to be admitted to hospital and if they have any spiritual preferences.

Good

Is the service well-led?

Our findings

The service continued to be well led. People lived in a service where the provider's caring values were embedded into the leadership and culture of the service. People and staff all spoke highly of the registered manager and how approachable they were. Comments included, "The managers are very nice and friendly and approachable, they come round and see me quite often" and "We do have people in command here, they come around, not bosses just people." A relative said, "The manager here is very friendly and open, I like them a lot, I have attended meetings in the past, and I always complete the quality surveys when asked to do so. I chose this home for my relative and I would recommend this home to anyone."

The registered manager provided clear leadership and was introducing a range of new ideas, such as improving the home's links with it's community. The provider's governance framework helped monitor the management and leadership of the service, as well as the ongoing quality and safety of the care people were receiving. For example, systems and process were in place such as, accidents and incidents, environmental, care planning and nutrition audits. These helped to promptly highlight when improvements were required.

The registered manager was open and transparent and was very committed to the service and the staff, but mostly the people who lived there. They felt it was important to select the right staff for the job and so they also had to let staff go who did not have the right culture for the home. People benefited from a provider and management team who worked with external agencies in an open and transparent way and there were positive relationships fostered.

The service used surveys and meetings to consult, discuss and obtain feedback from people and their relatives. Matters discussed included menus, activities, staffing and maintenance. The registered manger had a very detailed survey for 2018 and could demonstrate that actions or issues identified during residents and relatives' meetings were addressed

People lived in a service which was continuously and positively adapting to changes in practice and legislation. The provider was fully aware of and had implemented the Care Quality Commission changes to the Key Lines of Enquiry (KLOE). They had also looked at how the Accessible Information Standard would benefit the service and the people who lived in it. Regular staff meetings took place to involve staff in the running of the service. Meetings were used to provide updates, share learning and good practice. Staff were clear about their roles and responsibilities and were committed to providing good care and improving people's well-being. One member of staff said, "We are a good team and support each other. We work together to make people happy."

The provider worked on learning from mistakes and ensured people were safe. The registered manager and registered provider had an ethos of honesty and transparency. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment. The registered manager complied with the requirements of their legal registration by providing us with notifications of significant incidents as required and the service displayed the rating of their last inspection in a public area.