Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Aspen Lodge Care Home

Yarborough Road, Skegness, PE25 2NX

Tel: 01754610320

Date of Inspection: 04 February 2014

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We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Management of medicines	✗ Action needed
Staffing	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	Doulton Court Limited
Registered Manager	Mrs. Katrina Morris
Overview of the service	Aspen Lodge Care Home is situated on the outskirts of Skegness, a seaside resort in Lincolnshire. It provides personal and nursing care for up to 52 people, some of whom may have mental health needs, physical disabilities or dementia.
Type of services	Care home service with nursing Care home service without nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 4 February 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

What people told us and what we found

When we visited Aspen Lodge 35 people were living there. We spoke with eight people as well as the manager, members of nursing and care staff and two relatives. We also had discussions with visiting health care professionals and a training provider.

We looked at records and observed how staff supported the people living in the home.

Before people received care or treatment they were asked for their consent. Staff respected their wishes. For people who could not make an informed decision, the provider acted in accordance with legal requirements.

People told us they were happy living in the home. One person said, "I'm cared for properly; no doubt about it. I couldn't be looked after any better." Care records were comprehensive and reflected people's needs.

Staff did not administer medication unless they had received appropriate training. However, we found the home was not following the provider's policy for the control and administration of medicines.

People we spoke with had divided views about whether there were enough staff on duty all the time. We found at the time of our visit there were enough qualified, skilled and experienced staff to meet people's needs. A validated dependency tool for assessing people's individual needs was not in place.

People told us they knew how to make a complaint and to whom. There was an effective complaints system in place. Comments and complaints people made were responded to appropriately.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 13 March 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.
Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

The people we spoke with told us staff asked their permission before they did anything for them, for example helping to support them at mealtimes or taking them to the toilet.

When we sat and observed care being delivered in the dining room we saw staff asked people if they wanted help cutting their food up or if they wanted sauce on their lunch. It was only when a person responded positively the support was given.

One person told us, "They always ask me if they can do things first." A visiting health care professional told us, "I haven't heard anybody do anything for people without asking for their consent first."

The care files we looked at showed every person had a care plan in place relating to consent. It included consent for photographs and receiving care. In some cases capacity assessments had been undertaken for important things such as having bed rails in place. Capacity assessments are a way of deciding if a person has the ability to make a decision.

We saw where appropriate best interest meetings had taken place. The Mental Capacity Act 2005 (MCA) states that if a person lacks mental capacity to make a particular decision then whoever is making that decision or taking any action on that person's behalf must do it in the person's best interests. This is one of the principles of the MCA.
In one file we saw a best interest reporting form for a decision about a person's admission to hospital. There was evidence that all interested parties had been involved in the decision, for example relatives, social workers and health care professionals.

Qualified nurses and care staff we spoke with knew of the systems and processes in place to support people who lacked capacity to make decisions on their own.

Staff were also aware of the need to be aware of people's non-verbal communication when ensuring they had consent to support them. One member of staff told us, "I am very aware of people's facial expressions, body language and gestures. I know when people do not want to do something or have a drink for example and I respect that."

We looked at training the staff had received in relation to the MCA. We saw 98% of staff had received the training. The manager informed us training on the subject would be repeated in 2014 for all staff.

The service had completed a check on 19 January 2014 on the number of people who had a do not resuscitate form signed by a doctor in their care records. We found there were 11 people. We looked at a sample of them. Some did not indicate whether people's capacity had been assessed or relatives had been involved before the decision had been made. We saw they had been completed when people had been in hospital.

In one record, the decision was meant to have been reviewed on 14 October 2013 and this had not been undertaken. However, the manager was aware of this and told us all the forms would be reviewed and where necessary a discussion had with their GP.

We saw the provider had policies and procedures in place relating to consent for staff to refer to.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

People felt safe and felt well cared for by staff who were responsive to their needs.

During our visit the home appeared calm and people looked clean and tidy. A qualified nurse told us the home had a clear divide between responsibilities for those requiring nursing and residential care. Care staff were responsible for those requiring personal care only and qualified nurses were responsible for those requiring nursing care. However, they also told us nurses would always help if a personal care client required urgent attention. We saw staff worked as a team.

The majority of people we spoke with told us they were well cared for and staff were kind to them. One person said, "I'm cared for properly; no doubt about it. I couldn't be looked after any better."

A relative told us, "Sometimes xxxx looks as though they've been dragged through a hedge backwards; it depends on who's on duty." On the day of our visit xxxx looked well cared for and settled. However, we fed back the relative's remarks to the manager for them to address.

We spoke with one relative who told us the wired call bell for their loved one had been removed from the wall. We saw three people's bells had been removed and asked a member of staff why this had happened. They told us one bell had been removed as it was a trip hazard to the person and the others had been removed because both people were unable to use them. There were however, additional checks made on each person which were documented. The checks occurred every half hour or every hour. Staff could still use the wall mounted call system to summon help if it was required.

We looked at four people's care records in detail during our visit. They all had different needs. They were filed in exactly the same way. The care records were very comprehensive but were difficult to read because of the amount of paperwork that was required to complete them. The provider may wish to note care records should be easy to read for staff in order that care needs can be identified quickly.

The care plans included each person's care needs and what staff should do for them in order to meet those needs. For example, personal hygiene and continence needs. Risk assessments were also in place and how staff could reduce those risks, for example the risk of falling when mobilising. Care plans were reviewed on a monthly basis or more regularly if needs changed.

All the staff we spoke with knew the care needs of the people we case-tracked very well.

We saw life histories were in place for people. This is particularly important for people with a memory loss. A member of staff told us it was sometimes difficult to obtain details of a person's life from relatives.

Records were in place which reflected visits by district nurses, GP's or hospital appointments.

My Journal documents were kept in each room. Visitors were encouraged to fill them in each time they visited. In one of the documents we saw an entry which said, "Visited xxx, quiet and sleepy, enjoyed lunch"

During a period of observation in the dining room at lunchtime we saw staff helping people when it was necessary but at the same time promoting independence. When necessary staff supported people in a calm and relaxed manner to eat their lunch. They sat beside people making good eye contact and not rushing them.

Lunch looked appetising and people told us they enjoyed the food at the home and were offered choices of food at each meal time. On the day of our visit the lunch meal choices were lasagne or a vegetable bake.

The home employed two activity organisers providing 30 hours of activities each week. We spoke with one of them who told us about some of the activities they undertook. They included farmyard bingo and music and movement. They told us they were arranging special celebrations for Pancake day and an Irish day. People living at the home told us they enjoyed the activities. One to one activities were given for people who stayed in their rooms, for example hand massage and reading newspapers.

Management of medicines ✖ Action needed

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines. The provider had appropriate arrangements in place to manage medicines but staff were not adhering to them.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People were not safe because the systems and processes in place were not robust enough to ensure the safe administration, storage and disposal of medicines.

People we spoke with told us they received their medicines on time and if necessary could request pain relieving medicine which they were always given.

The home had two medicine trolleys; one for medicines for people receiving personal care only and one for those receiving nursing care. Qualified nurses administered the medicines for nursing clients. Care staff administered medicines for people receiving personal care.

We saw all staff had received training to administer medicines which was updated on a regular basis. Annual supervision was given to staff during a medicine round to ensure they were administering medicines in a safe way. This was documented.

We looked at a random selection of medication administration records (MAR) and found staff had signed them to evidence they had administered them. Photographs were present on the charts to ensure people were correctly identified. However, in one instance a member of staff had used a code on the MAR chart on a number of occasions to indicate the person had not received their medicine. There was no explanation given on the MAR chart of what the code meant. We found it was because the person had been asleep.

We saw body maps were being used for identifying where pain relieving patches had been placed so the same place was not being used regularly. However body maps were not always in place to identify where skin creams should be applied. A local chemist had offered to supply training for this.

We looked at the way the home stored and administered controlled drugs. (CD's). Controlled drugs are drugs that are controlled under the Safer Management of Controlled

Drugs Regulations 2006. We saw the storage of the drugs was appropriate and the register had been completed correctly and signed by two members of staff. The number of CD's remaining in the cupboard corresponded to the register.

Controlled drugs which were no longer in use in a home that provided nursing care must be disposed of safely using a controlled drug destruction kit. The home used a destruction kit on a once only basis and returned it.

We looked at the cupboard for storing medicines that could not be administered in blister packs. We saw it was very full and stock rotation was poor. For example, one boxed medicine had been issued in August 2013 and every month thereafter. The box issued in August was on the bottom of the stock pile instead of the top to be used first. This meant it may not be used until the expiry date had passed.

There were three books in use for unused, wasted or returned medicines to go back to the chemist. The qualified nurse we spoke with told us there should only be one in use at a time.

We looked at all three books. There were gaps evident for example, the reason for the medicine's return and where a witness signature should have been present. In addition there were no signatures present of people collecting waste medicines from the home.

We looked in the waste medicines bin and found three tablets that had not been individually bagged and labelled. We also saw inappropriate waste in the bin for example tissues and cellophane wrapping.

We looked at the home's medicine policy. The home was not following the provider's policy for the control and administration of medicines.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

People we spoke to were divided about whether there were enough staff on all the time to meet the needs of people in the home.

Two people living in the home told us there were enough staff on duty and they did not have to wait long for their bell to be answered if they needed attention. One person told us, "Oh, they came quite quickly really."

Two relatives felt there weren't always enough staff to meet their loved one's needs. One of them told us, "There aren't always enough staff to take xxx to the toilet when they want to go." We told the manager about this who said they would look at the problem.

We saw from the off duty for a period of two months, one nurse was on duty throughout each twenty-four hour period. Seven care staff were on duty between 7.30 am and 2.30 pm, six care staff were on duty between 2.30 pm and 8.30 pm and four between 8.30 pm and 7:30 am.
We were told there were no handover times built into the staffing rotas. Nurses and senior staff came in early in their own time to ensure they knew about any change in care needs for people during the previous shift.

The manager, who was not included in the shift patterns and who was also a qualified nurse, was generally on duty Monday to Fridays each week. However we saw they also covered nursing shifts when required. Bank staff were available to cover sickness and annual leave.

In addition ancillary staff were employed for cleaning, laundry, catering and general maintenance duties.

Nursing and care staff were deployed according to the needs of the people in the home; one person required a member of care staff with them all the time.

Staff told us that most week days at least one member of the care staff on duty was required to accompany people to GP, hospital, dental and optician visits in the town. Some

of the hospital visits could take many hours.

Staff we spoke with told us they were always busy and felt they did not have time to speak with people except when they were undertaking personal tasks for them. They were particularly concerned when care staff had to accompany people to appointments.

We saw people in the lounges during our visit. A member care staff did not stay in the lounges all the time but kept checking on people on a regular basis to ensure they were safe; this was documented.

We asked about the number of falls that had taken place in the lounges in the last six months. We were informed there had been seven, five of which had not been witnessed. Most of the falls had occurred during late afternoon or early evening.

Staff told us people did not have individual call-bells in the lounges to alert staff if they required help. They generally relied upon one person to call them if someone needed attention. The provider may wish to note consideration should be given to ensuring people can always attract staff attention on an individual basis if it is required.

The manager told us the home did not have the facility to undertake call bell checks to ensure they were answered promptly, so we could not see this. However, during our visit call bells were answered promptly.

There was no evidence in care plans that individual dependency assessments were undertaken on a regular basis to determine safe staffing levels using a validated tool. We spoke with the manager about this. They informed us the dependency levels of people in the home were getting higher and the provider was piloting a validated tool in some of their homes. They expected this to be introduced into the other homes in the organisation soon. The provider may wish to note consideration should be given to ensure the validated tool takes account of the time care staff undertake escort duties for people and are therefore not in the home.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

We saw a copy of the provider's complaint policy which had been placed on the wall in the entrance to the home. The policy was very clear on who to contact.

When we arrived at the home people living in the home were having a meeting with a senior member of staff. We sat and spoke with people after the meeting had finished.

We saw the minutes of the meeting later in the day and people had raised a number of issues, for example concerns about the heating and automatic door closures to some rooms. The manager informed us they would request the maintenance person dealt with them as soon as possible.

People and relatives we spoke with in the home knew how to complain and who to complain to if they had concerns about anything. One person told us, "I would tell xxx. They would sort it out for me."

One relative spoke about concerns they had raised informally twelve months previously. These had been resolved. Another relative told us they had some concerns but would not raise them as a complaint because of fear of reprisals on their loved one. They gave us permission to speak with the manager about them which we did. The manager was concerned they had not been informed about them and told us they would deal with the situation sympathetically.

Staff were aware of how to deal with concerns about the home; they would pass it to the manager of the home immediately.

We looked at the complaints folder in the home and saw five complaints and two compliments had been logged in 2013.The complaints had been fully investigated and the outcome documented within the stated timescales. This meant the home had responded to people's concerns.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: People were not protected against the risks associated with medicines. The provider had appropriate arrangements in place to manage medicines but staff were not adhering to them. Regulation 13

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 13 March 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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