Camelot Care (Somerset) Limited

Acacia Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook an unannounced inspection of Acacia Nursing Home on 5, 6, 9 and 10 August 2018. This inspection was undertaken in response to concerns we had received from relatives and external healthcare professionals who visited the service. The concerns primarily related to people receiving safe care and treatment, staffing and leadership and governance.

Acacia Nursing Home was last inspected in February 2018, we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. We identified significant concerns with the safe care and treatment of people including medicine management, choking risks and pressure care. People who lacked capacity were not having decisions made in line with current guidance. Staff levels and training were not adequate to keep people safe. There was a lack of governance by the management to monitor the quality of care people were receiving. Legal notifications had not been received by the Care Quality Commission as required.

Following the inspection, we restricted admissions to the service and required the provider to send us a monthly report of how they were improving the concerns we found. The provider sent monthly audits to demonstrate the progress they thought they had made. We also placed the service in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures. to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

During this inspection, in August 2018, we found some improvements had been made. Most people who lacked capacity now had decisions made in line with statutory guidance. Staff had improved amounts of

training. There was improvement around fire safety in the home and people were at less risk of choking. The management had started to work on the culture of the home and improve the environment. Recruitment systems for new staff had improved.

However, significant concerns were still found with the management of medicines, pressure care and the management of the home. Staff levels were not safe enough to meet people's care and health needs. Accidents and incidents had been logged yet patterns of concerns had not been investigated. Quality assurance systems had not identified shortfalls found during this inspection. Where they had identified issues, they had not always been followed. One safeguarding had not been identified and not all significant events had been notified to the Care Quality Commission in line with their statutory requirements.

Acacia Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service can accommodate up to 39 people. There were up to 24 people living at the home during this inspection because two people had time in hospital. The building is purpose built and has a courtyard garden in the middle. There are three floors with communal spaces such as lounges and dining rooms on each floor. At this inspection everyone had their own individual bedroom.

One of the directors was acting as the manager at the time of this inspection. This was because a manager was absent who was currently completing the process of becoming the registered manager. 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.

The service continued to not be well led and some shortfalls identified during this inspection had not been identified by the quality assurance processes. There was still some disorganisation by the management and systems in place to audit the service people were receiving were not always acted upon. The provider had still not completed all statutory notifications in line with legislation to inform external agencies of significant events. There continued to be issues locating some documents and providing information in the required time frames.

People remained unsafe at the home because people did not receive care and treatment in line with their health needs. There were risks of infections spreading because practices found around the home did not always keep it clean. Some risk assessments were carried out to enable people to retain their independence and receive care with minimum risk to themselves or others. However, when people had a new health risk, systems had not been put in place to mitigate them. Medicines were still not managed safely.

Staff had received most of the training to have the skills and knowledge required to effectively support people. However, when people were identified as at risk of seizures no training had been provided and medicines competency checks for nurses had not been completed. People told us their healthcare needs were met and staff supported them to see other health professionals. Most people who required special diets and drink now had their needs met. One person with a special diet had not been reviewed since moving into the home. Meal times were not always treated as a social opportunity and special thickening agents were left unsecure in people's bedrooms.

There were not enough staff to meet people's needs consistently and keep them safe. People were not always protected from potential abuse because systems had not always identified when this had occurred.

Staff understood how to recognise signs of abuse and knew who to report it to. The recruitment procedures were in place to protect people from unsuitable staff supporting them.

Some staff had developed incredibly positive relationships with people. Most people's privacy and dignity had been respected. However, there were many times interactions between staff and people were task based. Staff did not always offer choice to people.

There were no permanent activity coordinators at the time of the inspection. Despite this activities were provided in communal spaces on the ground floor. However, there were times people's personal interests had not been considered. People in their bedrooms lacked activities. There continued to be mixed opinions about whether complaints were investigated and responded to in a timely manner. No records of actions taken to prevent reoccurrence had been made.

Most people and their relatives told us, that permanent staff were kind and patient. People's care plans had been improved to make them personal. However, they still contained inconsistencies and there was sometimes a lack of specific information to guide staff to people's needs and wishes. People continued to not always be supported to have all areas of their life considered prior to their death.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In addition, a breach of the Care Quality Commission (Registration) Regulations 2009 was also identified. All of these breaches were repeated from the previous inspection in February 2018. You can see the action we took at the end of the report.

The overall rating for this service is 'Inadequate' and the service therefore will remain in 'special measures'.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's medicines were not managed safely and people were not consistently receiving safe care and treatment.

People were not supported by enough staff to meet their health and care needs.

People had risks of abuse or harm minimised because staff understood the correct processes to be followed. However, the management were not always identifying potential abuse.

People were not always kept safe from the spread of infection because the service was not always kept clean.

People were protected because there had been an improvement with recruitment of new staff.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported by staff who had received most training needed. Not all staff had their competency levels regularly checked.

Most people who lacked mental capacity had decisions made in line with current legislation. However, there were occasions this had not been considered.

People did not always have a social experience at meal times.

People had access to medical and community healthcare support. However, when there was a new health need this was not always promptly resolved.

Is the service caring?

Requires Improvement

The service was not always caring.

People's decisions were sometimes made by staff without consulting people or based on the needs of the service.

People's needs were met by some staff who were kind and caring. Improvements were required because staff were task orientated.

People's privacy and dignity was respected by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not benefit from activities in accordance with people's interests.

People's care plans were more personalised. However, there was not enough guidance for staff in some care plans to meet people's needs and wishes.

People and their relatives knew how to raise concerns. However, there was a mixed opinion about whether action had been taken.

People did not always have a dignified death planned with them.

Is the service well-led?

Inadequate

The service was not well led.

People were living in a service where scrutiny by the management and external consultants had not ensured they were receiving care and treatment in line with their needs. There were no clear systems identifying actions taken to shortfalls identified.

People were supported in a service which was striving to have an open culture. However, it was not felt by staff this was being achieved all of the time.

People's care and safety was compromised because other agencies were not being sent information in line with the provider's statutory responsibilities.

People lived in a service where the provider was striving to make improvements.

Acacia 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.

This inspection was carried out by two adult social care inspectors for every day of the inspection, a medicine inspector for one day and a nurse specialist adviser for one day. This inspection was undertaken in response to concerns we had received from relatives and external healthcare professionals who visited the service. The concerns primarily related to people receiving safe care and treatment, staffing and leadership and governance.

When Acacia Nursing Home was last inspected in February 2018, we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009.

As this inspection was brought forward following concerns received the provider had not completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection we reviewed the information that we had about the service including the information of concern we had received that triggered the inspection, the provider's action plan, safeguarding records, complaints, and statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

Some people in the service were living with dementia and were not able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences. We 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 eight people who used the service and five people's relatives or visitors. We also spoke with 15 members of staff. This included two directors, the deputy manager, nursing staff, care staff and ancillary staff.

During the inspection, we looked at 12 people's care and support records. We also reviewed records associated with people's care provision such as medicine records and daily care records relating to food and fluid consumption. We reviewed records relating to the management of the service such as the staffing rotas, policies, incident and accident records, recruitment and training records, meeting minutes and audit reports.

During the inspection we asked for 14 documents and explanations to be sent to us which we were unable to find at the home. Eight of these were not sent within the deadline. Most were discussed prior to the inspection closing with the management. They sent further information to us following the inspection.

Inadequate

Is the service safe?

Our findings

At our inspection in February 2018, we identified that people were not safe living at the home. This was because there was a wide range of concerns found including the management of accidents and incidents, unsafe recruitment, preventing the spread of infection, staffing levels and training, medicine management, pressure care, managing the risks of choking and health and safety concerns including fire safety.

Following the inspection we restricted admissions to the service and required the provider to send us a monthly report of how they were improving the concerns we found. The provider sent monthly audits to demonstrate the progress they thought they had made. During this inspection, in August 2018, we found some improvements had been made. Work had been completed around the home to improve fire safety. There was a system in place to record most accidents and incidents. Risks of people choking had been reduced through staff training and specialist guidance. There was now a system in place to ensure risks were reduced to people when staff were recruited. However, the service remained in breach of the regulations. We continued to find concerns in relation to the management of medicines, pressure care issues, assessing risks and staffing. New concerns were found in relation to people with specific health conditions such as seizures.

Staff used medication administration records (MARs) to record when a medicine had been given. We reviewed ten MARs and found they had been satisfactorily completed which was an improvement since the last inspection. People who were prescribed patches containing medicine, had separate recording charts which had been appropriately completed. Medicines were mainly stored securely. People who required medicines to be administered hidden in food now had the correct processes in place.

However, some medicines were not being administered as directed by the prescriber, and some medicines had not been administered at all with no reason recorded. This was brought to the attention of the staff and they told us these would be investigated. Handwritten additions to MARs had mostly been dated, signed and double checked by a second member of staff. Although, there was one entry where the dose had been increased by a hand-written change with no signature or date present to confirm the change.

Medicines continued to not always be stored in conditions as directed by the manufacturers. Fridge and room temperatures were being recorded daily. Records showed that the fridge temperature was considerably higher than the recommended range. There was no evidence that the raised temperatures had been investigated. This meant the medicines may not be safe or effective. When this was raised at the inspection the provider arranged for a replacement fridge to be obtained. One member of staff arranged for replacement medicines to be prescribed and supplied.

On one day some eye drops which should be stored in the fridge were found on top of a medicine trolley. Two staff members told us there was only one set of keys for the medicines fridge despite two nurses completing the medicines round at the same time. Two thickening agents were not stored securely despite people walking around floors unattended. This meant they were at risk of digesting the powder which could lead to asphyxiation.

Opening dates were being recorded on most liquids and eye drops however we did find one bottle of eye drops which was currently being administered that did not have this recorded. Staff told us they had no assurance that they had not expired. They were disposed of and a new bottle placed in the trolley to be opened that evening.

Staff had some additional information for most medicines prescribed to be taken 'when required' and they explained when medicines could be given. These lacked details on assessments of needs that needed to be made to identify when the medicine should be administered. We also saw some protocols about when the medicines should be administered missing from records on the day of inspection. This meant staff may not give doses of medicines as intended by the prescriber. Records did not show how assessments had been made before administration and did not show the outcome of the use of these medicines. By not recording the outcome staff were unable to determine if the medicine had been effectively used.

People continued to be at risk of pressure ulcers despite small improvements in systems to monitor pressure care in the home. People's weights had been recorded on the pump to control the air pressure for the air mattresses and they were being checked by senior staff weekly. Regardless of these systems three were found incorrectly set. By not being correctly set there was a risk people lying on them would not benefit from the pressure relieving qualities. On the second and third days of inspection one person's mattress had an emergency alarm muted and was incorrectly set. The alarm was meant to sound if there was a fault with the mattress. Another mattress was set for a person weighing 125 kilograms even though they weighed 69.4 kilograms. Members of management went round and checked all the mattresses when we informed them of our concerns.

On the last day of inspection three people were found in wheelchairs with no pressure relieving cushions. One member of staff told us two of the people had been in the wheelchairs for 45 minutes. All three people had been identified as very high risk of pressure ulcers. One of the people complained about a "burning sensation" whilst pointing at their bottom. Staff checked the person and they had a red mark appearing. The deputy manager informed us they would make contact with the person's GP to get some special barrier cream. The director who was acting manager was looking into the situation with the pressure relieving cushions. The people were moved by staff downstairs to more comfortable seating.

Other people were not being repositioned in line with their care plans. For example, one person identified as very high risk of pressure ulcers with poor mobility was recorded as not being repositioned for 10 hours on one day. Their care plan said they should have been moved every three hours during the day. This person had been seen sitting in a chair by the inspection team. Another person was found to have not been repositioned in their records multiple times in line with their care plan guidance. They were found by the inspection team sitting in a chair on a pressure cushion with a hand towel between the cushion and them. By not moving them regularly there was a potential risk of them developing pressure ulcers.

A new concern was found for two people who were at risk of seizures. One person had a diagnosis of epilepsy. Another person had been hospitalised due to a seizure at the end of July 2018. Their care plan had not been updated to reflect this new risk to them. They were found in someone else's bedroom asleep on the first floor by the inspection team because no staff were available on the floor. By being left alone on a floor in the home there was a potential risk the person could have another seizure without staff knowing. There were no records to demonstrate the potential risk of seizures was being monitored and no staff had received training in the subject. No follow up appointment had been made with the person's doctor following a hospital stay. Three staff were unable to confirm what a seizure looked like.

There had been small improvements to reduce the risk of the spread of infection. One person told us every

month their bedroom was deep cleaned by staff. Special bags were in place for soiled clothes so they could be put straight into the washing machine. However, in some people's en-suite bathrooms there were strong smells of stale urine. There were used gloves and used bedding found in people's bedrooms. On day four of the inspection water jugs containing orange squash were still in people's bedrooms after 1400hrs dated the day before. On the first day there was food still on tables and under a table in the dining room hours after people had eaten lunch. Cleaning rotas were on the backs of bedroom doors; none had been updated for August 2018. One person's bedroom had no August 2018 rota and there were five gaps on their July 2018 rota. This meant there was potential risks of people becoming unwell due to cleanliness issues. Following the inspection, the provider informed us they had changed the system of how providers recorded the cleaning they completed to their new electronic records system.

This is a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were still insufficient staff to ensure people were safe. One person said, "There are far too many agency staff". Another person told us that sometimes they had to wait twenty minutes to have their call bell answered. This had led to them having an accident in the past because they were unable to get to the toilet in time. One relative told us there had been so many changes in staff in the last few months.

There appeared to be a blanket approach to most people being taken downstairs. One person objected strongly to going downstairs to multiple staff which was ignored. We were informed by staff members this was due all staff being instructed to be downstairs. Following the inspection, the provider told us the person we witnessed was moved downstairs was to help them be in a more social environment. People who remained on the upper floors were checked hourly. One person had a pressure mat to inform staff when they stood as they were at high risk of falls. The mat was activated when no staff were on the floor and it took four minutes for them to respond. This person had a walking frame to reduce their risk of falls. It was found on two occasions to be placed across the other side of the room out of reach. Staff told us the person used furniture to move around the bedroom. The person's care plan stated, "Care staff to encourage [name of person] to use his walking frame when he is mobilising around his bedroom". By not having the walking frame located close to them it increased the likelihood of the person falling.

On day three of the inspection five people were on the top floor at lunchtime. They were all eating and there was no staff available on the floor to ensure they were safe. One staff member informed us that eight staff was not enough to run the home safely. They explained one of the directors would not let the home use more staff. Another staff member said, "We never have enough staff on, the days you have someone who does not work as part of the team it is exhausting." One person told us how they liked to go to the pub next door but there were not enough staff to take them so they had not been for nearly two months. Following the inspection, the provider told us the person had limited access to the pub because of changes in staff prior to the inspection.

On the second day of inspection there were more staff than written on the rota. One member of staff told us they had been asked to come into work earlier than their shift. Other staff were not on the rota. One person informed us a member of staff who had now been working care shifts was back to being an activity staff member. Following the inspection, the provider informed us one member of management came in to provide additional support during the inspection. Other members of staff had changes in their rota to meet the needs of the people. The director, who was the acting manager, had an approach of two care staff for each of the floors. On the middle floor most people required two members of staff to help them get up. We were told by staff there was an expectation a member of staff from the top floor should go and help the middle floor in the mornings. This left one staff member on the top floor. Although there was a weekly report

on how many hours care people had received, there was no evidence the management had analysed the information to determine how many staff were required to keep people safe and meet their needs.

This is a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some lessons had been learnt from the last inspection and systems had been put in place when there were accidents and incidents. Following falls there were observations forms to demonstrate people's health was monitored. Some actions had been suggested following specific incidents. However, accident and incident monitoring was inconsistent. There were occasions when the systems were only being used as a tick box exercise so not being analysed for trends and patterns. For example, we identified several incidents of facial bruising which had not been investigated. We also found one complaints record which had not been identified as safeguarding. This meant people were still at risk of potential harm or abuse going unrecognised. During the inspection the management worked on the facial bruising incidents to try and identify if there were any patterns. Following the inspection, we updated the local authority about our continued concerns in relation to accidents and incidents.

Recruitment systems had improved since the last inspection. Work had been carried out by the management. This ensured appropriate checks had been carried out prior to a member of staff starting work. These included with previous employers and checks to confirm staff were safe to work with vulnerable people. One of the directors expressed how hard they had worked to improve the systems in relation to recruitment.

One person said, "I feel quite safe". One relative said, "Oh yes, definitely he [meaning their family member] is safe". Whilst another relative had mixed opinions. They thought their relative was safe when there were staff working that they knew. The provider had policies and procedures in place for safeguarding. Staff we spoke with had an understanding of safeguarding. There were systems to record most safeguarding concerns and demonstrate the management had taken some actions to keep people safe. Guidance was still being provided by the local authority and health authority to support the management.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, in February 2018, we identified that people did not always receive effective care at the home. This was because there were concerns about staff training and decisions being made for people who lacked capacity in line with current legislation. Some people had not always had positive experiences during meal times.

Following the inspection, we restricted admissions to the service and required the provider to send us a monthly report of how they were improving the concerns we found. The provider sent monthly audits to demonstrate the progress they thought they had made. During this inspection, in August 2018, we found some improvements had been made. Although concerns were still found some breaches of Regulations had been resolved. There was more focus on making decisions in line with current legislation. Meal times for some people had improved and there had been a focus on staff training. However, there was still an issue about ensuring people had appropriate assessments when their needs changed. Some restrictive practices, such as the use of physical restraint and lap belts, were not being understood by the management. There were occasions when people had not been referred to other health and social care professionals where required.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

At our previous inspection in February 2018, we found some people who lacked capacity had not always had decisions made on their behalf following the principles of the MCA. One person who had the use of a pressure mat to alert staff had not had their capacity assessed and best interest considered. Other people lacked information about who had been consulted during the process. During this inspection we found there had been some improvements. People with some restrictive practices such as bed rails and pressure mats to alert staff had the correct processes followed.

However, following one incident when a person had an unwitnessed fall the management recorded a learning point which did not demonstrate understanding about restrictive practices. It read, "Not to leave any residents in wheelchairs without lap belts and brakes on". The person this involved lacked capacity to agree to have their lap belt on. They did not have any mental capacity assessment or best interest decision in place following this incident around the use of lap belts. On the final day of inspection, they were found alone with other people in a communal space in a wheelchair with a lap strap on. This meant there was a restrictive practice being used without following current legislation to ensure it was the least restrictive practice.

There had been improvements with the quality of food and flexibility of the kitchen staff. One person said, "The food is really good". One relative told us they were happy they could come in for breakfast with their

family member. Nearly every person enjoyed the food which was served to them. One person told us there were always choices on the menu they liked and if they wanted something different it would be provided. Most people who required specialist diets had input from a speech and language therapist to ensure it was suitable for them. People were being encouraged to drink fluids in the hot weather. One person said, "I have been told off for not drinking enough".

However, on the first day during the meal people who required support to eat had to wait until a member of staff was available to support them. This resulted in some people sitting in the main dining room waiting for staff to be able to support them. They were watching other people eat whilst waiting. Three people were in a lounge and one member of staff was sitting with them. A different member of staff called out to find out which people had already eaten. The member of staff sitting with them said, "She's had" pointing to one person. Then the staff member pointed at the other two people and indicated they had not eaten yet. This demonstrated a lack of respect was shown to the people being supported.

One person was admitted to the home on a specialist diet from hospital. No information had been obtained from the hospital about these assessments and requirements. No reassessment had been asked for by a speech and language therapist to ensure the diet was still appropriate. This meant there was a risk the person at risk of potentially choking if receiving an inappropriate diet. Following the inspection, the management of the home informed us they would obtain records of any specialist diets when people were admitted from hospital.

At the last inspection, in February 2018, we found people were not always supported by staff who had received training in subjects relevant to their care and health need. During this inspection we identified there had been some improvements. One relative said, "Everyone [meaning staff] has been trained". There were regular group supervisions being carried out during morning hand over which included training for care staff.

However, one member of staff informed us at least one of the DVDs used for training had out of date information on them. By not reflecting current best practice there was a risk inappropriate care and support could be provided to people. The DVDs on site were a couple of years old. One of the directors contacted the training provider to try and resolve this. Training in the safe management of seizures had not been carried out even when one person had a significant seizure at the end of August 2018. On the third day of the inspection we were informed staff had all received training in the safe management of seizures. Records given to us at the time showed group supervisions had been carried out with staff during morning handover. One staff member told us the training had been interesting. By not identifying new training needs in the home the management were placing people at potential risk of not having their health and care needs met.

There was written evidence in care plans some people had seen a range of other health and social care professionals in the home. On the second day of inspection the podiatrist was in to support people with their footcare. One person had been to hospital to have a review of their long term health condition. Other people with diabetes had records of seeing a specialist nurse to review their treatment. However, the person who had recently returned from hospital following a seizure had no record of follow up appointments with specialists. The person had been placed on strong medicine to reduce the risks of further seizures. No staff at the home had checked there was more information such as appointments with specialists to monitor the new medicine. The deputy manager informed us they would follow this up after the inspection.

Some work was carried out during the inspection to make areas of the home more interesting to people who may be living with dementia and improve the environment. Large numbers and people's photographs had been placed on bedroom doors. Images had been placed around the home and people had been

involved in selecting them. One person was seen looking closely at some of the pictures when they walked around the home. However, on the "dementia floor" there was no use of additional directions and no use of memory boxes to help people find their room. There were no areas in the home that had been used to stimulate memories in line with current best practice. The communal areas downstairs were not large enough for all people living in the home to use comfortably. Consequentially on each day of the inspection the downstairs lounge areas were cramped and overcrowded.

Requires Improvement

Is the service caring?

Our findings

At our last inspection, in February 2018, we identified that there was not always a caring environment at the home. This was because there was a task orientated approach by staff. People had not been supported in a way which respected their dignity and privacy or choices.

Following the inspection, we restricted admissions to the service and required the provider to send us a monthly report of how they were improving the concerns we found. The provider sent monthly audits to demonstrate the progress they thought they had made. During this inspection, in August 2018, we found some improvements had been made. There were some incredibly caring interactions between specific staff and people. For example, one person had chosen to stay in their bedroom. One member of staff came to check on them and spoke in an affectionate, caring way. Jokes were had between them where they were both laughing.

However, the overall impression for the whole inspection was that the staff were still task orientated and not able to change things through the day to meet people's changing needs and wishes. Some people were taken downstairs without the option to stay in their bedrooms or communal spaces on different floors. Some staff would walk in and out of rooms to complete tasks whilst speaking very little to the person they supported and did not acknowledge other people in the room. One person was struggling to sit in a chair comfortably due to declining health. Despite one member of staff feeling, in their professional opinion, the person should be in bed they were kept downstairs following instructions given to them by management.

Staff did not appear to always be proactive about identifying issues and then resolving them in a caring way. One relative told us about an incident where two people became agitated. They told us they found the incident "very frightening" and their family member was "very, very anxious". Yet staff who were present had not resolved the situation until the relative had prompted them multiple times. The relative told us it felt like, "Nobody really cared". On another occasion an inspector was speaking with one of the directors and a member of staff. Both were unaware the person behind them was becoming distressed. The inspector had to step in and suggested we respected what the person was trying to communicate.

Staff were very conscious of knocking on doors and shutting doors and curtains during intimate care. However, they would leave notices on doors all day saying 'personal care being carried out'. One person regularly became vocal when receiving personal care and their window was left open so the neighbouring properties could hear. Notices were placed on the outside of people's bedroom doors about procedures staff and visitors needed to follow to reduce the risk of infection spreading. These did not demonstrate the person's dignity had been considered around this personal issue. It did not promote a homely atmosphere.

Special occasions for people were considered to help them feel cared for. One person told us they had attended the local pub on their birthday. One relative told us in the past there had been some celebrations for people on special days. They explained their family member had a significant birthday so the kitchen staff found out what type of cake the person wanted and then made it for them.

One person told us, "The permanent staff are really good". Another person nodded when we asked if they liked living at the home. One relative told us, "The care staff are really very good" and continued, "I have found them very kind and helpful". There was a general feeling of too many changes in staff and high use of agency staff. Another relative said, "I can't understand why they were in this position I come every day. Care is excellent the staff are brilliant."

Compliments had been received by the home from relatives and other professionals. One person told staff they were "grateful for all of the care and support" they had received. One relative had "expressed how happy he was" with their family members care. Another relative told the staff they thought their family member received good food and "is well cared for". There were compliments about the improvement in the communication between the staff and relatives. Some health and care professionals complimented the provider on the more detailed care plans and the additional work the management had completed

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, in February 2018, we identified that people did not always receive responsive care. Although care plans had some personal information they lacked clear guidance for staff. Care plans contained generic statements rather than individualised care.

Following the inspection, we restricted admissions to the service and required the provider to send us a monthly report of how they were improving the concerns we found. The provider sent monthly audits to demonstrate the progress they thought they had made. During this inspection, in August 2018, we found some improvements had been made because the provider had purchased a new electronic care plan system. Less generic statements were used and more personalised information was included.

However, we found ongoing concerns about the lack of recorded guidance provided to staff for people with some specific needs. Other care plans contained contradictions. When people's needs had changed updates to care plans had not been completed in a timely manner. New concerns were found that not everyone had their end of life wishes considered and there had been a lack of activities recently.

One person had an unwitnessed fall recorded in the incident and accident folder. Their care plan had not been updated in line with this. The overview stated, "Historically [name of person] had had falls when he was at home; since admission to Acacia he had not had any falls". Two staff were not aware of the recent fall and were unsure about the support the person required with mobility. The same person recently had a seizure requiring hospitalisation. There was nothing in their care plan about this and no seizure care plan. Three staff were unaware how to identify further seizures. Another person told us about specific medical clothing being put on incorrectly. They said, "I was in agony". There was no guidance in their care plan for new staff or agency staff to follow about how this clothing should be correctly put on. This meant people were not always receiving the relevant support they require.

When care plans were updated it was not always clear the rationale behind the change. One person had a risk of becoming anxious which led to escalating behaviour. They used to be closely observed when anxious. Their care plan gave three different versions of when or how they should be closely observed. Two staff were unaware of what the current position was. There were no records to demonstrate why the choice to end close observation at certain times had been removed other than a specific incident. Nor were there details about who had been consulted about this decision. During the inspection parts of this person's care plan were updated, yet inconsistencies were still found on the third day of inspection.

This is a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although some people had basic guidance in place for the end of their life such as which funeral director and where they wanted the funeral. Some people who had specific requests at the end of their life had not always been discussed or recorded. One person wanted to donate their body to science. Their care plan had

no record of this decision. Both the deputy manager and one director were unaware about this person's preference. One person had recently died and some specific requests were recorded about not being alone and having company. Their daily records did not demonstrate this had happened. This meant people were not always being supported to have a dignified death in line with their wishes.

People's care plans had been updated onto the new system. It was unclear how involved people and relatives had been with this process. One person showed us a copy of what they thought was their care plan. It appeared to be from the old system rather than the new one. There was little information recorded on the care plan.

During the inspection there were some activities being held in the main downstairs lounges. These were general sing along sessions, ball games and recognising television theme tunes. None of the people choosing to stay in their bedrooms had visits from the activity staff. The activities we saw did not appear to reflect some of the views of people and relatives. One person said, "I prefer to sit up here [meaning in their bedroom] rather than downstairs" because there were no activities. They continued, "We used to have entertainers once a week" and thought there was a reason they had been stopped. One member of staff had recently been working as a care staff. One person told us there were no activities last week. They then said a member of staff who had transferred from activities to care had to then do activities again. The person said, "Poor [name of staff member] was asked to do it [meaning the activities]. She is very good at it. She had moved to care".

There appeared to be a high turnover of activity staff. One relative told us there had been multiple activity coordinators since Christmas. They continued, "Whenever they get an activity person they need training. They have not known how to do it. That is a pity". Another relative said, "My husband loved going into the lounge". They continued, "Some days no one is brought down for activities" and, "[Name of family member] has not wanted to go into the lounge as no activities". This meant people did not receive stimulation which respected their interest and hobbies whilst living at the home. For example, one person enjoyed going to the pub regularly and another person enjoyed participating in quizzes. Prior to the inspection there had been an activity coordinator who tried to achieve this. Following the inspection the provider sent some updates about future plans they had for activities. These were limited and the timetable of activity coordinators did not demonstrate the types of activities being planned. They did tell us they had four sessions of reminiscent activities organised from a specialist company. The provider also explained there had been multiple reasons why there had been a turnover in activity coordinators.

This is a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives continued to have mixed opinions about how complaints and concerns were managed. One person told us they had raised a minor concern and felt despite asking numerous times they did not feel listened to because nothing had changed. They ended up taking the matter into their own hands to resolve it. One relative explained they were unhappy about specific aspects of their family members care. They spoke with staff about this who immediately updated the person's care plan. The relative said, "Staff are very responsive". Another relative told us they have tried speaking with one of the directors. They explained the director did not like people or relatives to question things commenting when you did the director could become "defensive."

There was now a more structured complaints system in place. There were some records about the process taken to investigate the concerns. Once they had been investigated some lessons learnt were starting to be recorded. However, on one occasion the management had not identified the complaint should have been

referred to safeguarding because it involved a member of staff and person. We informed them of this so they could investigate it and learn for the future. None of the complaints which had been managed had action plans relating to learning recorded to prevent reoccurrence of similar issue. Following the inspection, we shared our concerns about the potential safeguarding with the local authority.

Inadequate

Is the service well-led?

Our findings

At our inspection in February 2018, we found significant concerns around the management of the home. Documents which should have been readily available in the home were not. The quality assurance systems had been inconsistently completed and used. One of the directors, who was a nurse, was unable to tell us the clinical needs of people. Policies and procedures contained out of date information. The provider had continued to not notify the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal responsibilities. There was no registered manager in post.

Following the inspection, we restricted admissions to the service and required the provider to send us a monthly report of how they were improving the concerns we found. The provider sent monthly audits to demonstrate the progress they thought they had made. During this inspection, in August 2018, we found some improvements. The provider had acquired external audits from a range of companies. A new manager was currently going through the registration process with CQC. There were some systems in place to monitor the quality of care and keep people safe. Some notifications had been sent to CQC.

However, we still found numerous things had not been improved enough to meet the regulations and ensure safe care and treatment for people. Not all notifiable events were being sent to CQC. The management did not find the shortfalls identified during this inspection, through their own monitoring systems, or take action where they were found. Where they had identified concerns actions had not been planned to rectify them. The management, still appeared to lack some knowledge about people's clinical needs. There continued to be occasions when the management struggled to provide documents which should have been readily available.

We found some improvements had occurred because there were now quality assurance systems being completed internally and by an external consultancy firm. These were identifying some issues where actions had not been taken but not all. For example, advanced care planning for end of life had been highlighted as being needed in two audits. During this inspection we found concerns around people's end of life wishes. Multiple concerns were found around the management of medicine. Again, at this inspection further shortfalls were found. The issue around actions taken following complaints had been identified as an issue in the external audits. Again, at this inspection we found the same concern still existed. No action plans had been created to demonstrate the time scales these shortfalls were due to be completed or by whom to prevent reoccurrences.

Other shortfalls found on this inspection had not been identified by the management or external audits. Examples of this were medicine fridge temperatures being out of range for a long period of time. Care plans did not always contain up to date information and at times there were contradictions within them. The management had not identified the shortage of pressure relieving cushions for wheelchairs which had resulted in one person beginning to develop a pressure ulcer. This meant there were still risks of people being harmed because the management had not taken action to reduce the likelihood of it happening.

Paperwork in place had not always been updated. The management had failed to identify this within their

auditing systems. There was a document at the front of the safeguarding file with a procedure staff should follow. This had a previous manager's name on it as part of the escalation process. The director who was the acting manager told us they thought it was a useful document so had left it in the safeguarding file. It still had not been updated by the end of the inspection. Within the rota file was a handover sheet which new staff or agency would use for the most up to date information about people. On the first day of inspection the last update to the handover sheet was from the beginning of June 2018. This had information which was incorrect such as the wrong bedroom numbers for people. It also had incorrect instructions about three people's mobility and out of date information about resuscitation preferences for one person. This meant people could potentially receive incorrect support from staff which was also against their wishes. During the inspection an updated handover form was created once we had requested it. Following the inspection, the provider told us the handover sheet was no longer used due to the electronic care plan system in place.

There were still occasions during the inspection when one of the directors, who was the acting manager, would walk off whilst trying to talk through a concern with the inspection team. As with the last inspection, requests were made for documents multiple times. For example, there was a safeguarding document which was requested three times and it was not produced until the final day. The management continued to be asked for documents which were not provided within the specified time frames. At the end of the second day a request was made for 14 documents or explanations to be produced within 48-hours. Eight of these requests were not met.

The inspection team identified there were instances when documents were being created during the inspection. On one occasion an inspector witnessed blank medicine error records being printed by an administrator. This was following a request from another inspector about the medicine error records. Later a file full of medicine error records was handed to the inspection team. We were told that the member of staff was just creating an index for the file. By not having this information readily available medicine errors may not have been investigated in a timely manner to reduce the risk of harm to people. We requested competency checks for nurses to ensure the standards of care they were delivering was safe. Competency checks for medicine administration were produced with a date which occurred during the inspection. The director, who was acting manager told us they had been monitoring the nursing since the last inspection. No records supported this.

Although there had been small improvements with the management's knowledge of people in the home. They still appeared to be unaware of some of the needs of people. On the first day of inspection, both the deputy manager and one of the directors, who were both nurses, told us about people in the home who had type one diabetes. We found two people had a different type of diabetes and this was confirmed in their records on the daily handover sheets and in care plans. There were other occasions the director, who was a nurse, relied on other members of staff to provide up to date information of people's clinical needs. This was despite being the acting manager at the time of the inspection. For example, when discussing the use of certain medicines to help manage people's anxiety they required the deputy manager to provide support and responses. This meant there was a lack of understanding of people's needs and how best to support them in line with current regulations.

New systems to record information, such as care plans, had been put in place and there were times staff were unfamiliar with what they should be completing. During this inspection we found there was no clear instruction given to staff about codes which were being used for repositioning people on the new electronic records. One code read 'up'. The director, who was acting manager, was unable to tell us what this meant. The deputy manager informed us it meant one thing and members of staff had different interpretations. This meant there was not clear guidance being provided by the management to ensure all systems were being used consistently.

The director, who was acting manager, was unaware of some of the concerns we found around the home. For example, someone's specialist mattress had an alarm muted. They agreed this was a potential risk to the person. This director also informed us they leave special powder to thicken drinks in unlocked places in people's bedrooms. They thought they were encouraging staff to get people to drink at night. No concern was shown that these powders could cause asphyxiation if accidentally ingested by a person. Two tins of powder were found unsecure in people's bedrooms on the third day of the inspection.

This was a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been some improvement to the notifications to other agencies by the provider in line with current legislation to help them monitor people's safety and care. We continued to be notified about deaths of people at the home. Notifications had been received in line with some safeguardings and significant incidents. However, several notifications had not been made in line with statutory requirements. Two safeguardings present in their safeguarding folder had not been notified to CQC. The directors were not aware of their responsibility to notify other agencies in line with statutory guidance. Neither had another incident been identified as a notifiable safeguarding so it was not sent to CQC or the local authority. This meant there was a risk other agencies would be unable to monitor the care and safety of people living at the home.

This is a breach of Regulation 18 of the Care Quality Commission (Registrations) Regulations 2009.

Since the last inspection the provider informed us they had been working hard on changing the culture in the home to being more open. People and relatives were positive about the new manager if they had met them. One relative explained they were shocked about the last inspection. They told us the management, "Listened and apologised". Then continued, "They are taking things seriously". Another relative said, "[Name of director] tries to do her best" and then described some challenges the director had recently faced.

Although communication with relatives had appeared to improve it was not consistent. For example, one relative was unaware that an activities coordinator had just resigned. Resident and relatives meetings were held. However, there were no systems to demonstrate what actions, if any, had been taken following comments or suggestions made. Staff continued to feel not listened to by management and felt that there was a blame culture. One person said, "Main problem is [name of director] upsets staff and changes things". Staff continued to be reluctant to raise issues they had found. This meant there was a potential impact on the care and support people received.

The management informed us how they were striving to improve the service for people. Developments were found with the fire safety systems due to positive liaising with external bodies such as the fire service and a specialist company. They had introduced a new fridge in the dining room so people and relatives could access fresh fruit. There was a sweet trolley for people and visitors to purchase snacks. They had improved the staff levels for maintenance and administrators. They had focussed on creating a more positive environment for people including the new pictures and table cloths on dining tables at meal times. We were told Karaoke machines had been purchased out of the 'resident fund' at the choice of the people.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Care Quality Condition of all significant incidents in line with statutory requirements.

The enforcement action we took:

We have now closed the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that the care people received was personalised.

The enforcement action we took:

We have now closed the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure care and treatment was provided in a safe way for service users.

The enforcement action we took:

We have now closed the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure people received safe, effective and responsive high quality care which was person centred and had not fully put in place systems to monitor the quality of care people received. Those which were in place had

not operated effectively to ensure compliance.

The enforcement action we took:

We have now closed the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs.

The enforcement action we took:

We have now closed the home.