Medicrest Limited

# Acorn House - Croydon

## Inspection report

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## Ratings

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| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

Acorn House - Croydon 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. Acorn House does not provide nursing care. Acorn House accommodates up to 31 older people in one adapted building. At the time of our inspection 21 people were using the service, many of whom were living with dementia.

At our previous inspection on 21 and 23 February 2017 we found the provider was in breach of legal requirements relating to need for consent, premises and staff recruitment. We rated the service 'requires improvement' overall and for the key questions 'safe', 'effective' and 'well-led'. They were rated good for the key questions 'caring' and 'responsive.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to address the breaches of regulation and improve the key questions 'safe', 'effective' and 'well-led' to at least good.

At this inspection we found whilst the provider had addressed the breaches of legal requirements relating to premises and staff recruitment, they had not taken sufficient action to address the breach of legal requirement relating to need for consent. We also found additional breaches of legal requirements. The service remains rated 'requires improvement' overall and are now rated 'requires improvement' for each of the key questions.

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

Staff did not always treat people with dignity and respect. Staff did not always speak to people politely and there was little interaction between staff and people. Some elements of the service were overly structured impacting on the flexibility of people's preferred routine and choices. Staff did not adhere to the principles of the Mental Capacity Act 2005 and had not applied for legal authorisation to deprive people of their liberty.

A safe environment was not provided and risks to people's safety were not adequately identified or managed. Accurate and complete records were not maintained about the daily support provided to people. Care records outlined people's needs but at times these lacked detail.

The provider had not arranged for staff to receive regular training to ensure they had the knowledge and skills to undertake their duties and adhere to good practice guidelines.

A new governance framework had been introduced but this was not fully embedded and needed expanding

to ensure it captured all areas of service delivery. There were no formal systems in use to capture the views of people and their relatives about the service.

Activities were available and staff had been encouraged to provide more stimulation and engagement for people. However, we found there was a lack of flexibility in the activity programme and it did not adequately take into account people's individual interests. We recommend the provider consults national guidance on providing activities for people living with dementia. The provider did not make information accessible and we recommend the provider consults guidance about implementing the accessible information standard.

The provider had improved the environment. However, we saw further work was required to complete the refurbishment and redecoration plans. We recommend the provider consults national good practice about developing their environment to support the needs of people living with dementia.

Staff were able to describe signs of possible abuse and were aware of safeguarding adults' procedures. On the whole we found safeguarding adults' procedures were adhered to. We also found on the whole safe practices were followed to prevent and control the spread of infection and ensure a clean environment was provided. However, improvements were required in both areas to ensure adherence with good practice guidance.

Improvements had been made to ensure safe staff recruitment practices were followed and there were sufficient numbers of staff on duty.

People received their medicines as prescribed and safe medicines management processes were in place. People received support with their dietary and nutritional needs and staff arranged for people to receive support with their health needs when required.

Staff respected people's privacy when providing personal care support. People's preferences regarding the gender of staff supporting them was taken into account. Information about people's religion, culture and sexuality was collected as part of the admission process and people were provided with any support required. There were no restrictions to visitors.

A complaints process remained in place and the deputy manager reviewed all complaints on a monthly basis to identify any trends and learning.

The service was currently in 'provider concerns' with the local authority and they were working with the local authority to demonstrate improvements with the quality of service delivery. The registered manager was aware of their CQC registration responsibilities and to submit statutory notifications about key events that occurred at the service.

The provider was in the process of recruiting to strengthen the management team across both this service and their sister service. We will assess the impact of this change at our next inspection.

The provider was in breach of legal requirements relating to need for consent, treating people with dignity and respect, safe care and treatment, staff training and good governance. You can see what action we have asked the provider to take at the back of the main report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

Some aspects of the service were not safe. A safe environment was not provided and risks to people's safety were not adequately identified or managed.

Improvements had been made to ensure safe staff recruitment practices were followed and there were sufficient numbers of staff on duty.

Staff were able to describe signs of possible abuse and were aware of safeguarding adults' procedures. On the whole we found safeguarding adults' procedures were adhered to. We also found on the whole safe practices were followed to prevent and control the spread of infection and ensure a clean environment was provided. However, improvements were required in both areas to ensure adherence with good practice guidance.

People received their medicines as prescribed and safe medicines management processes were in place.

### Is the service effective?

**Requires Improvement**

Some aspects of the service were not effective. Staff did not adhere to the principles of the Mental Capacity Act 2005 and had not applied for legal authorisation to deprive people of their liberty. The provider had not arranged for staff to receive regular training to ensure they had the knowledge and skills to undertake their duties and adhere to good practice guidelines.

The provider had improved the environment. However, we saw further work was required to complete the refurbishment and redecoration plans. We recommend the provider consults national good practice about developing their environment to support the needs of people living with dementia.

People received support with their dietary and nutrition needs and arranged for support with their health needs when required.

### Is the service caring?

**Requires Improvement**

Some aspects of the service were not caring. Staff did not always treat people with dignity and respect. Staff did not always speak

to people politely and there was little interaction between staff and people. The provider did not make information accessible in other formats and we recommend the provider consults guidance about implementing the accessible information standard. Some elements of the service were overly structured impacting on the flexibility of people's preferred routine and choices.

Staff respected people's privacy when providing support with personal care. People's preferences regarding the gender of staff supporting them was taken into account. Information about people's religion, culture and sexuality was collected as part of the admission process and people were provided with any support required. There were no restrictions to visitors.

## Is the service responsive?

**Requires Improvement**

Some aspects of the service were not responsive. Accurate and complete records were not maintained about the daily support provided to people. Care records outlined people's needs but at times these lacked detail. Staff had worked with the local hospice to hold discussions with people and their families about advance decisions and end of life care preferences.

Activities were available and staff had been encouraged to provide more stimulation and engagement for people. However, we found there was a lack of flexibility in the activity programme and it did not adequately take into account people's individual interests. We recommend the provider consults national guidance on providing activities for people living with dementia.

A complaints process remained in place and the deputy manager reviewed all complaints on a monthly basis to identify any trends and learning.

## Is the service well-led?

**Requires Improvement**

Some aspects of the service were not well-led. A new governance framework had been introduced but this was not fully embedded and needed expanding to ensure it captured all areas of service delivery. There were no formal systems in use to capture the views of people and their relatives about the service or to use this to improve the quality of service provision.

The provider was in the process of recruiting to strengthen the management team across both this service and their sister service. We will assess the impact of this change at our next inspection.

The service was currently in 'provider concerns' with the local authority and they were working with the local authority to demonstrate improvements with the quality of service delivery.

The registered manager was aware of their CQC registration responsibilities and to submit statutory notifications about key events that occurred at the service.

# Acorn House - Croydon

**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 took place on 24 April 2018 and was unannounced. The inspection was undertaken by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service, including statutory notifications submitted about key events that occurred at the service. We also reviewed the information included in the 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.

During the inspection we spoke with four people. We interacted with seven people in total but not all were able to have meaningful conversations. We spoke with seven staff, including the registered manager, the provider, care staff and the chef. We also spoke with the visiting GP. We undertook general observations and use the short observational framework for inspection (SOFI) during lunchtime in the main dining room. SOFI is a recognised tool for obtaining the views of people who are not able to communicate with us. We reviewed three people's care records and staff records including two staff recruitment records, three staff's supervision and appraisal records, the staff team's training matrix and staff rotas. We reviewed medicines management records and records relating to the management of the service.

After the inspection we spoke with representatives from the local authority, including the safeguarding adults' team.

Requires Improvement

# Is the service safe?

## Our findings

We received mixed feedback from people about the safety at the service. The majority of people told us they felt safe, with one person commenting, "Yes, very safe and it's a very nice place." However, a couple of people told us that due to the unpredictable nature of some people's behaviour they felt their safety was at risk at times.

A safe environment was not always provided. Windows were not sufficiently restricted meaning people were at risk of falling from height. Portable radiators were in communal lounges and people's bedrooms. These were labelled as not to be covered, however, there was a risk that people, particularly those living with dementia, may not read or understand this label. The staff had not risk assessed the use of these portable radiators leaving people at risk of burns or scalds. There were also no systems in place to regularly check and monitor water temperatures to ensure these were within a safe range for people to use and did not pose a risk of burns or scalds. We saw that some fire exits were not alarmed meaning people may be able to leave the service without staff knowing. This was of concern for people who were not able to understand the risks to their safety in the community.

Staff had assessed individual risks to people's safety. However, these were not always comprehensive and did not provide detailed information about how these risks were to be managed. We also saw that information in different areas of people's care records were contradictory about the risks to people's care. For example, one person's care records said they had developed right side weakness following a fall and used a wheelchair for long distances, however, their 'hospital passport' stated they were independently mobile. We also saw one person's 'keeping healthy plan' stated they were at risk of developing pressure ulcers, however, there was no risk assessment in place regarding skin integrity. Information was also lacking regarding equipment used to support people's mobility. For example, there was no information about size of slings or what colour loops to use when using the hoist. This meant sufficient information was not being made available to staff to ensure people's safety and welfare was maintained. Assessments contained information about people's behaviour that may be challenging to staff but did not provide information about how this was to be managed.

Incidents were not being consistently and appropriately reported and managed. We saw a note in the daily records folder that a person had trapped their leg in-between their bed rails which had caused a skin tear. Whilst the injury had been addressed, the registered manager was not made aware of the incident and no action had been taken to prevent recurrence. When we bought this incident to the registered manager's attention they told us they would ensure a referral was made to the occupational therapy team to obtain bumpers for the bedrail to reduce the risk of further injury.

The provider was in breach of regulation 12 of the HSCA 2008 (Regulated Activities) Regulations 2014.

At our previous inspection on 21 and 23 February 2017 we found the provider's recruitment and selection processes were not fully protecting people living in the home. The staff files we checked did not consistently show that criminal record checks were carried out for each staff member. At this inspection we saw

appropriate checks had been undertaken to ensure suitable staff were employed. This included obtaining references from previous employers, checking staff's eligibility to work in the UK and undertaking criminal record checks. We also saw from completed applications that the majority of staff had experience of working in a care setting and had relevant qualifications or training.

Staff were able to describe to us signs that a person's safety may be at risk and could recognise signs of possible abuse. They told us they would discuss any concerns they had with the shift leader and they were able to approach and discuss any concerns with the registered manager. The registered manager was aware of their responsibility to refer any safeguarding concerns to the local authority and on the whole we saw this was done. However, from speaking with representatives from the local authority safeguarding adults' team we heard about an incident that was not appropriately referred. This incident had now been identified and was being investigated. The registered manager told us they attended any safeguarding meetings and followed the advice given. At the time of our inspection there were some safeguarding referrals being investigated and the registered manager liaised with the police when required due to concerns about a person's safety or welfare.

On the whole staff adhered to the procedures to control and prevent the spread of infection. Cleaning schedules were in place and on the whole the service was clean. However, we observed one person had been incontinence whilst seated in the lounge area. This was identified by staff and they were appropriately supported, however, the wet seat protector was not removed and the urine on the carpet was not cleaned. We also observed that people were not offered the opportunity to wash their hands prior to meals. Infection control policies and procedures were in place, the majority of staff had completed infection control training, and there was access to personal protective equipment (PPE). An infection control audit was undertaken to review adherence to good practice guidance, including wearing PPE and the disposal of clinical waste, and where improvements were identified as being required these were addressed.

People received their medicines as prescribed. Medicines were stored securely and safe medicines management processes were followed. Accurate records were maintained about the medicines administered and stock checks ensured all medicines were accounted for. Staff were aware of how people expressed if they were in pain and when one person told staff they were experiencing pain they were prompt to provide pain relief. Systems were in place for the ordering, return and disposal of medicines. Staff had received medicines management training.

Staffing levels were based on people's dependency levels and from reviewing the staffing rotas we observed staffing numbers were as expected. People told us there were usually enough staff on duty at all times and accepted that there were busy times of day when things were a little stretched such as the mornings and evenings when people were preparing to get up or get ready for bed. Staff confirmed there were sufficient staff on duty to enable them to undertake their duties and support people. We observed call bells were answered promptly.

Requires Improvement

# Is the service effective?

## Our findings

At our previous inspection on 21 and 23 February 2017 we found there were generic assessments about people's capacity to consent. They were not decision specific. There was no clear information about who had lasting power of attorney to make decisions on people's behalf, where these had been appointed.

At this inspection the provider continued to not adhere to the principles of the Mental Capacity Act (MCA) 2005. There were no MCA capacity assessments included in people's care records and no evidence of best interest meetings being held. Care records did not state what elements of their care people did not have the capacity to consent to and therefore the assumption is that people have capacity in line with the principles of the MCA. However, when speaking with the registered manager they told us people did not have the capacity to consent to certain aspects of their care and acknowledged that this was not being captured in their care records or formally assessed. Many people at the service had bed rails in place. There was no consent form signed for the use of this equipment.

Since our last inspection the registered manager had begun to devise a tracker to enable them to have greater oversight of who was deprived of their liberty, when they had applied for DoLS authorisation and when the DoLS authorisation expired. However, this process had not been completed. When we discussed it with the registered manager they told us none of the people using the service had the capacity to understand the risks to their safety in the community and therefore were being deprived of their liberty. However, the registered manager had not applied to the relevant local authority for legal authorisation to do so for each person.

The provider continued to be in breach of regulation 11 of the HSCA 2008 (Regulated Activities) Regulations 2014.

Staff were complimentary about the training offered by the provider and told us they had regular access to training to update their knowledge and skills. However, the provider's training matrix showed staff were not up to date with their mandatory training and had not consistently received regular refresher courses. Seven were not up to date with their manual handling training, seven staff had not completed training in supporting people living with dementia, 11 staff had not completed training on supporting people when displaying behaviour that challenged, 15 staff had not completed training in diabetes care, 14 staff had not completed training on the MCA and 12 staff had not completed training in person centred care. One person told us at times they felt staff did not have the knowledge and skills to support people with their mobility. One person said, "No, …I've noticed when they move some from chairs using the hoist…. it's not always done properly. There's times when I think…. Oh!!" We observed staff supporting people with their mobility and there appeared to be some confusion about how to do this safely. We also noticed that the breaks were not applied on the person's wheelchair whilst they were being transferred which increased the risk of injury if the wheelchair moved unexpectedly.

Some staff did not have English as a first language and this impacted on their knowledge and understanding of some basic terms related to people's care needs. We spoke with the registered manager about this and

the benefit of providing staff with English courses to improve their written and verbal English language skills.

From the paragraphs above, this shows the provider was in breach of regulation 18 of the HSCA 2008 (Regulated Activities) Regulations 2014.

Since the deputy manager came into post they had taken on the responsibility of supervising staff. Supervision sessions had been re-established and the staff records we saw showed staff had been supervised in line with the provider's policy of at least six monthly meetings. However, we saw the supervision records maintained were the same for each staff member. We could not be assured that staff supervision meetings were tailored to meet the needs of each individual staff member.

At our previous inspection on 21 and 23 February 2017 we found some areas of the service were not well maintained. The bathrooms on the first floor did not provide a pleasant environment for people. At this inspection we saw the bathrooms had been refurbished and new flooring had been laid throughout the service. The provider was no longer in breach of regulation regarding premises. However, we found that some areas of the service still required redecoration. There was stained paintwork and some areas of the service were looking tired. The provider was still in the process of completing their refurbishment and redecoration plan across both of their services – Acorn House and Acorn lodge.

Many of the people living at Acorn House were living with dementia. The service had signs on the toilet doors to help distinguish these, however, there were no other environmental changes to support people with dementia to navigate around the service. The service had not used colour or light to distinguish different areas. There was a lack of signage or pictorial information to identify different areas, and there was no reminiscence objects and little sensory objects for people to interact with.

We recommend the provider consults national good practice about developing a dementia friendly environment.

People's nutrition and hydration needs were met. We observed people receiving breakfast, lunch and snacks throughout the day. People also had access to hot drinks at set times and cold drinks throughout the day. We saw drinks were left within people's reach. People were complimentary about the food. One person commented, "It's very nice, indeed it is my dear".

Care staff updated the chef about people's dietary requirements. At the time of inspection there was no-one using the service with any food allergies or dietary requirements due to their religion, however, the chef said they would be able to cater to these needs if people required them. Information was provided to the chef to ensure people who needed to put weight on had bigger portions, those who were diabetic had sugar controlled diets and those who required pureed meals because of a risk of choking. Adapted cutlery and crockery was available to enable people to eat and drink independently.

People received support with their health needs. The visiting GP said they had a good relationship with the staff and the continuity within the management and staff team had enabled this. They told us staff referred people appropriately to the GP service and in a timely manner to ensure their health needs were assessed and treated as needed. If staff had concerns about a person's health they arranged for the GP to undertake a home visit. On the day of our inspection staff had identified changes in a person's behaviour and their mobility. Staff arranged for the GP to visit the person on the same day. When required staff liaised with specialist healthcare professionals and followed advice provided. Some people received regular visits from the district nurse and other community professionals. If staff were concerned about significant changes in a

person's health they would obtain emergency medical assistance and supported people to attend hospital appointments.

Requires Improvement

# Is the service caring?

## Our findings

People told us the staff were kind and caring. People's comments included, "Yes, they are caring" and "It's okay…they're kind and caring". However, we found that staff's interactions with people did not always show kindness or compassion. Staff did not always treat people with dignity and respect when interacting with them. Comments we overheard staff say to people included, "[person's name] come", "[person's name], lunch is coming, sit down, sit", "no more food in the mouth, drink, drink first", "sit properly [person's name]", "Did you [staff member] want to feed this one [the person]?".

Throughout our observations we saw people were not supported by staff to maintain their dignity. We saw one gentleman's trousers were too big for them and were hanging down, showing his underwear. Another gentleman's trousers were too small for them. Their trousers were being held up by their belt but this meant their flies were coming undone because they could not be fully zipped up.

Staff were assisting some people with their breakfast. There was no communication from the staff member assisting the person. They did not explain what was available for breakfast or check they were enjoying it. We were in the dining room for 25 minutes in the morning and we observed one lady sitting at a table on her own. Various staff walked past this person on numerous occasions but none of them interacted with them.

We observed staff walking past people without acknowledging them and on many occasions if a person entered a room that staff were in they were not welcomed, staff did not say hello and did not enter into any conversation with the person.

We also observed things being done to people without their permission, without communication from staff and without offering choice. For example, aprons were put on people at mealtimes without people's permission or staff explaining what they were doing. Staff were also observed supporting people with their moving and handling without explaining what they were going to do or where they were taking the person.

The paragraphs above show the provider was in breach of regulation 10 of the HSCA 2008 (Regulated Activities) Regulations 2014.

Staff were aware of how people communicated and information was included in people's care records about people's communication methods. For those that were unable to communicate verbally, there was information about the non-verbal communication they used. However, we observed staff did not use any other type of communication, other than verbal, to communicate with people. There was a lack of pictorial information or use of objects of reference to support communication.

We recommend the provider adheres to the accessible information standard to ensure information was available in a format which people understood.

Some elements of service delivery were overly structured impacting on the flexibility of people's routine and choice. We observed hot drinks were served at set times each day and the fluid intake charts were formatted

so there were only set times fluid intake could be recorded. This indicated that hot drinks were not available outside of these times. Other aspects of the service were structured or chosen by staff impacting on people's choice and involvement in decision making. For example, the menu was designed by the registered manager and whilst there was a choice of sides at mealtimes, there was only one main meal on offer, unless you were vegetarian. One person told us, "No choice – you have what's there".

People's friends and family were welcomed at the service and there were no restrictions regarding visiting. People told us, "The family come twice a week…my two sons. They would take me out if I wanted to go" and "My son occasionally visits and my daughter-in-law visits also. They look out for me and bring me what I need". Some of the people using the service did not have any regular visitors. Whilst the registered manager said on occasion advocates were available to support the person during care reviews, there were no opportunities for regular visits and support. We discussed with the registered manager about accessing a befriending service for these individuals and they said they would look into it.

People told us staff did respect their privacy and dignity when supporting them with their personal care. One person told us, "They wash you down my dear…they do that alright. The doors are kept closed, and they do respect my dignity….oh yeh…they do my dear". Staff said they would support people with their personal care in the privacy of their bedrooms and ensure the doors and curtains were closed. Information was collected about people's preferences regarding the gender of staff supporting them with their personal care so they felt comfortable whilst being supported.

People were asked about their faiths and if they wanted any support practicing their faith. The service arranged for representatives from the Catholic church and church of England to visit the service. At the time of inspection, staff told us no-one using the service was of any other faith, except Christian, however, they were able to and would provide support to people of other faiths.

Staff collected information about people's sexuality as part of the assessment process. Staff were not discriminatory towards anyone due to their sexual preferences and people from the lesbian, gay, bisexual and transgender (LGBT+) communities were welcome at the service.

Requires Improvement

# Is the service responsive?

## Our findings

Care plans had been developed outlining people's support needs. These records provided information about people's wishes in regards to their daily routines and how they wished to be supported. Information was also provided about people's dependency and outlined what areas of their personal care they were able to manage independently. Information was gathered about people's life histories, their previous occupations and information about their families and those important to them. However, we found that care plans lacked detail. For example, there was no information about people's specific needs, including what size incontinence pads they used.

We found accurate and complete records were not maintained about the daily support offered to people. This included food and fluid charts. Of the three records we viewed, all of them had gaps regarding recording of fluid intake, this was particularly in regards to the evening drink offered at 8pm.

Accurate, complete and contemporaneous records were not maintained about people's daily care provision. The evidence in the paragraph above adds to the evidence in the key question 'well led' to show the provider was in breach of regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014.

Despite the paragraphs above we did see that instructions in people's care records to support people to reposition regularly to minimise the risk of developing pressure ulcers were adhered to and daily repositioning charts confirmed this.

Arrangements were in place to support people at the end of their lives. Staff had worked with and received training from the local hospice about providing good end of life support. They had worked with people and their families to complete 'looking ahead' documents outlining people's wishes and preferences in regards to end of life care and after death arrangements. This included their wishes for funeral arrangements and religious preferences. However, we saw that people's family were not always involved in discussions regarding 'do not attempt cardio pulmonary resuscitation' decisions. We discussed this with the registered manager and ensuring that end of life decisions were made with the involvement of all of those people important to the person and health and social care staff involved in their care.

Since our last inspection the provider had created a sensory garden which was shared by the sister home next door. It was a well thought out tranquil area with plenty of space for people. The provider arranged for a number of external entertainers to attend the service including Elderdance, exercise to music, fluffs and reptiles animal service. The activity and events coordinator organised a seven day activities programme to be delivered by the care staff including, puzzles, board games, arts and crafts, parachute activity, skittles, floor games, ball games, pamper sessions and afternoon singalongs. However, we observed varying levels of engagement with people from care staff. We also saw that the same activity was being delivered for long periods of time and many people were not engaging with it. Care staff had not taken the initiative to access resources for other activities available and stuck strictly to the pre-organised activities. The provision of activities did not take into account people's individual interests, hobbies or their moods on the day. There was also a lack of sensory activities and the delivery of activities did not account for people living with

dementia who often find it difficult to concentrate for long periods of time. Comments from people about activities included, "They take you for walks in the garden…. apart from that there's not a great deal to do" and "I don't go to many activities, but I walk about a lot for exercise. I do go when they have an entertainer".

One person at the service was much younger than the rest of the people using the service. This was mentioned in their care records and staff were instructed to take this into account when undertaking activities to ensure they were appropriate for this person. However, we did not see this in practice on the day of inspection.

We were informed by the registered manager they had recently had a staff meeting where the delivery of activities was an important agenda item, as they had observed that some care staff were not providing the level of engagement and stimulation for people as expected.

We recommend the provider consults national guidance in providing meaningful activities and stimulation for people living with dementia.

A complaints process was in place and a complaints book was available in the hallway for people and relatives to complete. The registered manager told us they had an open door policy and welcomed comments from people and relatives about the service. We saw as part of the new governance structure in place, the deputy manager reviewed all complaints received monthly to ensure they were appropriately investigated and as much as possible resolved to the satisfaction of the complainant. People told us if they were unhappy with something at the service they would speak to a member of the management team.

Requires Improvement

# Is the service well-led?

## Our findings

Since our last inspection a deputy manager had been appointed. When discussing roles and responsibilities between the registered manager and deputy manager there was a lack of clarity as to how the management of the service was being organised. Part of this was being impacted on because the service's sister service had a vacancy in their management team meaning the registered manager was having to spend more time at that service. Nevertheless, we saw the deputy manager had implemented new systems to strengthen governance procedures at the service.

There was a clear governance process in place, but this was relatively new and was not fully embedded at the time of inspection. This included a process of regular reviews, checks and audits of different elements of service delivery. Audits were completed in regards to infection control, care plans, falls, staff supervision and appraisals, incidents and complaints. Where improvements were required these were identified and addressed. From reviewing the findings from these checks we saw that many actions had been addressed but the management team were still identifying areas requiring improvement. We also saw this governance system needed expanding to take into account all areas of service delivery as they were not identifying the concerns we identified during this inspection.

The service held 'resident and relative' meetings but staff said many people were not able to contribute to these meetings and attendance at the meetings was low. The service, with input from a consultancy firm, had developed satisfaction surveys to obtain formal feedback from people and relatives about their experiences of the service. However, these were not being used at the time of our inspection.

From the paragraphs above and the evidence in responsive, this shows the provider was in breach of regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014.

CCTV had been installed in communal areas. Signs had been put up informing people about the cameras in operation and relatives had been spoken with. The management team had installed these cameras following concerns raised about the level and quality of care people received. They told us since the installation of the cameras they had seen an improvement in the delivery of activities and engagement between staff and people. However, our observations during the inspection showed further improvement was required.

Staff said, "Teamwork is great. We ensure everything is done." And "[The registered manager] is who you can rely on. She listens to everyone's concern." The team felt there was an open culture at the service and everyone we spoke with felt able to express their opinions and that their views were listened to. There were regular staff meetings that were joint meetings across the whole staff team that worked at this service and the sister service Acorn Lodge. The registered manager told us the focus of the last meeting was about increasing the day to day activity provision at the service.

From discussions with the provider it was clear that the focus for the upcoming year was to strengthen the management structure across both services – Acorn House and Acorn Lodge. There were plans to have joint

management across the services at care coordinator, deputy manager and registered manager levels. They felt this would provide better consistency of care across the services and improve the day to day management and quality of care. This was not in place at the time of our inspection and we will review the impact of this management change at our next inspection.

The registered manager was aware of their responsibility to notify the Care Quality Commission of certain events that occurred at the service as required by their registration so we could take further action when required.

The provider and registered manager had regular meetings with the local authority. The service was currently in 'provider concerns' with the local authority due to previous concerns with the quality of service provision. The provider was working with the local authority to provide evidence of improvements, however, the evidence we found at our inspection showed further work was required to ensure sustained improvements and continuously develop the service in line with national good practice and legal requirements.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>The registered persons had not ensured that service users were treated with dignity and respect.<br>Regulation 10 (1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The registered persons had not ensured that service users were supported in line with the 2005 Mental Capacity Act.<br>Regulation 11 (1) (3) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The registered persons had not ensured care and treatment was provided in a safe way and that risks to service users' safety were adequately assessed and mitigated. The registered persons had not ensured the premises were safe to use for their intended purpose.<br>Regulation 12 (1) (2) (a) (b) (d) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The registered persons had not ensured |

adequate systems were in place to assess, monitor and improve the quality and safety of the service; to assess, monitor and mitigate risks to people's safety, health or welfare, and had not maintained accurate, complete and contemporaneous records for each service user.
Regulation 17 (1) (2) (a) (b) (c)

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The registered persons had not ensured staff received appropriate support, training and professional development to carry out their duties.<br>Regulation 18 (2) (a) |