Acorn Lodge Limited

Acorn Lodge Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Acorn Lodge Care Centre is a care home providing personal and nursing care to older people who may be living with dementia or a mental health condition. The service can support up to 98 people in a purpose built four storey building.

People's experience of using this service and what we found
People's medicines were not always managed safely. For example, unclear documentation about medicines to be administered as required had meant that a person had received too much of one of their medicines putting them at risk of harm. The provider had asked a pharmacist to review this person's medicines. During the inspection, the provider contacted the person's GP about the error.

The home had identified the risks people faced and had comprehensive plans in place to mitigate against a range of issues that may cause harm, for example ones relating to epilepsy, pressure sores and people's mental health. However, people's plans did not always contain enough information about people living with diabetes for staff to follow.

Staff were recruited safely and there were enough staff working at the service to meet people's needs in a timely fashion. Staff understood how to safeguard people from abuse.

There were a range of infection prevention and control measures in place to minimise the risk of the spread of infection.

People and their relatives told us they felt safe and the service was well-run. Staff told us the registered manager was approachable and had input into how the service was run. The provider monitored the service using a range of control audits however, the medicine audits were not effective enough to pick up the issues we found during the inspection.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection and update
The last rating for this service was requires improvement (published 17 October 2019) and there were two breaches of the regulations. At this inspection enough improvement had not been made and the provider was still in breach of regulations. The service remains rated requires improvement in the safe and well led key questions. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 11 September 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe and well-led which contain those requirements.
The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained as requires improvement. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Acorn Lodge Care Centre on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to safe care and treatment and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Acorn Lodge Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

At a recent inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services. Please find details in the report published on 2 December 2020.

Inspection team
The inspection team consisted of an inspector, a medicines inspector, a nurse specialist advisor 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

Service and service type
Acorn Lodge Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
We announced the inspection on the morning of the visit date in order to minimise the risk of the spread of infection. Inspection activity started on 9 November 2020 and ended on 26 November 2020. We visited the care home premises on 13 November 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information

about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with a person who used the service and 11 relatives about their experience of the care provided. We spoke with six members of staff including the registered manager, the clinical lead, three nurses, and the chef. We made general observations of the service.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance records and we spoke with three care workers.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our last comprehensive inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people and were nor managing medicines safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found some improvements had been made to risk management but medicines were still not always managed safely.

Using medicines safely

- We found issues with the calibration of blood glucose meters. The solution used to calibrate one of the machines had expired. This was not identified by staff during the weekly check. In addition, staff had not acted when the results of the calibration test were out of range. This meant that the results obtained from the blood glucose testing kits could not be relied upon as accurate. We could not ascertain if anyone came to harm as a result of this.
- Medicines that were taken when required were recorded on a different MAR chart to regular medicines. This may have contributed to two occasions where a resident was given too much paracetamol. Staff had not identified these errors prior to this inspection. The registered manager had agreed to work with the care home support pharmacist to review the MAR chart template.
- Whilst fridge temperatures were in range most of the time, the day before and the day of the inspection, the minimum temperature was out of range. Staff had not identified this issue and had not acted to safeguard the medicines until this was highlighted during this inspection. There was minimal risk of harm to people at the service due to the nature of the products being stored at the time of this inspection.
- The provider had a consent form that was signed by relevant healthcare professionals for the administration of crushed and covertly administered medicines. However, staff did not always have specific instructions for the administration of medicines given via an enteral feeding tube. When this information was available, not all staff knew where to find it.

The above issues were a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- After the inspection, the provider put a system in place to prevent the situation happening again.
- People's relatives told us their family members received the right medicines at the right time.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- The provider had identified a range of risks people faced to their health and wellbeing.
- The provider had implemented robust plans to mitigate the risks associated with pressure ulcers, epilepsy,

continency and mental health.
● People living with diabetes had a diabetic risk assessment including steps for staff to monitor for signs of hypoglycaemia. Staff we spoke with knew how to support people living with diabetes, however, there was not always enough information about people's diabetic diets, tissue viability and foot care in their records. We recommend the provider review people's diabetic care plans to include all the relevant information.

● Relevant referrals were made when people's needs changed to maintain their safety. For example, people had input from dieticians, speech and language therapists, and tissue viability nurses when required.
● Staff we spoke with knew how to follow these professionals' treatment plans which were well communicated at hand over meetings. Daily notes confirmed treatment plans were being followed.
● A person's relatives told us, "We think [person] is being looked after really well. [Person] has [medical condition] and we feel [they are] content there and being cared for by the home."
● People's records were updated by the clinical lead when their needs changed and these were discussed with the aligned GP and the person's family as appropriate. One relative said, "They called us recently to update us about the fact [family member] was unwell but [they] seem alright now."
● The provider analysed why things went wrong and put plans in place to help prevent it happening again for example following a fall a person was referred to their GP and new equipment was purchased to help keep them safe .

Systems and processes to safeguard people from the risk of abuse
● People were safeguarded from the risk of abuse and harm. Relatives told us their family members were safe living at the home.
● Staff we spoke with understood how to monitor people for signs of abuse and knew they needed to report any concerns to the nurse or the registered manager. One staff member said, "if I see anything, bruise or mark, I inform the nurse. If someone complains we have to inform nurse or report it to manager to make sure they're safe. We will look after them."
● Staff knew how to blow the whistle if their concerns were not acted upon. One staff member said, "If nothing is done, we will talk to someone higher. If still nothing is done, we would report to the CQC. But this hasn't happened."
● The registered manager understood their responsibility to alert the local authority and the CQC of any safeguarding allegations and records confirmed this.

Staffing and recruitment
● There were enough staff to meet people's needs. Relatives told us, "There are enough staff as far as I can see." A second relative said, "I think there are enough staff but it is hard to tell at the moment with COVID. The buzzer was always answered quickly." A third said, "[Relative] seems to be answered quickly if she needs to call for anyone."
● Most staff we spoke with said there were enough staff to meet people's needs and the service appeared calm and unhurried during the inspection. One staff member told us there were always two people working with people who required it.
● The provider had assessed the number of staff needed using a dependency tool. We noted there were the correct number of staff working during the inspection and the provider was not using agency staff as they had enough staff.
● Recruitment records showed people were hired safely and included, references and criminal record checks to ensure staff were suitable to work in a care setting.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
More details can be found in our report published on 2 December 2020.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection the provider had failed to implement a system to check medicines were managed safely and care records were effective. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

- Managers and staff were clear about their roles. The registered manager was well supported by the clinical lead and nursing team. Care workers and domestic staff understood their roles and responsibilities.
- The provider had implemented a range of checks and audits to monitor the quality of the care provided. These included night spot checks on staff to check they were carrying out their roles appropriately, care plan audits, and medicine audits.
- However the care plan and medicine audits were not robust enough to highlight the issues we found during the inspection meaning a person had received too much medicine on two separate days putting them at risk of harm. Diabetic care plans also lacked sufficient detail to provide comprehensive guidance of the care people living with diabetes required to keep them safe.

These issues amounted to a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager immediately put plans in place to address these concerns.
- The provider had made great strides to improve the care provided since the last inspection and had advanced care quality while implementing new infection control measures during the COVID-19 pandemic. For example, other areas of concern found at the last inspection, including catheter care, personalisation, assessing risks associated with living with epilepsy had all been improved.
- Relatives told us the service was very good and had improved.
- The register manager understood their duty of candour to report any concerns about the service to the commissioning local authority and the care quality commission.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● There was an open and positive culture at the service. Staff told us they enjoyed their jobs and wanted to help people as best they could.

● Staff felt communication was good and they were able to have an input about service delivery during regular team meetings. Records confirmed this. One staff member said, "I'm very happy with the service. We work like a family, I don't have any problems. Good teamwork, I'm always happy when I go to work."

● Relatives told us they felt the home was well run. One relative said, "[Family member] has no problems with the staff and is well looked after here. I would say it's well-run and [family member] seems to get on with all the staff who help [them]."

● Relatives spoke highly of the registered manager and told us she was very visible and approachable. One relative said, "I would say it's very well managed and yes I know who the manager is. It's a well-run home and they are all very helpful and accommodating."

● Relatives felt communication with the service was good and they were kept up to date about their loved ones' wellbeing. One relative said, "I know the manager very well and she is easy to get in touch with. I would say it's well run. They have yearly meetings I think. I am sure any issues would try to be resolved to the best of their abilities and I feel happy knowing my [relative] is being cared for here."

● The home worked in close partnership with other health and social care professionals such as the aligned GP and practice nurse, tissue viability nurses and physiotherapists in order to effectively meet people's needs.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely. Regulation 12(1)(2)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not established robust systems to assess and monitor the safety of the service. Regulation 17(1)(2)(a)(b)(c).