Ramos Healthcare Limited

Acacia Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

This unannounced inspection took place on 5 April 2016.

Acacia Court is a care home which provides personal care and accommodation for up to 27 people living with dementia. It comprises two large detached houses joined by an extension. The accommodation includes a large lounge, a spacious dining area and a large garden to the rear of the property. There is parking to the front of the building.

Sixteen people were living at the home at the time of the inspection.

A registered manager was in post and had been working at the home since 2010. They were not managing the service at the time of the inspection. A registered manager from one of the provider's other services was managing Acacia Court in their absence.

A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

As the overall rating for Acacia Court was 'Inadequate' at the last inspection the home was placed into 'Special measures' by CQC. The purpose of special measures is to:

•□Ensure that providers found to be providing inadequate care significantly improve

•□Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made

•□Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in Special Measures will be inspected again within six months and this inspection was undertaken within that timeframe to establish if sufficient improvements had been made. Adequate improvements had been made therefore the home has been taken out of Special Measures.

Although some improvements had been made to medicines management since the last inspection, we found that the management of medicines was still not robust. Further improvements needed to be made, including auditing of medicines, monitoring of fridge temperatures and clear documentation regarding variable doses of medicines, recording allergies and documentation of the destruction of Controlled Drugs.

Recruitment processes had improved and were effective in ensuring that new staff were suitable to work at the home. Staff had completed the training they required to fulfil their role and training records confirmed this. Staff told us they were receiving regular supervision and had received an annual appraisal of their performance. Records confirmed this.

Staffing levels had improved since the last inspection. Families who were visiting at the time of the inspection told us the staffing levels were better and there were enough staff on duty at all times. Through observation, we concluded there were enough staff to meet people's needs. There was a member of staff in the lounge at all times during the inspection.

Some improvements had been made in relation to seeking people's consent to care and treatment. Although the service was mainly working within the principles of the Mental Capacity Act (2005), there was still some scope for improvement in relation to undertaking mental capacity assessments. We made a recommendation about this.

The restrictions in place to maintain people's safety was done so lawfully and in accordance with Applications to deprive people of their liberty had been submitted to the Local Authority.

Improvements had been made in relation to safeguarding people from abuse. Safeguarding concerns were being appropriately reported to the Local Authority. Staff could clearly describe how they would recognise abuse and the action they would take to ensure any concerns they had were reported. Training records confirmed the staff team was up-to-date with training in the safeguarding of vulnerable adults. Staff were aware of the whistle blowing policy and said they would not hesitate to use it.

Improvements had been made to the environment and arrangements to monitor and check the premises were more robust. The privacy of people's bedrooms was ensured as people had locks for their bedroom doors, which meant other people could not access their rooms. Some action had been taken to ensure the environment was dementia-friendly, including signage on doors and the use of colour to distinguish rooms.

People and families were satisfied with the quality of the food and the choice of meals available. We noted from the care records that alternative arrangements had not been put in place to check the weight of people who refused to or could not use a scale.

Families told us that the recreational activities had improved but were still limited to certain times. They said more needed to be done to occupy people during the day. Families said that their relatives would benefit from direct access to the back garden.

Improvements had been made to individual risk assessments and care plans but further work was needed to ensure that care plans included sufficient detail for staff to understand how to manage individual in a consistent way.

Audits or checks to monitor the quality of care provided had been developed further and were more robust. However, were not effective as they had not picked up on issues we identified. These included the medicines audit and care plan audits.

Confidential information was now being stored in a secure way because the manager's office had been reconfigured so was no longer used by visitors to access a person's bedroom.

Information related to an adult safeguarding concern had been shared with the local safeguarding that was

not accurate. A process was established to manage and monitor accidents, including a process for analysing accidents on a monthly basis. The analysis was limited as it focussed on falls rather than the full range of incidents that occurred at the home.

A procedure was established for managing complaints. Families we spoke with were aware of what to do should they have a concern or complaint.

The provider was informing the Care Quality Commission (CQC) of all the events CQC are required to be notified about.

You can see what action we asked the provider to take at the back of this 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

The service was not always safe.

Relevant risk assessments had been undertaken depending on each person's individual needs but they did not always include sufficient detail about how to manage the risk.

Staff understood what abuse meant and knew what action to take if they thought someone was being abused.

Measures were not robust enough to fully ensure the safe management of medicines.
Measures were in place to regularly check the safety of the environment and equipment.

There were enough staff on duty at all times. Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff sought the consent of people before providing care and support. Although the home was following the principles of the Mental Capacity Act (2005) for people who lacked mental capacity to make their own decisions, further improvements were needed.

Families told us they liked the food and said their relatives got plenty to eat and drink. Alternative arrangements had not been made for people who either refused to or could not use a weighing scale.

People had access to external health care professionals and staff arranged appointments when people needed them.

Staff were well supported through induction, supervision, appraisal and on-going training.

Work had started to develop the environment in a dementia friendly way.

Is the service caring?

Requires Improvement

The service was caring.

Families told us they were happy with the care their relatives were receiving. We observed positive engagement between people living at the home and staff.

Staff treated people with respect, privacy and dignity. They had a good understanding of people's needs and preferences.

Although improvements had been made since the previous inspection, we have not revised the ratings for this domain above 'Requires improvement'. To improve the rating to 'Good' would require a longer term track record of consistent good practice.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were regularly reviewed and reflected their current and individual needs. We observed that care requests were responded to in a timely way.

A programme of recreational activities was available for people living at the home to participate in. However, activities were provided over a limited number of hours each week and were not based on individual preferences.

A process for managing complaints was in place. Families we spoke with knew how to raise a concern or make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Processes for routinely monitoring the quality of the service had been improved and regular audits were taking place. However, some of the audits were not effective as they did not identify some of the issues we found, such as discrepancies with medicines.

We found that information shared with the Local Authority regarding a safeguarding concern was not accurate.

A process was established to manage and monitor accidents, including a process for analysing accidents on a monthly basis. The analysis was limited as it focussed on falls rather than the full range of incidents that occurred at the home.

Staff were aware of the whistle blowing policy and said they would not hesitate to use it.	

Acacia Court

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 unannounced inspection took place on 6 April 2016.

The inspection team consisted of an adult social care inspector and a pharmacist specialist.

Before our inspection we reviewed the information we held about the home, including notifications and other information the Care Quality Commission had received about the service. We contacted the commissioners of the service to see if they had any updates about the service. They had no concerns.

During the inspection we spent time with three people who were living at the home and seven family members who were visiting their relatives at the time of our inspection. We also spoke with the director, registered manager, human resources officer, care manager and two care staff.

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 looked at the care records for four people living at the home, four staff personnel files and records relevant to the quality monitoring of the service. We looked round the home, including people's bedrooms, bathrooms, dining rooms and lounge areas.

Requires Improvement

Is the service safe?

Our findings

When we carried out a comprehensive inspection of Acacia Court in December 2015, we identified breaches of regulation in relation to keeping people safe. The 'safe' domain was judged to be 'inadequate'. This inspection checked the action the provider had taken to address the breaches in regulation. The breaches were in relation to safeguarding people, staffing levels, the recruitment of staff, management of medicines, safety of the environment and risk management in relation to the care and treatment of individuals.

At this inspection we found further improvements still needed to be made in relation to medicines management, including auditing of medicines, monitoring of fridge temperatures and clear documentation regarding variable doses of medicines, recording allergies and documentation of the destruction of controlled drugs. These are medicines which are liable to misuse and therefore need close monitoring.

Care plans were not always clear for staff to support people who had medicines only when needed (often referred to as PRN medicine). We saw evidence that audits had been carried out but they had not identified the issues we found on inspection.

We checked the medicines and records for five out of the 16 people in the home; including medicines administration records (MAR) and care plans. We also looked at the most recent medicines audit. We spoke with four members of staff including the manager and a care staff responsible for medicines administration.

Medicines were kept safely in a locked trolley secured to the wall as the medicines trolley did not fit in the locked clinic room. We found ordering processes were in place to make sure medicines were available when people needed them and stock control was appropriate. Documentation of medicines administration was clear and we saw no evidence of people missing medicines.

There was a locked fridge in the medicines clinic room but recording of maximum and minimum temperatures was not carried out as recommended in national guidance. On the day of our inspection there were no medicines needing refrigeration.

We found that controlled drugs were stored securely. Registers were in place to record the handling of controlled drugs but these did not accurately reflect the stock we saw in the cupboard. The provider told us this was because stock had been returned to the supplying pharmacy for destruction, although they were unable to provide documentation for this.

Weekly medication audits were completed; however the audit had not identified the issues we saw on our visit. For example, the audit stated all stock balances of controlled drugs matched the controlled drugs book but on our visit we found this was not the case.

We observed people being given their medicines by a senior care staff. This was done on time and in a caring person centred manner. We saw the staff member check to see if people were in pain and told them what their medicines were for. For example, one person was told, "This is your antibiotic for your chest." This

helps people to be supported to make a choice if they want to take their medicines or not. However, we saw that medicines were not always given in accordance with their directions. For example, we saw a person being given a medicine that needed to be given before food at the same time as a medicine that needed to be given after food. Both of these tablets were given with the lunchtime meal. This means the medicines may not work as effectively.

We saw two people were given their medicines covertly (given in food or drink without their knowledge). We looked at the documentation for this and found it did not reflect the way that people were given their medicines. This means medicines may not be given in the same way by different members of staff. Some of this documentation was updated on the day of our visit.

We saw people had identification sheets in place with their MAR. This helps prevent medicines being given to the wrong person. These did not always detail allergies the person had, which is not in line with current guidance. Having allergies recorded can reduce the risk of medicines being given to someone with an allergy.

We looked at the information available to staff for medicines to be administered 'when required'. We found some incidences where written guidance was not available for staff if there was a variable dose. For example, details of the situations where someone might need to take one tablet or situations where someone might need to take two tablets. Staff told us some people could tell them whether they wanted one or two tablets. We saw one person who was living with dementia was not always able to verbalise their needs. Staff told us that when this person could not tell them if they needed medicines they would look for signs instead but this was not recorded. This meant that there was a risk that new or inexperienced staff may not have had enough information about how this person liked to take their medicines.

We found a tablet on the floor in the bedroom of a person living at the home. The person told us that staff left the tablets with them and did not observe them taking them. The person said they experienced numbness in their fingers and probably dropped the tablet without noticing.

This was a continued breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection we found that incidents of physical altercations between people living at the home had not always been referred to the local adult safeguarding team. Improvements had been made as we found at this inspection that incidents of a similar nature had been appropriately referred to safeguarding. The staff we spoke with were clear about what constituted abuse and the action they would take to ensure actual or potential abuse was managed appropriately. An adult safeguarding policy was in place for the home. Staff confirmed they had received safeguarding training and our review of the staff training records confirmed this.

Families we spoke with had no concerns in relation to the safety of their relatives living at the home. A family member said, "If I had any serious misgivings I would take [relative] elsewhere. There is not one bad carer among them."

At the previous inspection we found that the staffing levels were insufficient to meet people's needs and maintain people's safety. During this inspection we found that improvements had been made to the staffing levels. The families we spoke with identified staffing levels as one of the main areas of improvement since the last inspection. A family member said, "Sometimes in the past there were just three staff in the afternoon. It was not enough. Now they do have enough staff. Now there is always staff in the lounge."

Another family member told us, "Only recently is there a member of staff in the lounge. Frequently [in the past] there were no staff watching the lounge. I had to intervene and mention it at a review."

The manager described the staffing levels each day, which was confirmed by the duty rotas. They showed a clear increase in staff staffing levels. In contrast to the previous inspection, the manager and deputy manager were now routinely supernumerary and not included in the staffing levels. The manager explained that they had introduced a dependency tool to determine staffing levels and it had been used to identify and justify the increase in staffing levels.

Care staff we spoke with confirmed that the staffing levels had improved and they said there was enough staff to ensure people received support and care when they needed it. We spent periods of time observing the activity in the lounge and noted that a member of staff was routinely monitoring the lounge. There was an unhurried atmosphere and staff took their time when supporting people. We noted that people's requests and needs were responded to in a timely way.

At the previous inspection we found that effective staff recruitment processes were not in place and the registered manager was unable to provide the recruitment details for a member of staff who had worked two night shifts in November 2015. Improvements had been made in this area. We spent time with the human resources officer who explained that changes had been to the recruitment process. The changes included, a revised application form that requested additional information, a revised induction process and new job descriptions. The manager confirmed that that they knew all of the staff who were working at the home and had been involved in their recruitment.

We looked a selection of personnel records for staff recently recruited and could see that recruitment checks had been carried out to confirm the staff were suitable to work with vulnerable adults. Two references had been obtained for each member of staff. Photographic identification and a record of the staff member's performance at interview were retained in the personnel records.

At the last inspection we identified a number of concerns in relation to environmental and risk management, including the safe monitoring of equipment. At this inspection fire safety checks were up-to-date. Staff we spoke with confirmed they had received training in fire safety. Staff training records confirmed the majority of staff were up-to-date with fire training. Personal emergency evacuation plans (PEEP) were in place for each person and they were now located in an easily accessible area. The care manager told us this was in the process of being up-dated.

Risk assessments were in place for the environment and they had been updated in January 2016. Arrangements were in place for checking the environment, such as the safety of the water, door sensory alarms, nurse call system and cleanliness of the environment. Window restrictors had been replaced to ensure they met the recommended national standards. They were being checked on a regular basis. Assessments were in place for chemicals used within the home.

Staff we spoke said the maintenance of the environment had improved. A member of staff said, "Maintenance is better since the last inspection." Concerns we identified with unsafe access to the basement and the laundry area had been addressed in accordance with the Management of Health and Safety at Work Regulations 1999. Because of the low ceiling in the laundry staff told us the provider (owner) had said they should spend no longer than 15 minutes in the basement. There was no system to monitor this and staff were unsure how long they spend on each occasion that they were carrying out laundry duties. Staff also demonstrated how they struggled to hold open the basement fire doors when carrying laundry and other items up to the ground floor. We discussed both these concerns with the director who agreed to

address them.

Arrangements were also in place for monitoring the safety of equipment. Evidence was in place to confirm routine checks of lifting equipment and accessories was being carried out in accordance with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER), including the passenger lift, wheelchairs, hoist and slings. We observed that the furniture and fittings in a person's bedroom was shabby. The carpet was threadbare and ruched in places, which could cause a trip hazard. The chest of drawers was broken, which also could present a risk. The manager told us the person did not like anyone interfering in their room. However, we reiterated our concerns about safety and the manager said they would look at how they could address this.

We found some good improvements had been made regarding individual risk assessments and associated care plans. We saw that detailed assessments and care plans were in place for most people who displayed risky behaviour or behaviour that could be challenging to others. However, not all documentation was this detailed. For example, a care plan for a person failed to describe how the person displayed behaviour that challenges, the triggers to this behaviour and the strategies to support with de-escalating the behaviour.

We also looked at a care plan for a person who had epilepsy. Although there was a lot of information in the care recorded about seizures associated with epilepsy, the care plan did not provide specific detail about how the person's epilepsy presented itself. Having detailed care plans in place is important so that staff, in particular new staff to the service, have clear guidance in how to support a person. In addition, a good quality care plan is important so that all staff take a consistent approach when supporting a person. We discussed this with the care manager who advised us that each person's care records were in the process of being revised and they agreed to address the specific risk assessments and care plans we highlighted that lacked detail.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection we identified breaches of regulation in relation to the effectiveness of the service. The 'effective' domain was judged to be 'inadequate'. This inspection checked the action the provider had taken to address the breaches in regulation. The breaches were in relation to the 2005 Mental Capacity Act (MCA), staff training and ensuring the environment was suitable to the needs of the people living at the home.

At the previous inspection we found that mental capacity assessments were not completed in accordance with the principles of the MCA or the provider's policy on consent, which made reference to seeking consent regarding "significant, unusual or one off-off decisions". Some improvements had been made in this area.

The 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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Deprivation of Liberty Safeguards (DoLS) had been submitted to the Local Authority for each of the people living at the home. Some of the DoLS had been authorised and some were awaiting a DoLS assessment. From the care records that we looked at there was no evidence that a mental capacity assessment had been completed to indicate the person lacked capacity to make a decision about living at the home.

We spoke with a family member who stated their relative living at the home had capacity and therefore they requested that the application for DoLS be withdrawn. It was withdrawn by the care manager. Undertaking a mental capacity assessment prior to the completion of the DoLS application would have identified whether the person lacked capacity or not. We noted the following recorded in another person's care plan for DoLS - "[Person] was placed on a DoLS due to having a diagnosis Alzheimer's disease." This showed a lack of understanding as a diagnosis of dementia does not assume a person lacks capacity to make decisions. We checked the staff training records and could see that staff were up-to-date with training in DoLS, most of whom had completed the training since the previous inspection.

We recommend that the service considers current best practice guidance in relation to Deprivation of Liberty Safeguards and revises its practice accordingly.

Staff told us that people's wishes regarding their end-of-life care were known, including their decisions about resuscitation. We could see that Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) plans were in place for some people. These were in accordance with the MCA and had been coordinated by the person's GP. We noted that one DNACPR form indicated that the GP had not discussed the matter with the person's representative. Another DNACPR form had been completed in 2013 but was not on the paperwork

routinely used by GPs. We mentioned both these issues to the care manager who agreed to follow them up.

At the previous inspection we found that staff training was not current. In particular, few staff had completed training in relation to caring for people living with dementia. Improvements had been made in this area. The care staff we spoke with told us they had received training the provider required them to complete in order to undertake their role. They also told us they received regular supervision. The training records and personnel records we looked at confirmed staff were up-to-date with training, supervision and appraisal. All staff had received training in dementia care. We spoke with a member of staff who had recently started working at the home. They told us they had been supported with a thorough induction and had been given the time to complete the training as part of their induction.

At the previous inspection we found that the environment was not configured in a way that was dementia-friendly. Some improvements had been made in this area. The director informed us they were now using a nationally recognised dementia-friendly home assessment tool to review the environment. We had a look around the building. Clear easy-read signage had been placed on the doors of key rooms, such as the toilets, bathrooms, lounge and dining room. This provided people with cues for orientation around the building and supported them with maintaining their independence. Directional signage was not in place and the manager confirmed this was planned to be put in place. The doors of the bathrooms had been painted dark blue to ensure they were distinguishable from other rooms. Additional hand rails had been fitted on the corridors but some areas, such as the dining room would benefit from further handrails. Colour had not been used effectively to support people in identifying the handrails or to identify their bedroom door from the wall. Each bedroom door included the person's name and their photograph but the photograph was too small to clearly identify the person.

The families we spoke with recognised the improvements that had been made to the environment but some felt further improvements needed to be made. A suggestion included making the lounge less "institutionalised" looking by better use of colour and arranging the seating differently. We observed that there were no particular points of interest, such as photographs or artworks of a size that could be easily seen. Memory boxes, rummage boxes or similar were not available for people to access. At previous inspections we noted that direct access to the garden had been raised on a number of occasions by families providing feedback on the service. This had not improved and families again raised it at the inspection. We discussed access to the garden with the director and they informed us that this was part of a broader plan to develop the service.

Although we did not have concerns about nutrition and hydration at the previous inspection, families told us the food had improved. A family member said to us, "The food choice is great. It has changed to accommodate [relative's] changing needs." Another family member said, "The food was always good but it has got better and there is plenty of choice." A person living at the home said, "The food is always good." A person living at the home said, "I enjoy the dinners here. It's a good place to eat at." People told us they enjoyed their lunch on the day of the inspection.

We observed that a menu was not displayed and staff told us they did not use pictorial menus. The manager advised that pictorial menus were part of the plan for further developments of the service. A water machine was available but this was located in the dining area, a room that people did not routinely use throughout the day. We discussed with the manager whether it could be better positioned so people and their families were prompted to access it by its visual presence.

We had identified at the previous inspection that some people either refused to be weighed or could not use a scales so their weight was not being regularly checked. An audit by the director carried out in February

2016 identified that some people were not being weighed "due to refusal" and that "alternatives needed to be explored". This had not happened for everyone. From the care records we looked at, we identified that a person's weight had not been checked for 12 months due to refusal and alternative measures to check the person's weight had not been used. This meant sufficient measures were not in place to ensure people's nutritional and hydration intake was being monitored.

This was a breach of Regulation 14(4)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to needs associated with memory loss, people living at the home were unable to verbally share with us whether they were supported to maintain good health care. Families we spoke with were satisfied that the staff monitored their relative's health care needs and took action when needed.

From our conversations with staff it was clear they had a good knowledge of each person's health care needs. People's care records informed us they had regular input from professionals if they needed it, including the district nurse, optician and chiropodist. A form was in place to record all consultations with health or social care professionals. We could see that some people received specialist health care input if they needed it. This included input from the local community mental health team and the speech and language therapy service.

Requires Improvement

Is the service caring?

Our findings

At the previous inspection we identified a breach of regulation in relation to the 'caring' domain, which was judged as 'requires improvement'. This inspection checked the action the provider had taken to address the breach, which was in relation to maintaining the privacy of people living at the home.

We found that improvements had been made. Since the previous inspection locks had been put on the bedroom doors that were regularly being accessed by people living at the home who liked to regularly walk about. The locks had been put in place in accordance with the principles of the Mental Capacity Act (2005), in the person's best interest. Families confirmed that they had been involved in discussions about this and their involvement was also recorded in the care records. The manager informed us that the bedrooms were not locked when people were using their bedrooms.

Because not all of the people living at the home were able to share their views with us, we spent periods of time throughout the day observing and listening to how staff interacted with people. There was a calm and unhurried atmosphere throughout the inspection. People were comfortable and at ease when staff approached them. Staff not only spent time with people when they were providing care and support but also just sat with people periodically talking with them. We observed staff encouraging people to make choices. Staff were kind and caring in the way they engaged with people. They spoke about people with warmth and demonstrated a positive regard for the people living at the home. Staff we spoke with had a good understanding of each person's needs and preferences.

We looked to see if people's preferred routines/preferences were recorded so that staff had access to this information if people were unable to verbally express their preferences. We observed from all the care records we looked that each person's preferred time for getting up in the morning was recorded as "various". This was not very person-centred or helpful to staff. People's preferred gender of staff to support them was not recorded in the care records we looked at. The care manager said they would address these matters.

Overall, families we spoke with were pleased with the way in which their relatives were being cared for. A family member said, "They [staff] are very kind to the residents. I have every respect for the carers." Another told us, "Most of the carers, in particular the new carers are good. Some staff can be a bit sharp in the way they speak to the residents - less than gentle but not unkind."

Families we spoke with said they were involved with the care of their relatives, including discussions about the care plans. A family member said, "I've looked at the care plans. The keyworker has gone through the files with me and I signed some off." Some of the families we spoke with said they had been invited to a review about their relative's care. A family member said they had asked for a care review and this had been accommodated in a timely way.

The manager advised us that they could access local advocacy services if people needed someone to represent them. We looked at the care records for a person who had an advocate in the absence of family

representation. We noted the advocate had been actively involved in discussions about care as they had signed the person's care plans.

Although improvements had been made since the inspection in November 2015, we have not revised the ratings for this domain above 'Requires improvement'. To improve the rating to 'Good' would require a longer term track record of consistent good practice.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection this domain was judged as 'requires improvement'. Although there were no breaches of regulation, we identified that further improvements needed to be made.

The assessments and care plans we looked at had been or were in the process of being reviewed and revised to ensure they were person-centred and reflected people's needs, choices and preferences. Life histories were in place in some of the care records we looked. The quality and content of the life histories was variable. The care manager explained that a 'This is my life' booklet was sent to families to complete but they were slow coming back. We looked at one that had been returned and it included rich information about the person's life and included photographs. There was no alternative identified to seek this information if families did not complete and return the completed booklet or for people who did not have a family member or someone close to represent them. One of the people living at the home refused to share their life story with staff and staff respected their wishes.

Families told us that staff communicated with them in a timely way if there were any changes to their relative's needs, including if their relative had an accident or needed to see a doctor.

There were mixed views expressed by families in relation to social and recreational activities at the home. Some families were pleased with the type of activities, such as the singer who visited the home, chair exercises and painting. Others said there should be regular activities each day and/or things for people to look at i.e. rummage box. A family member said, "There are no signs of puzzles, books and magazines in the lounge. They [staff] could encourage people to use adult colouring books." Another told us, "If there was more going on [activities] it would be better."

An activities coordinator was not employed at the home. Staff told us that an external entertainer/facilitator came to the home for one hour four days per week. They said there were trips out occasionally and parties. Some families we spoke with said this was not enough to occupy people. A family member said some care staff were good and would sit and talk with people. However, they said most of the care staff did not routinely engage people with an activity even if they had the time to do so but sat in "huddles talking to each other".

Although, we did not observe any organised or meaningful activities taking place on the day of the inspection, some of the care staff spent time with individual people when it was quiet. We observed staff setting the dining room tables at lunch time and queried whether people who lived at the home were encouraged to support staff with household tasks as this is a good way to engage with a person who may enjoy this type of activity. This was not something staff had thought about. There was no evidence from the care records or from talking to families and staff that the current activities were based on people's individual preferred hobbies and interests.

A complaints procedure was in place. A complaints leaflet was available in each of the bedrooms. Families we spoke with were aware of how to make a complaint but assured us they had no complaints about the

service. A family member said, "I may have [complained] in the past and the home has dealt with it."

Requires Improvement

Is the service well-led?

Our findings

When we carried out a comprehensive inspection of Acacia Court in December 2015, we identified breaches of regulation in relation to the management of the home. The 'well-led domain was judged to be 'inadequate'. This inspection checked the action the provider had taken to address the breaches in regulation. The breaches were in relation to a failure to inform CQC of a notifiable event and the absence of effective systems to manage the risks relating to the health, safety and welfare of people living at the home, staff and others.

At the previous inspection the audit and checks that took place to monitor the quality and safety of the service had not being happening on a regular basis so concerns we identified, particularly with the care records and medicines management, had not been identified by the provider. At this inspection we found that more stringent checks had been put in place in relation to monitoring the service, including the safety of the environment.

The director carried out a monthly audit. Initially we were just provided with the summary/outcome of the audit. We asked to see the full audit in order to check the measurement criteria and were provided with the audit for February/March 2016 on the second day of the inspection. The audit process incorporated checks of matters, such as the care records, medicines, staff personnel records and the management of people's finances. Although we recognised that there had been significant improvement in this area, the audits were not effective enough as they did not identify concerns we found with the medicines. They also were not being used to look at the content and quality of care plans as we found some care plans lacked detail to provide staff with sufficient guidelines about how to how to support the person.

A process was in place for recording, monitoring and analysing incidents that occurred at the home. The analysis was not truly reflective of the type of incidents that happened because it just focussed on falls. We observed incident forms that recorded altercations between people and these incidents, including other types of accidents had not been taken into account in the analysis. The purpose of analysis is to identify themes and patterns in order to minimise the risk of the incident occurring again. This means looking at issues, such as the time and place the incident happened, any triggers and staff presence. None of these factors were included in the analysis. Incidents were referred to as 'minor' and 'major' with no descriptor for either.

We recommend that the provider considers current best practice guidance in relation to audit and analysis regarding the quality and safety of the service, and revises its practice accordingly.

At the previous inspection a bedroom was located off the office. The family and friends of the person who occupied the room had to access the bedroom through the manager's office. This meant confidential and sensitive information located in the office was accessible to visitors. Since the inspection building work had taken place to create a corridor to access the bedroom so confidential information was now secure.

Since the last inspection we established that the manager was now making appropriate notifications to

CQC. These included notifications in relation to allegations of abuse, serious injuries and DoLS that had been authorised.

Whilst reviewing the safeguarding referrals we observed a "provider response" form that had been sent to the local adult safeguarding team. We were concerned about the information recorded as it was clearly not accurate and we could provide evidence to support this. We highlighted this to both the manager and the director. It meant that any decisions made by the safeguarding team regarding the referral could be based on this inaccurate information. We discussed the matter with a representative from the safeguarding team following the inspection.

This was a breach of Regulation 20(1)(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A registered manager had been in post since 2010. They were not managing the service at the time of this inspection. A registered manager from one of the provider's other services was managing Acacia Court in their absence.

A family member we spoke with was unaware of the outcome of the previous inspection. We checked and the rating from the previous CQC inspection was displayed in the porch of the home. It was not in an obvious place as it was partially obscured once the door was opened. Another family member expressed concern that the communication had been "poor" regarding the outcome of the last inspection and the subsequent changes to management and staff. They felt they should have been directly informed rather than hearing it from other sources.

The manager informed us that they held a "clinic" every Thursday for people living at the home and their relatives. This meant people and families could spend time with the manager to discuss care or raise concerns. All the families we spoke with were unaware of this facility. The manager advised us that they put notices up around the home about the "clinic". We did not see these notices during the inspection and discussed with the manager alternative methods of informing families of the "clinic". The families we spoke with said they had not been invited to complete a feedback survey for some time

We asked families what improvements had been made since the last inspection. They all commented that the staffing levels were much better and that improvements had been made to the environment. Families were pleased that their relative's bedroom doors were now locked to prevent other people living at the home entering the room.

We asked staff about the improvements that had been made since the last inspection. They too said the staffing levels were better and that concerns with the environment had been made. They also said that the care records were better. The care manager told us that the admission process had been improved in terms of the information sought from the pre-admission assessment. They also said that two managers had to agree before a person could be admitted. Staff meetings had started and they had been held in January and February 2016. The manager said that these meetings would take place every six weeks.

We were concerned at the last inspection that the provider was permitting staff to work excessive hours without regard for the Working Time Regulations 1998. We noted from the personnel records we looked at and the human resources officer confirmed that staff had signed to opt-out of the 48-hour week. We were also reassured that staff were no longer working 24-hour shifts. The duty rotas we looked at confirmed this.

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue.

Having a whistle blowing policy supports with the promotion of a transparent and open culture within the home.

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 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Sufficient arrangements were not in place to ensure people's weight was checked on a regular basis.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour Information provided to an external stakeholder regarding a potential safeguarding concern was inaccurate.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed in a safe way.

The enforcement action we took:

Warning notice