London Residential Health Care Limited

Acacia Care Centre

Inspection report

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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Good**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Overall summary

We visited Acacia Care Centre on 24 and 25 March 2015.

The service provides nursing and residential care for up to up to 62 people who may have poor health, dementia, or other neurological needs. At the time of our inspection there were 60 people using the service. At our previous inspection the service was meeting all the regulations we reviewed.

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

People at the service felt safe and secure. Staff knew how to recognise and respond to abuse and had completed safeguarding of vulnerable adults training. They knew how to report safeguarding incidents and escalate concerns if necessary. People's needs were assessed and corresponding risk assessments were developed. There

Summary of findings

were sufficient numbers of staff to meet people's needs and safe recruitment procedures were followed. We saw that people were receiving their medicines safely and as prescribed.

Staff had the skills, knowledge and experience to deliver effective care and treatment. Mental capacity assessments had been completed to establish each person's capacity to make decisions and consent to care and treatment. Where it was necessary to deprive people of their liberty the service was obtaining appropriate authorisations under the Deprivation of Liberty Safeguards. People were supported to have a healthy diet and to maintain good health.

People and visitors commented positively about relationships with staff and we observed numerous examples of positive interactions. People and their representatives were supported to express their views and were involved in making decisions about their care and treatment. There were meetings for people and relatives where they could express their views and opinions about the day to day running of the home. Staff respected people's privacy and dignity.

People received personalised care. Care plans were person centred and addressed a wide range of social and healthcare needs. People were involved in the development of their care and treatment. Care plans and associated risk assessments reflected their needs and preferences. People were encouraged to take part in activities that helped enhanced their lives and reduced the risks social isolation. People were confident that they could raise concerns with staff and those concerns would be addressed.

We found the service did not have an effective system in place to audit and monitor their service provision at all times. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have asked the provider to take action details of which can be found in the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe. People felt safe and happy. Staff understood their responsibilities to protect people from the risk of abuse or harm. There were enough staff to support people's needs. The service provided a safe and comfortable environment. Medicines were administered appropriately.

Good

Is the service effective?
The service was effective. Staff received regular training and management support. Mental capacity assessments had been completed to establish each person's capacity to make decisions and consent to care and treatment. Authorities under the Deprivation of Liberty Safeguards were in the process of being obtained. People were supported with their health and well-being.

Good

Is the service caring?
The service was caring. People spoke positively about staff who were aware of people's needs, preferences and planned care and support. Staff respected people's privacy and dignity.

Good

Is the service responsive?
People received personalised care. Care plans were person centred and addressed a wide range of social and healthcare needs. People were involved in the development of their care and treatment. People were confident that they could raise concerns with staff.

Good

Is the service well-led?
The service was not always well-led. We found the service did not have an effective system in place to audit and monitor their service provision at all times.

Requires Improvement

Acacia Care Centre

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 and 25 March 2015 and was unannounced.

The inspection team comprised two inspectors and one expert by experience.

Before the inspection we reviewed information we held about the service which included statutory notifications and safeguarding alerts sent to us by the provider and spoke to one healthcare professional. During the inspection we spoke with 28 people using the service, 11 visitors and 11 members of staff including the manager. We carried out general observations throughout the inspection. We looked at records about people's care and support which included nine care files. We reviewed records about staff, policies and procedures, accidents and incidents, minutes of meetings and service audits. We spoke with one health professional after the inspection.

Is the service safe?

Our findings

People told us the care and support they received reassured them and that they felt safe living in this home. One person said, "I feel confident the staff are able to support me safely and I know that someone will come when I ring my bell. I don't have to wait long." Another person said, "I'm okay with things here. I do feel safe in the home." One person said, "The staff are all very nice and friendly, I trust them all." Relatives we spoke with also told us they thought the home was a safe place to live. One relative told us, "I feel it is well designed and a safe place to live. Staff have the right equipment for people and know how to use it to move people safely." Another relative said, "[My relative] is very safe here."

The provider had systems in place to ensure people were safe. We spoke with staff and found they had a good knowledge of safeguarding and could identify the types of abuse, signs of abuse and knew what to do if they witnessed any unacceptable practice. Staff showed a clear understanding about actions they should take to ensure people were safeguarded from abuse. They told us they had received training in safeguarding which was repeated each year. The staff records we saw supported this. In addition to training the service had policies and procedures to support staff. We checked our records and saw that the service had complied with legislative requirements by notifying us of safeguarding concerns as and when they arose.

Care and support was planned and delivered in a way that ensured people's safety and welfare. We found needs assessments were carried out by a senior member of staff before people came to live at the service. These assessments included the identification of risks which was ongoing throughout the time a person was with the service. The risk assessments provided information to determine if the service was appropriate and if a safe service could be provided. Risks such as choking, use of bed rails, moving around the home, skin integrity, falls, pressure care and malnutrition were assessed and appropriate management plans to address those risks were put in place. We found staff were aware of the risk assessments and used the guidance recorded in care plans when delivering care and treatment. For example, staff used hoists in an appropriate way and pressure relieving equipment was used to promote tissue viability. People who had swallowing issues were referred to and seen by speech and language therapists and staff followed professional's recommendations to help protect people against the risk of choking. Staff described how they managed situations when the behaviour of people in the service presented risks to themselves or others. They described how they assisted people in line with guidance from a behaviour specialist and explored reasons when people were challenging or distressed. We saw staff responding to people in a calm and reassuring way. We observed staff responding sensitively to a person with specific communication needs who became distressed. Staff used pictures to communicate with the person which helped them understand what was going on and provided reassurance. Moving and handling assessments were carried out and equipment such as hoists was provided to minimise risks of injury. We saw that staff took care to ensure people used the footplates correctly to avoid unnecessary injury. People's records about identified risks were up to date but we found some minor inconsistencies in how often the plans were reviewed.

People and visitors told us there was usually sufficient numbers of staff but there were occasions when they felt there was not enough, mainly on the ground and lower ground floors. One person who used the service told us, "I have seen a lot of changes of staff this past year, we were short but it has improved now." Another person told us, "Sometimes there is a shortage of staff." Staff told us of occasions when they have experienced staff shortages due to short notice absence, particularly in the case of nurses. One member of staff told us, "It is better now, we are not usually short of staff, people get the attention they deserve." The staff we spoke with told us they could meet the individual needs of people living in the home and felt there was generally enough staff on duty and this had improved recently. People told us staff were able to provide care and support for them as and when needed. The manager and head of care had both worked on the units to cover short term absences. On the first day of the inspection the nurse in charge of care was the only on duty nurse for the ground and lower ground floors. However, we did not see anyone waiting to be assisted and saw that staff attended quickly to people when required and call bells were answered quickly. The manager told us they had lost a number of staff in the past twelve months, but recruitment had taken place for vacant posts and new candidates had been selected subject to satisfactory

Is the service safe?

references and clearance from the Disclosure and Barring Service. Staffing levels were based on the numbers and needs of the people who lived at the service. The manager told us staffing levels were planned to reflect needs on each unit. The staff rota meant staff knew which shifts they were working in advance and could make plans as individuals. This helped to ensure appropriate numbers of staff with the right skills were on duty to meet people's needs. Staff were supported by administration, catering and domestic staff that enabled them to concentrate on meeting people's care and nursing needs. Planned absences of staff for commitments such as training and leave were accommodated within staff scheduling. Short term absences were covered by staff working overtime or from bank staff. The service only used agency staff for nurse absences and only at times where staff, the manager and the head of care could not provide cover. We checked four staff files and found the provider was following safe recruitment practises.

We found that medicines were administered safely. People were supported to take their medicines by qualified nurses who had been trained to administer medicines. We examined the medicine administration sheets (MAR) for four people, these were completed correctly with no gaps. There were suitable arrangements for the safe storage, management and disposal of people's medicines including controlled drugs. The service had an arrangement for ordering, receiving and administering medicine. Staff told us there were no people self-administering medicines. Two people were receiving covert medicines. We looked at a record of an assessment process for administering covert medicines. The person was assessed as not having the mental capacity to consent to taking medicines that were vital for their health. The GP, pharmacist and staff were involved in making the decision in the person's best interests. Staff administering medicines were familiar with protocols for administering covert medicines.

Is the service effective?

Our findings

People told us they felt that staff were suitably qualified to deliver their care and meet their needs. One person told us, "The staff I know are qualified to care for people.

People were cared for by staff who had the knowledge and skills they needed to deliver safe and effective care. New staff completed an induction process. Staff were provided with regular training relevant to their roles. We saw that there was a training matrix which identified courses the service considered to be mandatory for their staff and included safeguarding vulnerable adults, manual handling, first aid, fire safety and infection control. Staff had also received training shortly before our visit through workshops delivered by the local Care Support Team. Staff were supported to obtain further, relevant qualifications. We saw that most staff had National Vocational Qualifications (NVQ) or Qualifications and Credits Framework (QCF) in Health and Social Care. Those who did not were in the process of completing or were enrolled on courses to complete the QCF at various levels in Health and Social Care. Staff skills were also monitored and supported by the service through regular one-to-one supervisions and an annual appraisal.

We saw examples of the service responding to the needs of people they cared for and ensuring staff were suitably skilled. For example, one person displayed more challenging behaviour. The manager arranged relevant training for staff to manage this appropriately. Staff were observant of the people in their care and recognised changes in health requiring the attention of specialists such as a tissue viability nurse or a palliative care nurse. For example, the tissue viability nurse was referred to for advice on skin integrity and their recommendations were followed. One person receiving bed care told us about problems with their heels. They said, "Staff have been wonderful, they dress my wounds every three days, they supply these pressure relieving boots to help them heal, looks like it is working."

The service had policies and procedures for the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff were able to demonstrate their understanding of MCA and DoLS and the manager and staff had received specific training about the subjects. A number of people were assessed as not having capacity to make specific decisions and we saw evidence of best interest meetings involving health professionals, relatives and staff. For example a number of people had bed rails raised to keep them safe when they were in bed. One example was in relation to people having bed rails raised when they were in bed. Where people lacked the capacity to make that decision we saw that assessments of mental capacity and best interests meetings took place and the decisions made and supporting rationale were recorded. The manager was in the process of making 'DoLS' applications to the appropriate authorities.

People had sufficient food to eat and liquids to drink. One person told us, "Meals are quite enjoyable here, the chef makes every effort to prepare appetising meals that we like." Another person commented on how much they enjoyed the cooked breakfast. One person said, ""We get enough fluids, plenty and they top it up." A visitor told us their relative previously was underweight but since moving into the service they had gained weight. Another visitor said, "They are working hard to get [my relative] to eat." The meals were served from heated trolleys at the correct temperature. We saw there were choices of meals for people. Meals were planned on a four week rolling menu with consideration being given to individual preferences.

Staff were aware of the dietary needs of people they cared for and care records confirmed a suitably balanced diet was provided to promote people's health and well-being. Care records included risk assessments to identify if people were at risk of malnutrition. Staff had received training in using the 'Malnutrition Universal Screening Tool' (MUST) and used this to assess whether people were at nutritional risk. If they were, suitably prepared meals were provided such as pureed food. The need for fortified meals and drinks was discussed with the GP and occupational therapists. Fluid intake was monitored for people at risk of dehydration including those with catheters or under dialysis. Those at risk of dehydration were encouraged to drink and provided with drinks of their choosing. One person who found it difficult to take the recommended fluids told us staff gave them cranberry juice which they liked very much. We saw staff encouraged people to drink. A lot of people consumed fortified drinks in addition to meals to supplement their calorific intake to maintain or increase weight levels.

We observed mealtimes throughout the inspection. We saw good interactions between people and staff. Staff were motivating and engaging. People who required assistance to eat were given were given appropriate support. We

Is the service effective?

found that people at risk of malnutrition were given food supplements prescribed by their GP. Three staff sat with people and assisted them with eating. They were patient and totally focused on the person they were helping. One care worker maintained eye contact with the person they helped. Another care worker placed their arm around the person to reassure them and seek their cooperation. We saw one care worker identified a person was not eating, leaned over and gave them encouragement to start using their fork and eat independently.

People were supported with their healthcare needs. A range of healthcare professionals visited the service to provide advice and care for people. Staff arranged for these visits and supported people with external appointments. There was a visiting chiropodist, optician and a dentist. A physiotherapist came to the home weekly. They assessed and advised on suitable exercise programmes for people with restricted mobility. People were weighed monthly and their MUST assessment was updated. We saw there were regular clinical observations recorded for people requiring nursing care. The service was unable to secure the services of a single General Practice. In fact, seven General Practices were involved in providing medical care to people. This caused difficulties for staff. For example the GPs did not attend monthly care meetings arranged by staff to discuss advanced care planning.

Daily care records showed that people received the care in accordance with their care plan. It was also recorded if changes took place and if people were becoming unwell. People told us staff were responsive to their needs. Visiting relatives spoke of their confidence in the service because staff took prompt action to address appropriately any concerns. Two family members told us staff had kept them informed when their relatives had relapsed and required urgent medical attention. Another relative told us, “It is a wonderful home. When [my relative] came here they were really poorly. Staff provided loving care and did regular checks on their welfare. The family are really pleased with how our relative has progressed thanks to staff who have helped them improve.” We saw evidence that staff responded appropriately when medical intervention was necessary and summoned a doctor or other relevant health professional such as a psychiatrist. A health professional we spoke with said staff took on board their guidance and advice and used it in practice. We saw too evidence of staff being vigilant and monitoring closely the conditions of individuals. One person told us they had developed a chesty cough some days earlier, staff had arranged for the GP to visit. The person told us the doctor had prescribed antibiotics and they now felt much better. A member of staff told us they observed a person was becoming more depressed and declined to engage, they made contact with the psychiatrist who undertook a consultation. A positive outcome was experienced by the person following treatment.

Is the service caring?

Our findings

We spoke with people and visitors about their relationships with staff. People's comments were mostly positive and described staff as kind, caring and respectful. One person said, "Exceptional staff, pleasant calm and polite, one could not wish for more." Another person told us, "I am happy with the staff here." One person commented, "In general the staff are very good. One or two are good at popping in, the others not so." Relatives also spoke positively about staff and the care provided. One family member said, "I am really happy with the care here, they look after people well. Another visitor told us, "They are a great team of staff doing a terrific job, they seem to care, always polite." One visitor said, "The atmosphere of the staff is all very happy. Everyone knows [my relative] personally and are very nice to [my relative]. I am very happy with the care given by the nurses."

We observed actions of staff and listened to interactions between people and staff throughout the inspection. People and staff were on first name terms. We saw staff were respectful, attentive and knew people well. We saw staff stopping to chat with people. The positive body language and responses from people to staff reflected the comments made to us about staff. Staff were aware of people's needs. We heard staff members speak clearly and explain what they were doing, for example when using a hoist for transferring a person into a chair and when assisting a person into a dining chair from their wheelchair. A person recently admitted from hospital was unable to communicate verbally. The person's relative told us staff had worked closely with them to find out about their culture and background and used this information to engage with the person. A member of staff told us their understanding of a certain nation's culture had helped them develop a good rapport and a shared understanding with a person who had initially found it difficult to settle in their new surroundings.

People and their relatives were supported by the service to express their views and to be involved in their care. Care plans and risk assessments showed that people and relatives were involved in planning care and subsequent reviews and changes. Relatives told us that they were always contacted by staff whenever there were any accidents, incidents or changes in health. We saw that people's preferences and choices were recorded and staff were aware of them. The service introduced Resident of the Day to provide a structure to review a person's care planning in their presence with relatives and their key worker. All aspects of their care were looked at including care, lifestyle and services provided (housekeeping, catering and activities). To enhance the experience the person's room would be deep cleaned and there would be visits from maintenance, the chef and the activities coordinator to talk about how their stay could improve.

People's dignity and privacy were respected. One person told us, "They do draw curtains and shut the door when attending to me." Another person said, "I don't mind the men caring for me, they are very kind." A relative told us, "He has been allowed his space, his dignity has been respected." One staff member told us, "Everyone deserves to be treated with dignity and respect." We observed staff carrying out tasks. They explained to people what they were going to do when carrying out care and treatment. People appeared to be clean with tidy hair. Men were clean shaven if that was their choice. Staff ensured that people were dressed appropriately and if people's clothes became dirty, they assisted them to change into freshly laundered clothing. Staff were able to give us examples of people's preferences in what they ate, the best way to communicate with them and the activities they enjoyed. People using the service were supported to maintain relationships with their family and friends. Visitors said that they were able to visit freely and were made to feel welcome. One family member told us they could come at 'any reasonable time' and this had enabled them to visit more frequently.

Is the service responsive?

Our findings

People received care that was focussed on their needs. People's needs were assessed before they came to live at the home. A pre-admission assessment form was completed that helped staff to discuss with the person and their representatives how they preferred to be supported. Advanced preparations were made to have all the necessary equipment in place when the person was admitted. Care plans were then developed with people to ensure that their choices and preferences were recorded. We looked at care plans and saw they were person centred. They contained personal histories which could help staff to understand the person, provide topics of conversation to develop a relationship and deliver the care and support people needed. However, some personal profiles had limited information and had not been developed further. Care plans identified people's care and treatment needs and recorded people's choices and preferences. They were the framework for the provision of person centred care and provided staff with guidance to deliver safe and effective care. For example, a person recently admitted from hospital was unable to communicate due to having a stroke. The relative told us staff had taken on board all the information shared with them to arrange and deliver appropriate care. Staff knew to speak on the side where the person had good hearing and understood the facial expressions used by the person in response.

People took part in a range of activities that helped enhance their lives and prevented social isolation. Many informal activities took place every day and were carried out by people on their own, with other people, visitors and staff. These informal activities included reading, watching TV, conversations, meals, walks around the unit and visiting the hairdresser. There were also two activities coordinators who ran a three monthly activity programme for people in the service. These planned activities were aimed at larger groups of people from all of the units, people from a particular unit and individuals. People who had to remain in bed as a result of their health had one to one time dedicated to them. We observed that staff closely monitored people who remained in their bedrooms and engaged with them to prevent them being isolated. The activity programme included bingo, quizzes, baking, arts and crafts, occasional trips out for small groups and Oomph sessions. The latter activity was an exercise or dance class for people to improve fitness and flexibility whilst interacting socially with other people. One person told us, "I enjoyed the exercises, I like music."

The service had systems to listen and learn from people's experiences, concerns and complaints. Meetings for people using the service and their relatives were held approximately three times a year. In the October 2014 meeting minutes we saw the concept of 'Resident of the Day' was explained. There was a request to increase the number of religious services delivered by local churches. Questions were raised about activities on the dementia unit and the manager informed the meeting about their future plans. There were queries about the number of staff on leave at the same time resulting in shortages on some units. In response the manager had introduced a policy restricting staff leave periods to a maximum of two weeks. Accidents and incidents were recorded including actions that were taken in response both at the time and subsequently. If necessary, accidents and incidents were further investigated by the manager.

The service also learnt from safeguarding incidents and responded by addressing any areas requiring improvement. If appropriate, these were discussed in staff meetings and on occasions staff meetings were called in response. People and visitors were aware that there was a system for dealing with complaints. However, most of them said they would raise any concerns with a member of staff and usually it was addressed straight away. The manager's office was behind the reception desk in the entrance hall. The manager tried to deal with any concerns or issues at an early stage and tried to operate an open door policy for people and relatives. We were aware that there was a feedback facility on the provider's website. There was also a service customer satisfaction survey. We looked at the results for November and December 2014. The vast majority of responses rated the service as good or higher with 72% indicating the service was very good or excellent.

Is the service well-led?

Our findings

We found that the service was not always well-led. The service used a number of internal and external systems to monitor and assess the quality of service provided that included unannounced visits and audits. Assessment and monitoring visits took place approximately four times a year. We saw that these had taken place in January, March, June and October in 2014 and in January 2015. We also noted that a night inspection had taken place.

However, we found there were some inconsistencies in care records such as fluid charts, risk assessments, medication records and evidence that some monitoring and auditing processes were not fully effective or on occasions had not been completed. We looked at a selection of fluid and food charts for people on the ground floor and noted some inconsistencies over a period of time. On a number of days in the month there were gaps in the record of a person's fluid intake. A health professional we spoke with also commented about the recording on fluid charts. They found some of the fluid charts were not maintained as accurately as they should be. However, there were no concerns about people being dehydrated. When we looked at the daily reports and handover records for these people these showed they were making good progress.

In relation to the treatment of pressure ulcers we saw records were not always updated and found two of the monthly review forms were not accurately completed. Where leg ulcers and a pressure ulcer had healed staff had not updated the body maps and photographs of the wounds to reflect the positive changes. A health professional commented positively about improvements seen in the service over the past six months and staff being keen to do the right things to give people the care and treatment they need. They also commented about inconsistencies in some records. None of these had been identified or addressed in auditing processes. We also found there had been no audits recorded for the past three months to monitor medicine procedures and ensure medicine protocols were robust. We were told the pharmacist who supplied the medicines was due to attend the service during our inspection to complete an annual check. The service did not have an effective system in place to audit and monitor service provision at all times. This was

Members of staff spoke positively about the manager of the service. One member of staff said, "Things are so much better and have improved so much since the manager arrived." One member of staff told us, "Resources are very available from the management." Another member of staff said, "The management is very approachable." The manager was appropriately qualified and registered with the Care Quality Commission. The manager was supported by a Head of Care and they both had nursing backgrounds. The manager and Head of Care provided nursing cover when it was required at short notice. On the first day of our inspection the manager was administering medicines when we arrived. The Head of Care was covering nursing duties for two floors. The manager was regularly seen out on the floor by people, visitors and staff. One person said, "The manager sticks her head in occasionally to check if things are alright."

We were told by the manager and staff that staff meetings were held about once a month. At each meeting, providing confidentiality was not an issue, there were discussions about safeguarding reports and incidents and how they could learn lessons. We looked at the minutes for staff meetings since May 2014 and saw this was the case. In addition, there were unit meetings involving staff. The manager was involved in a monthly conference call with other managers from the provider's locations and senior members of the management team. Again, incidents were discussed so that lessons were learnt.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider was not operating effective systems and processes to make sure they assessed and monitored their provision of services at all times. Regulation 17(2)(a) and 17(2)(c).**