Ramos Healthcare Limited

Acacia Court

Inspection report

17-19 Roe Lane
Southport
Merseyside
PR9 9EB

Tel: 01704541034
Website: www.rhcare.co.uk

Date of inspection visit:
09 December 2015
10 December 2015
14 December 2015

Date of publication:
03 February 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 9,10 & 14 December 2015.

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.

Twenty three 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. 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.

We found the staffing levels were not sufficient to ensure people were being monitored at all times was. The staff duty rotas for October 2015 through to the first week in December 2015 showed a clear variation in staffing levels that did not reflect what staff said the staffing levels should be. Frequently the registered manager was working within the care staff numbers. You can see what action we told the provider (owner) to take at the back of the full version of this report.

People told us they felt safe in the way staff supported them. Staff we spoke with were clear about adult safeguarding. The majority of the staff team had not received training in adult safeguarding. We found five recorded incidents that should have been reported to the Local Authority as safeguarding concerns but had not. You can see what action we told the provider to take at the back of the full version of this report.

Medicines were not always managed in a safe way. We observed a topical medicine (cream) in a person's bedroom was not stored securely. The medication reference book available for staff to use was out-of-date. The fridge temperatures were not always within the acceptable range. Medicines given by hiding them in a person's drink or food was not done in line with the Mental Capacity Act 2005. The medication policy was not in accordance with good practice national guidance for managing medicines in care homes.

Recruitment practices were not robust. The home was short staffed so staff from the provider's other homes locally were helping out. We were able to account for all of these staff except one person who had worked two shifts in October 2015. Therefore we were unable to confirm how the person had been recruited and whether they were suitable to work with vulnerable. You can see what action we told the provider to take at the back of the full version of this report.

A whistle blowing policy was in place and staff said they knew what whistle blowing was and would not

hesitate to report any concerns.

Staff were receiving regular supervision and an annual appraisal. Training the provider required staff to complete was not up-to-date. For example, only 38% of staff had completed training in dementia care. Few staff had received food hygiene training. You can see what action we told the provider to take at the back of the full version of this report.

Arrangements to monitor the safety of the environment and equipment were not rigorous. For example, hoists and hoist slings were not being thoroughly examined in accordance with Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). New window restrictors had been fitted following a serious incident but these were not in accordance with national guidance on window restrictors in care homes. The environment had not been designed, adapted or decorated to support the independence and orientation of people living with dementia. You can see what action we told the provider to take at the back of the full version of this report.

Appropriate referrals had been made to the Local Authority to deprive people of their liberty. Staff had received awareness training in relation to the Mental Capacity Act (2005). The way in which mental capacity assessments had been developed was not in keeping with the principles of the Mental Capacity Act (2005). The completed mental capacity assessments we looked at were generic in nature and did not identify the decision the person was being assessed as needing to make. You can see what action we told the provider to take at the back of the full version of this report.

People and families we spoke with were satisfied with meals. People said they had access to drinks and snacks throughout the day.

People had access to health care when they needed it, including their GP, dentist, optician and community mental health service. A visiting healthcare professional told us the registered manager and staff were approachable and responsive.

Risk assessments and care plans were not being revised as people's needs changed. For example, a person had a care plan in place indicating they were at risk to falls even though the person was no longer mobile. You can see what action we told the provider to take at the back of the full version of this report.

People's privacy was not always maintained. Some people liked to walk about and to go in and out of other people's bedrooms. This was an on-going issue and we found a person asleep on another person's bedroom during the inspection. You can see what action we told the provider to take at the back of the full version of this report.

Staff were caring and kind in the way they supported people. They treated people with compassion and respect. They understood people's preferences and ensured people's privacy when supporting them with personal care activities. People's preferences and preferred routines were recorded and displayed in their bedrooms.

Recreational activities were externally facilitated for one hour four days per week. Very little recreational activity happened between these sessions. Occasional trips out were arranged and a trip to a pantomime was taking place on one of the days of the inspection.

A complaints procedure was in place and displayed in each person's bedroom. People we spoke with and families were aware of how to raise concerns.

The approach to checking and auditing the service was not robust. Medication audits were established but they had not picked up on some of the issues we identified. Care record audits had not taken place for some time, which meant some of the concerns we identified with the care records had not been recognised by the registered manager. You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this location is 'Inadequate'. This means that it has been 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. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

You can see what action we told the provider to take at the back of the full version 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?

Inadequate

The service was not safe.

Although medication was administered safely, prescribed creams were not stored securely. Medicine hidden in people's food or drink was not done in accordance with the Mental Capacity Act 2005.

Staffing levels were inadequate to ensure the safety of the people living at the home.

Staff had received training and were aware of what constituted an adult safeguarding concern. We found five incident reports that should have been reported to the Local Authority as safeguarding alerts but had not.

The arrangements for recruiting staff were not effective as a member of staff had worked at the home and we were unable to establish how they had been recruited.

Some of the window restrictors were not in accordance with national guidance. Hoists and hoist sling had not been serviced in accordance with the regulations on lifting equipment.

Is the service effective?

Inadequate

The service was not effective.

Supervision and appraisal was taking place for staff.

Not all staff were sufficiently trained for their role. For example, less than half the staff team had received training in dementia care.

People were satisfied with the food and said they had access to snacks and drinks throughout the day.

The principles of the Mental Capacity Act (2005) were not being adhered to. Mental capacity assessments were generic and not decision specific. This was not in keeping with the principles of the Act.

The environment had not been adapted, designed or decorated in accordance with national guidance regarding dementia friendly environments.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were caring, respectful and kind in the way they supported people. Staff understood people's preferences and preferred routines.

The registered manager engaged with people each month to seek their views of the care and support.

People's personal histories and background were recorded in their care files. Preferences and preferred routines were located in bedrooms.

Families said the registered manager was approachable, communicated well about any changes and took the time to listen them.

Measures had not been put in place to address the on-going issue of people going into other people's bedrooms and compromising their privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were not regularly reviewed and did not always reflect their current and individual needs.

We observed that staff responded to care requests in a timely way.

A limited range of recreational activities was available for people living at the home to participate in.

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

Is the service well-led?

Inadequate

The service was not well led.

Audits and checks were not robust. Care record audits had not taken place for some time so the issues we identified had not

been picked up on. The medicines audits were not effective as they had not identified concerns we found.

A feedback process was in place but suggested service improvements made by families had not been acted upon.

The provider did not notify CQC within five working days of the unplanned absence of the registered manager that happened shortly after our inspection.

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.

We also looked at how a serious incident resulting in an injury to a person living at the home had been managed in order to minimise such an event happening again. The incident was reported by the provider in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). From 1 April 2015 the Care Quality Commission (CQC) became the lead enforcement body for health and safety incidents in a health and social care setting where members of the public, including people who live in care homes are injured or die.

This unannounced inspection took place on 9, 10 & 14 December 2015.

The inspection team consisted of an adult social care inspector, a specialist advisor in health and safety, and an expert by experience with expertise in services for older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home. This usually includes a Provider Information Return (PIR) but CQC had not requested the provider (owner) submit a PIR. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the 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.

During the inspection we spent time with four people who were living at the home and three family members who were visiting their relatives at the time of our inspection. We also spoke with a visiting healthcare professional, the registered manager, the deputy manager and three care staff. In addition, we spoke with the maintenance person and the chef.

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 five 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.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at the home. They also said they felt safe in the way staff supported them. A person said to us that they "would tell the boss" if anyone was unkind or treated them unfairly. A family member said if they had any concerns they would "contact CQC."

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential abuse was reported in a timely way. They confirmed they had received adult safeguarding training. Training records confirmed that all but recently appointed staff were up-to-date with adult safeguarding training. An adult safeguarding policy was in place. Information was displayed in the registered manager's office about the process to take to report a safeguarding concern.

We found five incident reports; two from October 2015 and three from December 2015 that all involved a physical altercation between people living at the home. These had not been reported as safeguarding alerts to the Local Authority so meant processes were not being followed to make sure people were protected from abuse.

This was a breach of Regulation 13(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked families for their views on the staffing levels at the home. One family member told us there was sufficient staff and said, "You see staff watching them [people living at the home]." Another family member told us, "Usually there are. Sometimes they are a bit short at the weekends when there are not so many [staff] visible." I don't think anyone's put in danger but the evening meal might be a bit late." We noted from one of the feedback questionnaires that a family said staff were "stretched, particularly at the weekends."

The staff we spoke with said the staffing levels were not always sufficient to monitor people at all times to ensure their safety. A staff member said that staffing levels had gone down as the year went on. They said the registered manager and deputy had to become part of the numbers and work as carers because of the shortage of staff.

The registered manager and staff described the usual staffing levels as five care staff, including the deputy manager or senior carer from 8.00 am to 8.00 pm. A member of staff working from 4.00pm to 10.00pm but staff told us they worked in the kitchen until 7.00pm. Two care staff worked on the night shift. A chef, kitchen assistant and housekeeper were also on duty each day. Staff said recently there had been four staff on the day shift and sometimes just three staff. A member of staff told us that care staff were required to carry out laundry duties in the morning. They said this was stressful when caring and supporting people as the laundry facilities were located in the basement.

We looked in detail at the duty rotas for October through to the first week in December 2015 and they showed a clear variation in staffing levels. There were some occasions when five staff were on duty but mostly it was four staff during the day. The registered manager was frequently included in the numbers. We

noted at least 21 occasions when just three staff were on duty. This was often at the weekends. A member of staff told us there had been a small number of occasions when just two staff were on duty from 2.00 pm to 4.00 pm. There were numerous gaps in the duty rotas for the 4.00pm to 10.00 pm shift.

We asked the registered manager how staffing were levels were determined and reviewed. There was no evidence that a systematic approach, such as a dependency assessment of need, was used to decide on staffing levels. We were informed that if staff could not be sourced internally or via the provider's other care homes locally then the home had to operate with less staff as the provider did not permit the use of agency.

In order to understand the dependency of people living there, a member of staff described how people were accommodated over three floors. They said two people needed to be moved using a hoist and with the support of two staff. Three people displayed behaviour that challenges to others living at the home. Four people living at the home liked to walk about the premises much of the time and went in and out of other people's bedrooms. Staff said it was difficult with the staffing levels to monitor the people the people that liked to move about.

We observed that a member of staff was in the lounge the majority of the time with the lounge left unattended only for very short periods. We did see people walking about continually. While looking around the home we found a person asleep on another person's bed. The person had not been missed by staff and meant staff did not know where the person was. Overall, we determined that staffing levels were not adequate given the dependency needs of the people living there.

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the personnel records for two members of staff recruited in the last year. We could see that all required 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. Interview notes were retained on the personnel records. We spoke with a member of staff recruited within the last 12 months. They described an effective recruitment process and told us all the relevant checks had been conducted and references obtained before they started working at the home.

We noted a number of staff on the duty rotas who were not listed on the training or supervision matrix. The registered manager explained that these were staff recruited to work at the provider's other local homes and who were providing cover at Acacia Court. There was a named member of staff who covered two shifts in November 2015 that the registered manager was unable to account for. The registered manager confirmed they had not been involved in the recruitment of the staff member and had not placed them on the duty rota so was unable to provide assurance that the member of staff was appropriately recruited, skilled and trained to work with vulnerable adults.

This was a breach of Regulation 19(1)(a)(b)(2)(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people and families their views of the home environment and its upkeep. Everyone said the home was kept clean. A person living there said, "I think it's very well looked after. Considering the number of people they have here they do well." A family member told us, "I think it is cleaned well. Some of the rooms could do with a jolly good paint." Another family member advised us that, "There was an issue with the toilet in Mum's room and that was addressed quickly."

We had a look around the home. We found some areas of the home were cold and some of the people living there told us they were cold. For example, three people told us they were cold while they sat waiting for their lunch. We informed staff and they provided a jumper for one person and blankets for the other people. One of the care staff checked the radiator and found it had been turned off.

Basic fire checks were in place. Although fire drills were recorded, there was no evidence of timed simulated evacuation having taken place, including the equipment required to assist and/or any lessons learned from the simulations. We were unable to establish who the qualified fire wardens were and whether a fire warden was on duty for each shift. Evacuation plans had been developed for each person but these were not readily accessible in the event of an emergency requiring an evacuation. Given the low staffing levels at times, there was a risk that adequate support would not be available to evacuate people in a timely way.

We looked at how equipment was checked to ensure it was safe to use. We were not provided with evidence to demonstrate that mattresses and pressure relieving cushions were periodically checked for damage in line with national guidance. Although electrical profiling beds were supplied and maintained by an external health source, there was no evidence to show that they were subject to regular checks within the home so that wear and tear was identified in a timely way.

We found that the lifting equipment and accessories used at the home were not thoroughly examined at intervals of six months or less in accordance with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). For example, the stair lifts and passenger lift had been thoroughly examined on 18 May 2015 with a due date of 18 May 2016. As a further example, two hoists and two hoist slings had been thoroughly examined on 26 May 2015 so the next examination became due or before 26 November 2015. We were not provided with evidence to show this recent thorough examination had taken place. We noted that documentation was not available to show that another hoist and sling had been thoroughly examined between 11 February 2013 and 26 May 2015. LOLER regulations require information relating to lifting equipment is made available for inspection. In addition, we were not provided with evidence to show that internal routine checks of slings and hoists took place to monitor for wear, tear and defects.

A recent incident reported as a RIDDOR event involved a person living at the home overriding a window restrictor. These are devices fitted to windows to prevent the windows from opening too far thus minimising the risk of a person falling out of the window. Since the incident, restrictors to some of the windows had been replaced but not all were not in accordance with national guidance. The 'X' shaped screws used to attach them meant they could be overridden with a screwdriver or other non-specific tool, such as an item of cutlery. This meant the risk to people who liked to walk about and go into other people's bedrooms had not been effectively reduced.

The home had a risk assessment in place regarding window restrictors but it made no reference to the make or model of the restrictor. It was identified that the restrictors were checked weekly but the last check was recorded as taking place on 29 September 2015. This meant the restrictors had not been checked since the incident. In addition, the checking system did not identify what was to be checked and/or how the restrictors should be checked.

This was a breach of Regulation 12(1)(2)(d)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The laundry room in the basement was accessed via a steep wood staircase. There were no hazard markings to the edges of the stairs. This meant staff using the laundry and others were at risk to slips, trips and falls. There was an exposed gas pipe at head height at the bottom of the stairs with no hazard tape advising of an

oncoming hazard. The door to the drying room was at head height with no hazard warning tape. The laundry area had very low ceilings. We observed staff and external contractors, who were visiting the home during the inspection, had to bend their necks when walking through the laundry. There was no lone working risk assessment for staff working in the laundry environment. While the laundry area does not specifically impact on the care of people living at the home, it is a health and safety concern to employees under Management of Health and Safety at Work Regulations 1999.

This was a breach of Regulation 15(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked to see the medicines management policy. This was not up-to-date as it did not reflect NICE guidance for managing medicines in care homes. NICE (National Institute for Health and Care Excellence) provides national guidance and advice to improve health and social care. A list of staff authorised to administer medicines and their signatures was in place.

The deputy manager provided us with an overview of how medicines were managed within the home. The medicines trolley did not fit in the medicines room so the locked trolley secured to the wall in a corridor on the ground floor. Summary information for each person was held alongside each medication administration records (MAR). This included a picture of the person, any known allergies, a body chart for topical creams and a PRN (medicine given when needed) plan.

A nationally recognised medication reference book (referred to as the British National Formula or BNF) was in place for staff but it was produced in 1999. The BNF is refreshed every six months so this meant staff could potentially reference information about a medicine that was inaccurate.

We looked at some MAR sheets and these were correctly completed. A small number of MAR sheets were handwritten and these had been appropriately signed by two members of staff. Any refusals of medicines or errors in recording were explained. Arrangements were in place for the booking in and disposal of medicines.

Some people were prescribed controlled drugs. These are prescription medicines that have controls in place under the Misuse of Drugs legislation. They were stored correctly in line with the legislation and appropriately signed for once administered to the person.

Two people were receiving their medicines covertly. This means that medication is disguised in food or drink so the person is not aware they are receiving it. A mental capacity assessment had not been completed in relation to giving medicines to the people covertly. We were unable to locate the covert administration agreement from the GP in either the care records or the MAR file. The registered manager later located one of the written agreements. There was no evidence that pharmacy had provided advice on hiding medicine in food and drink. This is important as some medicines do not work as well if, for example, they are crushed or if placed in hot drinks. A plan was in place for each person to guide staff in how to administer the medication covertly.

Medicines requiring cold storage were kept in a dedicated medication fridge in a dedicated medication room. The fridge temperatures were monitored and recorded daily. We noted that three recorded temperatures in November and December were outside of the required temperatures for storage. These out-of-range temperatures had not been reported so that the fridge could be checked to ensure it was working correctly.

Although we were advised that topical creams were stored safely, we found a tub of cream that was visible and accessible in a person's bedroom. This meant the people who liked to walk about and go into other people's bedrooms were at risk of misusing the creams that were not stored safely.

A representative from Sefton Social Services reviewed the medicine records for a person as part of a safeguarding investigation two days after our inspection. They found that the person had been prescribed two types of medicines, including antibiotics, on the 1 December 2015. The medicine had not arrived and was followed up by the home until the 9 December 2015. It had still not arrived by the 10 December 2015. The person's health continued to deteriorate and not receiving their medicine when they needed it could have contributed to their deteriorating health.

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

We looked at the care records for five people to see what arrangements were in place so that known risks for each person were managed in a safe way. We found deficiencies in the risk assessments and care plans. Some care plans had not been updated to review current needs. For example, the registered manager confirmed that a person identified at risk to falls was no longer mobile but the care plan had not been revised to reflect this changing risk. Some of the care records we looked at identified that the people displayed behaviour that challenges yet care plans were either not in place or inadequately developed to guide staff in how to respond to such behaviour.

A care plan for diabetes lacked sufficient detail to inform staff about how to respond if a person had either low or high blood sugar. Staff confirmed the person often presented with unpredictable and unstable blood sugar levels and were clearly able to tell us in detail how they would respond. Given that the duty rotas showed staff from the provider's other care homes were working at the home, it was important that the care plan clearly reflected what staff should do in the event of a diabetic emergency.

As another example, we looked at the care records for a person who needed a hoist to move. The person was identified as being at risk to falls. There was no lifting and handling assessment or falls risk assessment in the care records. The care plan did not record the type of hoist or sling to be used. The person also had bedrails to prevent falls from bed. We did not see a bedrail risk assessment in the care records. This is important as bedrails can present an entrapment risk therefore ensuring risk assessments and care plans are up-to-date and regularly reviewed is important.

People were not being weighed on a regular basis. Alternative arrangements, such as arm measurements had not been considered for people who refused or could not be weighed on scales.

We looked at the care records for the person who exited the building via a window as we wished to check the measures that had been put in place to minimise the occurrence of a similar incident. Prior to incident it was clear from information held in the care records that the person experienced agitation specifically from early afternoon, and "wandered a lot going into other people's bedrooms". The staff duty rotas showed that staffing levels were lower before the incident than the optimum staffing levels described by staff. On the evening the incident took place there were three staff on duty. Staffing levels did not improve after the incident even though records showed that the person continued to be "wander some" and was "going into other residents bedrooms". For example, the weekend after the incident there were three staff on duty in the afternoon; the key time identified for the person to display agitation and walk about a lot. This showed that sufficient measures had not been put in place to ensure that the person was supervised at all times so their safety was maintained.

This was a breach of Regulation 12(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People living at the home and the families we spoke with said there was timely access to health care services. The registered manager said they had a very good rapport with the community nursing team and this was confirmed by the visiting health care professional we spoke with.

From our conversations with staff it was clear they had a good knowledge of each person's health care needs. We could see that people had regular and timely input from professionals when they needed it, including the GP, dentist, optician and chiropodist. A record template was in place to record all consultations with health or social care professionals. Some people received specialist health care input when necessary. This included input from the local community mental health team and the diabetic nurse.

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). 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.

Based on feedback from the outcome of a recent CQC inspection of one of the provider's other homes, the service had revised the way it structured mental capacity assessments. The feedback had not been appropriately interpreted and/or applied. The revised form failed to include both elements of the two-stage test of capacity. A further question had been added to the functional testing of capacity. It asked if the person could manage their own medication effectively and safely. This meant every capacity assessment conducted asked about medication regardless of whether the decision the person being assessed to make was about medication. Furthermore, all the capacity assessments we looked at were generic in nature and did not identify the decision the person was being assessed as needing to make. This was not 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".

The training matrix (overview record) informed us that the registered manager and deputy manager had completed training in DoLS in 2011. The registered manager advised us this was on-line training lasting approximately 40 minutes and they completed the same training as the care staff. Of the 16 care staff (including three senior carers) identified on the training matrix (record), 10 had completed training in DoLS and/or the MCA.

We looked at the care records of a person who used bedrails. There was no mental capacity assessment or

evidence of a best interest discussion in place to show how the person was supported with making a decision about the use of bedrails. One of the families we spoke with said their relative had bedrails and said that the use of bedrails and associated risks had been discussed with them.

This was a breach of Regulation 11(1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with two members of staff who started working at the home within the last 12 months. One member of staff said they did not have an induction but the other member of staff described a detailed induction that involved two days shadowing a more senior member of staff. They said they were also put forward for the required training when they started.

Staff told us they were up-to-date with their supervision and appraisal. The supervision matrix confirmed this. We reviewed the status of the staff training. Of the 16 care staff, six were identified on the training matrix as having completed training in dementia care. Given that the home supports people living with dementia including people with complex needs, the 38% of staff trained in dementia was low. In addition, only two staff were trained in food hygiene. The member of staff who regularly worked the 4.00 pm to 10.00 pm shift and prepared the evening meal was not identified as having received food hygiene training.

This was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using a nationally recognised dementia-friendly home assessment tool, we determined that the service did not provide a dementia-friendly environment. Colour had not been used to support people with finding their way about. The walls, doors and hand rails were in mute colours, which meant hand rails were not obvious if a person felt unsteady and tried to locate them. Bedroom and bathroom doors were not easy to distinguish from the walls. Colour had not been used in toilets, such a different coloured toilet seats to assist people in finding the toilet.

Names on bedroom doors were not in bold print and bedroom doors did not include a distinguishing sign, such as a picture of the occupant. Using pictures on bedroom doors can assist in helping people to locate their rooms and reduce the occasions whereby people go into other people's rooms. Signage is particularly important to promote the independence of people with dementia. Some corridors were narrow, particularly the corridor from the foyer to the lounge and there was no directional signage. Not all toilets included a sign or an appropriate sign to identify what the function of the room was. On the second day of the inspection the registered manager placed a large pictorial sign on the toilet adjacent to the lounge. On the third day of the inspection staff said one of the people living there had for the first time used this toilet on their own.

Staff told us that one of the toilets had been out of use for three weeks. Many of the people living there were used to using this toilet. There was no sign to indicate it was out of order. Staff told us a person constantly tried to access it and when they could not gain access they went to toilet on the carpet outside the toilet door. This had led to a noticeable pungent smell in the area. Directional signage could have prevented people from heading towards this out-of-order toilet. We observed the person trying to access the toilet. When we pointed out it was not working, the person then started to climb the stairs nearby looking for a toilet. No care staff were present so had we not been in the vicinity at the time there could have been an accident involving the stairs.

The lounge was arranged in a way that provided small group areas but the main arrangements of the chairs meant that some people were watching the television at an angle. There were no points of interest, such as

photographs or artworks of a size that could be easily seen. Memory boxes or similar were not in place. People did not have independent access to the garden. We noted that access to the garden had been raised on a number of occasions by families providing feedback on the service.

This was a breach of Regulation 15(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living at the home told us the meals were good and they got plenty to eat and drink throughout the day. A person said, "It's [food] alright. They [staff] ask me in the morning what I want for lunch. I get enough [to eat]". Another person told us, "It's [food] not bad, I get plenty". People told us they got plenty to drink, including water. A person said, "Sometimes I feel a bit peckish but I have a biscuit." The chef confirmed that if someone was hungry between meals then snacks were available. They said people sometimes asked for a sandwich between meals.

Families too were pleased with the meals. A family member said, "He loves his food, he gets enough to eat." Another family member told us, "She eats like a horse. It has to be liquidised but she has second helpings".

We spoke with the chef who had only recently started working at the home. He advised us that fresh meat was delivered weekly, the fish used was a mixture of fresh and frozen and fresh vegetables were served every day. Fresh fruit was not routinely available for people to snack on unless the chef made a fresh fruit salad. The chef provided a meat and vegetarian option for lunch every day, along with a pudding.

The chef advised us that people living at the home had not been involved in planning the menus, but said they were thinking of introducing pictorial menus. At the time of the inspection pureed diets were all mixed together. The chef highlighted that they were thinking of serving pureed foods so each item was separated out on the plate. The chef said, "I want those residents who are having pureed food to feel like they are having a proper meal".

Breakfast was usually cereal, porridge and toast but the chef was happy to provide people with whatever they wished to eat. People had the option of a hot meal at teatime, such as jacket potatoes and baked beans and there was always an option of soup and sandwiches. Sandwich fillings included a meat, fish and vegetarian option. The chef knew people's food preferences, special dietary needs and any allergies through speaking with people and staff.

We observed at lunch time that people were asked where they wished to sit. Support was provided for people who needed assistance with their meal. Staff provided encouragement to people if they appeared not to eating their meal.

Requires Improvement

Is the service caring?

Our findings

People living at the home told us they liked living at Acacia court and were happy with the way staff supported them. A person said to us it was because of the, "Atmosphere and the homeliness." Another person told us, "They [staff] are the nicest people here."

Equally families were satisfied with the care. A family member told us, "They [people living there] all seem content and happy; there's a lot of chatting." Another family member said, "I think they [staff] show real care. It's not the poshest place you will go in but the care is second to none." Families said visiting times were not restricted and that they could visit whenever they wished. The visiting healthcare professional said, "It's very laid back, very relaxed. They always take me to the resident and provide privacy."

Whilst we observed staff ensuring people's privacy was maintained when providing support with personal care, they could not guarantee that people's rooms remained private. This was because some people who liked to walk about much of the time went in and out of other people's bedrooms. We observed this happen during the inspection and on one occasion found a person asleep on another person's bed. We noted that this has been raised by a family on one of the feedback questionnaires.

This was a breach of Regulation 10(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager advised us that the people living there had family to represent them. A person with no such representation had an advocate in place.

We observed staff calling people by their preferred name and supporting people in a caring, respectful and dignified way. Staff spoke with people in a manner, level and pace that enabled conversation to take place. Despite being busy, staff were able to anticipate people's needs. They spoke in an encouraging way with people who needed support with their lunch time meal. We heard staff explaining to people what was happening prior to providing care or support.

Throughout the inspection we observed staff supporting people in an easy going and unhurried way. The staff we spoke with demonstrated a warm and genuine regard for the people living there. We observed a positive and on-going interaction between people and staff. We heard staff explaining things clearly to people in a way they understood. Personal care activities were carried out in private.

There was detailed evidence in the care records that the registered manager and senior manager communicated well and in a timely way with families as people's needs changed. Families we spoke with confirmed that the registered manager gave them time to talk through worries they had about their relatives who lived at the home. We observed the registered manager spending time with families who called to the home during the inspection. The majority of the care plans we looked at were signed by the person and/or a family member to say their care plan had been discussed with them.

We could see from the care records we looked at that the registered manager met with each of the people living at the home on a monthly basis and asked them for feedback on the care; whether they with happy with the care and satisfied with how staff supported them.

Requires Improvement

Is the service responsive?

Our findings

People we asked told us staff supported them and provided care at a time when they needed it. A person said, "Yes, anything I want [staff arrange]." Another person said, "I'm happy in my room, they [staff] don't bother me. If I want something I ring the bell."

People were unsure whether they could choose the staff gender when being supported with personal care. One of the ladies said, "You can't choose but it's always a female." We asked the same of families and they had no recall about being asked about the preferred gender of staff to support their relative with personal care.

The care records informed us that people's needs were thoroughly assessed before they were offered a place at the home. This meant the staff had a good understanding of how to support the person and could plan to ensure the person's needs were met once they moved to the home. People's care records contained information about the person that included information about people's background, including relationships, working career and interests. Some of these included good detail but had not been completed for people recently admitted to the home.
Care plans were in place for people but many had not been reviewed in a timely way or had not been revised as people's needs changed.

Individual preferences and preferred routines were displayed on a notice board in each person's bedroom. They were not in the care records and we queried with the registered manager how newly appointed staff had access to these preferred routines without going into each bedroom to read them. We also queried how they were reviewed and revised when located in bedrooms.

We asked people living at the home how they spent their day. A person said, "I just sit down. I can't do woodwork anymore." Another person said, "I just do whatever is happening on the day." Some people said they liked to read and/or watch television. A person said, "I like my telly. I would not be without SKY."

Families told us that regular activities took place that included, chair exercises, singing, hairdressing and painting. A family member said the staff held special events for birthdays and other significant dates. Staff said that an external entertainer/facilitator came to the home for one hour on a Tuesday, Wednesday, Thursday and Friday. An activities coordinator was not employed so aside from the one hour four days a week there was limited activity. Staff said they did not have the time to facilitate regular activities.

Throughout the inspection we observed that the majority of people spent their time in the lounge with a small number of people walking about the ground floor area. Mostly there was a member of staff in the lounge. Throughout the inspection we noted that there was minimal interaction between the member(s) of staff monitoring the lounge and the people sitting in the lounge.

A trip to watch a pantomime had been organised on the first day of our inspection. People told us they were looking forward to it. However, the wrong coach had been ordered; it was too big to come into the grounds

of the home. This meant a person could not go as he could not walk as far as the pavement. He was very disappointed as he had been looking forward to going.

A complaints procedure was in place. A complaints leaflet was available in each of the bedrooms. The registered manager confirmed that no complaints had been received in the last 12 months. 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."

People living at the home and families told us they had been asked about completing a feedback survey. A person said, "Somebody came in a while back and asked me. I'm quite happy." A family member advised us that they had completed a questionnaire about a year ago.

Inadequate

Is the service well-led?

Our findings

A registered manager was in post at the time of the inspection. They had been registered to manage the service since 2010.

We asked people living at the home their views about how the home was managed. People told us the manager was nice and one person gave us the thumbs up rather than verbalise their opinion. A person said, "She [registered manager] is great and runs the home well; the staff are great."

Families too expressed their satisfaction with how the home was run. A family member said, "Its well run, they [staff] are all on their toes." Another family member said, "It's good. The manager is very good. Families said they felt listened to." One family member responded with, "Yes, They are very open here."

We also asked the visiting professional their views about how the home was managed. They said, "Everyone's very polite and very approachable."

Staff told us that the home was managed well. A recently recruited member of staff said, "The manager is very approachable." Another member of staff said, "The manager and deputy are great. You can ask them anything. If they don't know the answer they will come back to you." Staff told there was an open and transparent culture in the home. They were aware of the whistle blowing process and said they would use it to report any concerns or poor practice.

We asked staff how changes and developments to the service were communicated to them. They described a good handover between staff shifts and also told us that regular staff meetings were held at the home. We were provided with minutes that showed staff meetings had been held in January, June and August 2015. The registered manager had also started a 'Staff Monthly Coffee Moment'. This was an alternative and inclusive approach to seeking staff feedback. We noted that some suggestions put forward included, spending more time with people living at the home, better security and more activities for people. The registered manager said they had not held one of these sessions for a while because they had been working within staff numbers.

Meetings were held to seek feedback on the service from people living at the home. We had a look at some of the minutes and noted the meetings comprised a series of mostly closed-ended questions, such as "Do you like your room?" and "Are you getting enough to drink?" We highlighted to the registered manager that using mostly closed-ended questions to seek feedback from people living with dementia was limiting in terms of the quality of the responses as the majority of the responses recorded were either "yes" or "no".

A questionnaire process was in place to seek feedback from families about the service and how it could be improved upon. There was some very good feedback, particularly in relation to the registered manager and staff. One of the comments was, "The staff are very friendly and helpful. They seem very caring." Another comment included, "The best thing is that the manager is always approachable….and never too busy to talk about any aspect of care."

Some of the suggested improvements made by families were issues of concern we identified at the inspection, such as low staffing levels, access to the garden, books and magazines in shared areas and people sleeping on other people's beds. A family member also suggested that a relative's group would be useful. The registered manager confirmed that a group had not been set up. An action plan had not been developed to show that the feedback had been taken into account with making improvements to the service. The registered manager advised us that professionals who visit the service had also completed feedback questionnaires. However, these could not be located during the inspection.

We asked about the audit and checks that took place to monitor performance and to drive continuous improvement. Medication audits were carried out weekly and monthly. However, they had not identified the issues that we picked up during the inspection. We asked about care record audits because we had identified there were gaps in assessment and care plan reviews. In addition, we found some care plans had not been revised as people's needs changed and people had not been weighed in accordance with the service guidance. The registered manager told us they had not undertaken any care record audits for some time because they had been mostly working within staff numbers for the last four months. We asked to see any audits related to care that the provider had undertaken and were not provided with any evidence that such audits had taken place.

We reviewed the duty rotas from October to the first week in December 2015. They showed that the registered manager had 6 days (mostly half days) supernumerary time over a nine week period. This meant the registered manager had less than one day supernummary time per week to effectively carry out their role, including their legal responsibilities as registered manager.

From our review of the duty rotas we observed that the registered manager had completed two night shifts straight from day shifts. The registered manager had been working within the care staff numbers on both day shifts. Similarly, the duty rotas showed that the deputy manager had also done a night shift straight from a day shift. They undertook these shifts as they had been unable to find staff to cover the shifts. Neither had signed to opt-out of the 48-hour week and both confirmed they had not had the required rest breaks when completing these 24-hour shifts. We also noticed on the aggregated working hours for week commencing 7 December 2015 that a member of staff had worked 66 hours. This evidence suggests a potential breach of the Working Time Regulations 1998.

Furthermore, working excessive hours without adequate rest breaks means there is a risk of work related stress occurring, which can have a serious impact on the health of the staff working excessive hours. This in turn can impact on people living at the home. For example, tiredness can result in errors of judgement and mistakes happening. It was stated in the provider's 'Health and Safety Handbook' – "Individuals who are tired due to excessive hours are more likely to suffer from mental health problems, general ill health and to make mistakes leading to accidents." Allowing staff to work excessive hours showed that the provider was not following its own practice guidance or the Management of Health and Safety at Work Regulations 1999. We reported this to the appropriate regulatory body following the inspection.

We understand that the provider met with Sefton Social Services on 11 November 2015 in relation to a safeguarding matter. The provider was advised of the importance of involving the registered manager when recruiting staff. Despite this, a member of staff unknown to the registered manager worked two night shifts a week after the meeting. This showed the advice from Social Services had not been followed.

When we asked to look in the chemical storage room, the registered manager advised us they did not have access to it but only ancillary staff had access to the room. We also found that the registered manager did not have the key code to the side gate and did not have a key to the front door of the home. Given that the

registered manager has legal responsibilities for ensuring the regulated activity is carried out in accordance with the regulations, we would expect that they should have access to all areas of the building in order to comply with their statutory duties.

A bedroom was located off the office. We observed the family and/or friend of the person who occupied the bedroom walking through the office. Staff also told us this had happened when meetings were taking place in the office. We observed confidential and sensitive information located in the office. For example, the incident forms were hanging on the wall in a clear plastic file. Care records awaiting transfer to storage were located on top of a filing cabinet. A risk assessment had not been conducted as to how visitors accessing the office would be managed.

This was a breach of Regulation 17(1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A file of policies and procedures were in place. These were located in the registered manager's office for staff to access. There was a signature sheet in place for staff to indicate that they had read the policies. It was unclear when some of the policies had been produced and/or revised as they were undated or did not include a date when they had been revised. Some policies were not up-to-date. For example, there was a policy on CRB (Criminal Records Bureau) that no longer exists. The complaints policy was not accurate as it suggested CQC deals with individual complaints which is not the case.

The provider did not notify CQC within the required time frame of the unplanned absence of the registered manager that happened shortly after our inspection.

This was a breach of Regulation 14(3) of the Health and Social Care Act 2008 (Registration) Regulations 2014.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The privacy of people living at the home was not maintained as other people living at the home were accessing other people's bedrooms. Regulation 10(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not being sought from people in accordance with the Mental Capacity Act (2005). Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from risks associated with the environment or equipment because appropriate checks and/or servicing had not taken place. Individual risk assessments and care plans had not been reviewed and/or revised to ensure they reflected people's current needs. Medicines were not always managed in a safe way. Regulation 12(1)(2)(a)(b)(d)(e)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and

	improper treatment People living at the home were not protected from abuse because all incidents of abuse between people living at the home were not being reported as a safeguarding matter through the correct local processes. Regulation 13(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises had not been adapted to take account of the needs of people living with dementia. The premises had not been adapted to take account of the needs of people living with dementia. The basement area used by staff and maintenance people visiting the home was not safe and not suitable for the purpose for which it was being used. Regulation 15(1)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The service was unable to confirm that all staff who worked at the home had been effectively recruited. Regulation 19(1)(b)

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 17 HSCA RA Regulations 2014 Good governance Robust systems were not in place to monitor and improve the quality of the service. Systems were not effective to identify and assess the risks to the health, safety and welfare of people living at the home. Records in relation to the care of people were not held securely. Regulation 17(1)(2)(b)(c)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were inadequate numbers of suitably qualified staff were on duty at all times to ensure people's safety was continually maintained. Regulation 18(1)

The enforcement action we took:

Warning notice