London Residential Healthcare Limited

Acacia Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Acacia Care Centre is a purpose built care home arranged over four floors. The service provides support to people with nursing needs including adults with complex health needs, and people living with dementia. The upper floor specialised in supporting people with dementia nursing needs. People had their own bedrooms with en-suite and shared bathroom facilities available. There were shared living and dining spaces on each floor. There was a bar area that people and relatives could book for special events.

People's experience of using this service
People did not always feel safe. Risks to people had not always been appropriately identified and measures in place to keep people safe were not always clear. The systems in place for the management of medicines did not ensure medicines were managed in a safe way.

People were not supported to have maximum choice and control of their lives and did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People and relatives were not consistently involved in planning and reviewing their care. Care plans lacked personalised details.

The governance arrangement had not identified or addressed issues with the quality and safety of the service.

Staff knew how to identify allegations of abuse, and knew what actions to take to ensure people were safe. The service cooperated with the local authority when allegations of abuse were made.

The provider had introduced a dependency assessment and staffing levels were based on people's needs. People and their relatives told us they sometimes had to wait, or felt rushed by staff. People told us, and we saw, their independence was not always promoted.

Staff had been recruited in a way that ensured they were suitable. Staff received the training and support they needed to perform their roles.

People and relatives told us the food had improved significantly in recent times. People and relatives had been invited to tasting evenings to test new menus.

People gave us mixed feedback about the activities provision within the home. While some people felt there had been improvements and there was a good range of activities, other people told us they were not supported with activities.

Although staff told us they supported people to practice their faith, and faith representatives visited the home, people told us this was not their experience.

People and relatives knew how to make complaints. The provider responded to complaints in line with their policy.

The provider was working with various external organisations to develop their practice and contribute to research. Projects included developing Lesbian, Gay, Bisexual and Transgender champions within the home, supporting care staff to achieve nursing qualifications and working with a university research project about staff retention.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection:
The last rating for this service was requires improvement (published December 2018).

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to safe care and treatment, good governance, person centred care and consent at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Acacia Care Centre

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by one inspector, two assistant inspectors, a directorate support coordinator and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we already held about the service. This included information submitted as notifications. Notifications are information about events that providers are required by law to inform us about. We considered feedback we had received from people and other agencies involved in working with the service. We reviewed the action plan the provider had submitted after their last inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with six people who lived in the home and nine relatives. We spoke with 17 staff including the registered manager, the head of quality and compliance, the regional manager, the head of care, the head of housekeeping, a domestic assistant, three nurses and five health care assistants. We reviewed the care records for six people who lived in the home and medicines information for 16 people. We reviewed recruitment information for five staff and the supervision records for ten staff. We reviewed training information, meeting records, audit records and other information relevant to the management of the service.

After the inspection
We received further information and documents by email from the provider which we considered when making our judgements and ratings.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to ensure there were enough staff to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider was now meeting this regulation but further work was needed to ensure this was sustained.

Staffing and recruitment

- The provider had introduced a dependency assessment to calculate the staffing levels required to meet people's needs.
- The provider scheduled enough staff to work and staff worked flexibly across the home to ensure staffing levels were maintained.
- Staff told us the staffing levels were sufficient, but staff did not always work together as a team. One staff member explained, "Yes [there are enough staff], but it depends who you are working with. If it is a bad team then it won't work. There are enough carers but just need to work more on the team dynamic."
- Relatives told us they could not always find staff to help their family members. Several family members told us they had difficulties finding nursing staff when they needed them. One relative said, "Sometimes we really have to hunt them down as we can't find anyone."
- People told us they felt staff were rushing and there were not enough staff available. This had a negative impact on their experience and the atmosphere in the home. One person said, "I would like a bath, but I just have a shower as it's quicker for staff." Another person said, "If we're in the lounge we have to shout for help, they [staff] are rushed off their feet at times." A third person said, "They could do with more staff as sometimes I have to wait for help to go to the toilet." The provider told us their records showed people's care preferences were respected.
- We saw staff did not always work well together to ensure people's needs were met. For example, we saw nurses did not stay in communal areas to help support care staff which meant care staff were unable to support people who wanted to return to their bedrooms. The care workers could not leave the room to get the extra staff they needed due to the needs of people in the room. When we gave feedback to nursing staff about care workers needing support to meet people's needs, the nurse told us the care workers just needed to ask for help. This did not recognise the care workers could not leave the room as it would have been unsafe. Further improvements were required to ensure staff worked well together to ensure people's needs were met. After the inspection the provider told us staff should have used the call bells in place to call for help.

● We reviewed the recruitment records for five staff who had started working at the service since our last inspection in 2018. We found the provider followed good practice which ensured staff were suitable to work in a care setting.

Assessing risk, safety monitoring and management

● The systems in place for the identification and mitigation of risk were not operating effectively to keep people safe.

● The provider used different tools to assess the level of risk faced by people receiving care. These tools were not being used consistently or effectively. For example, one person's risk of falls assessment had not been totalled correctly and had not included information about their medical history which would have increased their risk score. The measures in place to mitigate this person's risk of falls were not clear. Staff were instructed that the person "needs assistance of staff" but this assistance was not described.

● Risks associated with moving and handling had not been appropriately mitigated. Care plans relating to moving and handling did not describe the equipment to be used in detail, for example the size and type of sling to use in a hoist. Where people's moving and handling needs had changed there was conflicting information within their care file. For example, one person now used a standing hoist rather than a full body hoist but aspects of their care plan still referred to the standing hoist. This meant there was a risk the wrong equipment would be used.

● Other risk tools, including those used to calculate risk of malnutrition and pressure wounds had not been correctly totalled leading to risks not being properly identified or mitigated against. After the inspection the provider submitted correctly totalled malnutrition risk tools.

● People living in care homes are required to have Personal Emergency Evacuation Plans (PEEPs) to ensure there are clear plans in place about the support they will need to evacuate in an emergency. While some of the PEEPs described the measures to use in an emergency, others referred to using a hoist. This would not be appropriate in an emergency when the power supply would not be assured.

Using medicines safely

● The systems in place did not ensure the safe management of medicines.

● The provider used a medicines system where medicines were supplied in blister packs dispensed by the pharmacy. Staff relied on printed medicine administration records (MAR) supplied by the pharmacist which included the prescription instructions. This was the only information available to staff, which was insufficient, and in one case, incorrect.

● For example, one person had been supplied medicines as a patch, but the prescription instruction on the MAR referred to tablets. Other people had been prescribed medicines as a variable dose, for example pain relief medicines where a range of doses may be appropriate depending on the level of pain. There was no guidance for staff to tell them how to determine the dose to administer. Staff were not recording how much of a variable dose medicine had been administered.

● Controlled drugs are medicines which require additional systems in place to ensure their safe management. People had been prescribed controlled drugs, both to manage long term conditions and as anticipatory medicines. Anticipatory medicines are medicines prescribed to people approaching the last days of their life to ensure they do not have to wait for pain relief. They are prescribed on an 'as needed' basis. There was not enough information available to staff to ensure they knew when to administer these medicines. For example, one person was prescribed, "Morphine 10mg/ml PRN Palliative medicine." This was the only information available to staff and did not inform staff when to offer or administer, or how to determine if the person required this medicine. The guidance for other 'as needed' medicines was insufficient which meant staff were relying on their own knowledge, so if they did not know the person's communication well there was a risk they would not get their medicines as needed.

● Some people were given their medicines crushed and hidden in food or drink. This was either due to them

having swallowing difficulties, or because they would not take their medicines if they knew they were being given them. This is called covert administration. The covert medicines records in place did not describe how to disguise the medicines. One record showed there had been a recommendation made in April 2019 to change one medicine from tablet to liquid form and make it an 'as needed' medicine. Records showed the person was taking two tablets of this medicine each day. This showed the advice of healthcare professionals had not been followed and the person was not receiving medicines appropriately. Another person was having a tablet crushed when there are multiple alternate formulations available. There was no record to show the form of this medicine had been considered when the covert administration was put in place.

● Nursing staff used pill crushers to prepare medicines for covert administration. These had been left in the medicines trolleys in a dirty state, with residue inside them. On one unit we had to intervene to stop a member of staff using a dirty pill crusher. On another unit the nurse told us the crusher had been left in a dirty condition by the night staff, and they did not need to use it. It is poor practice for equipment to be left dirty on medicines trolleys and increases the risk of people receiving residue medicines that they were not prescribed.

● MAR had not been kept up to date, and the provider had not ensured the pharmacist removed discontinued prescriptions. While most MAR had been amended by hand where medicines had been discontinued, we saw one person had an antipsychotic medicine on the MAR which had not been supplied or signed as administered but had not been recorded as discontinued. This meant there was a risk this person wasn't getting their medicines as prescribed.

The above issues with risk assessments and medicines management are a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We checked the stocks of medicines and how they were stored and found the stocks were correct and storage systems appropriate. Records had been completed and staff had recorded when they had given people their medicines.

Systems and processes to safeguard people from the risk of abuse

● People and relatives gave us mixed feedback about their feelings of safety in the home. Most people told us they felt safe, and certain staff would support them if they felt unsafe.

● However, two relatives told us they worried about people going into their family member's rooms at night. One relative explained, "We don't know who is coming in, and [family member] can't get them out, there doesn't seem to be any way to stop them, so we as a family are concerned." There had been no assessments of this risk, or measures, such as door gates, put in place to protect people from the risks of other people going into their rooms. The provider showed us there were door sensors in place to alert staff when people went into bedrooms.

● We saw some people behaved in a way that made them vulnerable to abuse from others. For example, one person vocalised loudly to ensure their needs were met. They were unable to mobilise independently and the tone of their communications caused others to become distressed. The provider had not identified that this person was vulnerable to the reactions of others.

● Staff knew how to respond to allegations of abuse, and we saw they reported incidents to the manager who raised concerns with the local authority where this was necessary.

● Records showed that the provider cooperated with safeguarding investigations. Where safeguarding investigations identified learning points these were cascaded to staff. For example, a safeguarding investigation had identified concerns about monitoring people when they were unwell and we saw supervision records included detailed discussions around ensuring people were closely monitored.

Preventing and controlling infection

● There were effective systems in place to ensure the home was clean.
● There was a team of domestic staff who ensured the home was clean. There was sufficient personal protective equipment available to staff.
● However, some of the home's practices regarding laundry did not mitigate risks associated with cross contamination. This was because two staff members told us that while some people had their own net knickers to support their continence aids, there was also a 'pool' of shared net knickers. While these were laundered at high temperatures it is not appropriate for these items to be shared.

Learning lessons when things go wrong
● People and relatives did not feel that things always improved or changed after incidents occurred. The systems for ensuring lessons were learnt after things went wrong were not robust or operating effectively.
● Incident reports included actions that staff should take to reduce the risk of recurrence. However, these actions tended to be generic, and repeated policy rather than giving specific guidance for staff. For example, one person had fallen repeatedly over several months, the actions were to remind them to use their equipment and to monitor them closely. Their care plan and risk assessments had not been reviewed or updated to ensure this happened.
● The provider told us the introduction of the new electronic care planning and recording system would allow closer monitoring of follow up to incidents and accidents. We saw a sample of these records which the management team could access remotely. The system would allow managers to ensure increased monitoring, or other actions required following incidents, were taking place.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At our last inspection the provider had failed to follow the principles of the Mental Capacity Act 2005 and seek appropriate authorisation where people were deprived of their liberty. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11 (Need for Consent)

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (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.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- The provider had taken action with regard to making applications to the local authority for DoLS. However, other aspects of their practice in relation to the MCA did not reflect guidance or the law.
- Care plans and assessments showed the provider checked whether relatives had legal authority to make decisions on behalf of their family members. However, even when relatives did not have legal authority, they were signing to consent to care and treatment.
- There were some capacity assessments in people's care files, but these were not decision specific and did not record any efforts to involve people as far as possible in making decisions. For example, one person's file contained a best interests decision making record that stated in the 'decision that is considered to be in the person's best interest' section, "[Person] lacks capacity." This is not a decision or outcome.
- Care plans contained conflicting information about people's capacity to consent to their care. Care files

contained capacity assessments stating people were unable to consent to any aspect of their care, yet each care plan stated staff should gain consent before delivering care. There was no information about how to offer choices in a way that facilitated people being able to make their own decisions. This meant information was confusing and there was a risk that people were not offered choices they were able to make.

This was a continued breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Assessments of people's needs had been poorly completed and did not explore people's views and preferences.
● We reviewed the assessments for six people who had moved to Acacia Care Centre since our last inspection. The assessment template included space to record people's preferences as well as their level of need. The details of preferences had not been completed in any of the assessments viewed. Some of the assessments included that some areas, such as night time and moving and handling needs, would be 'assessed on admission' but there was no record that this assessment had been carried out in a timely way.
● Care plans did not include information about how to meet people's needs. The goals described were generic, and in some cases were framed in language that was inappropriate and did not reflect current guidance. For example, one person had a care plan for "behaviour" where the stated goals included, "To minimise / reduce and prevent [person] from being challenging."
● Care plans frequently described policy and did not include details required to ensure best practice guidance was followed. Some care plans were completed in a way that suggested staff had not understood their purpose. For example, each care file contained a care plan for 'altered states of consciousness.' In each case this was used to describe how to ensure the person had not fallen unconscious and how to respond to a medical emergency. They had not considered if the person had diagnoses that increased the risk of them experiencing altered states of consciousness.
● Following a recent safeguarding investigation, the provider had recognised shortcomings in the assessment process and was in the process of introducing a new approach to assessments which utilised an electronic care records system. Despite the provider telling us they were aware of the shortcomings in the assessments there was no record to demonstrate they were taking action to address these shortfalls as the electronic system had not yet been introduced for care plans.

The above issues with assessments and care plans are a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff told us and records confirmed they received regular training and supervision to support them in their roles.
● The provider required staff to complete regular online and face to face training in areas relevant to their roles. Records showed high completion rates and Acacia Care Centre had won an internal award from the provider for improving and maintaining its training levels.
● The provider told us they were planning to introduce various champion roles in different areas of care to help improve practice within the homes. These included dementia champions and equality champions focussing on people who identified as lesbian, gay, bisexual and transgender. The champions had been identified and would soon be supported to attend additional training to help develop the practice within the home.
● The provider worked with a local college to support staff to complete nationally recognised qualifications.

They were also working across homes to support staff to complete nurse associate courses to help develop staff as nurses from within the company.

Supporting people to eat and drink enough to maintain a balanced diet

● People did not always have a pleasant mealtime experience. People and relatives gave us mixed feedback about the variety of choices they were offered about the food.

● Relatives told us there had been a lot of recent changes to the mealtime experience, and the provider confirmed they had recently changed the approach to mealtimes by ensuring people were encouraged to eat together in dining rooms.

● However, our observations of mealtimes showed these changes had yet to be fully embedded and not everyone experienced a pleasant mealtime.

● Across two different mealtime observations we saw staff were trying to complete multiple tasks at the same time. The same member of staff was serving meals and supporting people to eat. This meant the person being supported to eat was left between mouthfuls as the staff member served others. In one area of the home we saw that some people wished to leave the dining area as soon as they had finished eating, but staff repeatedly stopped them standing up and leaving as they required staff support to mobilise and there was insufficient staff capacity to support the person to leave while others were still eating.

● People were offered choices from the menu, and where they did not want either option, an alternative was prepared for them. People were asked their views about the menu at residents' and relatives' meetings. Some people told us they would like more variety but overall people said there had been huge improvements in the quality of the food over the last few months.

Staff working with other agencies to provide consistent, effective, timely care

● People and relatives told us they received support from external agencies to ensure their needs were met. The provider told us about the work they had completed with the local hospice and other providers to ensure people received consistent care.

● Records showed input from external agencies was recorded in the multi-disciplinary team notes section of people's care files. During the inspection a physiotherapist ran a group session and updated people's notes.

● The provider told us they had an effective working relationship with the local authorities who commissioned care from them. They told us they were working to improve the relationship with the local safeguarding investigation team as they had encountered some barriers to effective joint working.

Adapting service, design, decoration to meet people's needs

● The building was a purpose built care home which was suitable for people's needs. The halls and bedrooms were large enough to accommodate the equipment people needed to have their needs met.

● The provider had identified some improvements were needed to make the decoration and signage more suitable for people living with dementia. There was a redecoration plan in place.

Supporting people to live healthier lives, access healthcare services and support

● People and relatives told us they were able to access the support of healthcare professionals when they needed. We saw the GP visited regularly and visited during the inspection.

● The advice and feedback of healthcare professionals was recorded within the daily notes for people. However, it was not consistently used to update care plans to ensure they reflected the advice of healthcare professionals.

● The provider told us the introduction of their new electronic care records system would ensure these updates would be reflected in care plans and risk assessments.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- As described in the Effective section of this report, details of people's personal characteristics were not recorded as part of the assessment process. This meant there was a risk that people were not supported to have their cultural and faith needs met as they were not described. People told us they were not always supported with their faith as they would wish.
- Care plans captured when people told staff they had a religious belief. Staff told us that faith representatives visited the home. However, people told us they did not feel they were given the support they needed to practice their faith. One person said, "I don't know if there are any services, my faith is very important to me." Another person said, "I would like to go to [place of worship] but I have been told this is not possible." A third person said, "I haven't been able to go to [place of worship]. I haven't seen [faith representative], it would be nice to."
- Relatives also told us they didn't feel the importance of their family member's faith was recognised. One relative explained, "[Family member] would love some music or even just to have services playing in the background but it doesn't happen. They [staff] don't think to do it. It's careless as [family member] can't express herself they just don't think to do it."
- People and relatives told us most care workers were kind and considerate. One person said, "Staff are very kind, they are very gentle with me." We saw staff interacted with people in a gentle and compassionate manner.
- However, people and relatives also described some interactions with staff which did not demonstrate a respectful attitude. Several relatives told us they had felt staff were shouting at them and people told us there were some night staff who they found did not display compassion towards their physical needs.
- This was discussed with the provider who told us they had some communication challenges with some family members which they were working constructively to resolve.

Supporting people to express their views and be involved in making decisions about their care

- People's experiences varied and staff did not consistently recognise and respond to people's communication and expressed views.
- As people's views and choices were not captured in their care plans, staff relied on their individual knowledge of people's views and choices. While we saw some staff offered choices and tried to involve people, this was inconsistent.
- Family members told us they felt frustrated that they had to keep telling staff the same things to ensure their views were listened to. As one relative explained, "We're always repeating ourselves. I don't know if it's

not written down, or not handed over, but we feel we have to keep saying it so they will include [family member]."

Respecting and promoting people's privacy, dignity and independence

● Staff told us the steps they took to promote people's privacy and dignity. This included ensuring people were covered during personal care and doors were shut.

● We saw people were offered support in a discrete and sensitive manner by staff when in communal areas of the home.

● However, we also saw staff did not always knock on people's doors before going into their bedrooms. We also saw that people's independence was not always supported. During one mealtime we saw staff held a person's hand out of the way to prevent them feeding themselves. The provider told us this was due to risk, but had not explored ways of supporting this person to feed themselves safely.

● Care plans did not include details of what people could do independently. People told us they were not always able to do things they could for themselves as staff were rushed. One person said, "Staff wash me. If I had more time, I could do some myself, but they are in a hurry, but they know what they are doing. You are under the staff so you have to be polite."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Care was not planned in a personalised way. People and relatives gave us mixed feedback about their involvement in care planning. Reviews of care happened regularly but did not identify shortfalls in care plans or add detail as staff got to know people better.

● Some people and relatives told us they were involved in writing and reviewing their care plans. One person said, "I had one [a care plan] when I came here and I saw it then, but not since." A relative said, "The care plan is something we are involved in and as things change so does the plan, we meet the staff and talk about it."

● Care files contained documents that were meant to support staff to get to know people. These had been completed by family members and where they had not answered questions there was no record that people and their relatives had been supported to capture the information requested. It was also not clear what happened where people did not have family members available to complete this information. The provider told us staff completed a 'knowing me and social profile' where people did not have relatives involved in their care.

● The provider had started to use an electronic system to record the care people received. We reviewed a sample of records. These showed that staff were delivering care as planned. However, they also showed staff were supporting people in ways that had not been described in their care plan. For example, one person's records showed staff had developed an effective approach to supporting them to calm down when they were agitated. This approach was not included in their care plan which meant there was a risk that not all staff knew to try this approach with this person.

● Records showed care plans were reviewed each month. However, these reviews were not effective or used to add detail to care plans. For example, each person's 'Altered states of consciousness' care plan review for each month stated, "Remains alert and conscious." Likewise, other reviews stated that people's needs had remained the same. Where changes were noted, such as where people used different equipment, while this was noted on the review, the care plan itself was not updated.

End of life care and support

● People living in the home were approaching the last stages of their life. The level of detail in care plans about their care needs and how to meet them meant there was a risk they did not always receive compassionate care at the end of their life.

● The lack of detail about medicines information described in the Safe domain meant there was a risk that people did not receive the pain relief they needed at the end of their lives.

● Care plans did not include details of the support people wished to receive, including relating to their faith, at the end of their lives. People's families had completed people's advance care plans, and it was not clear they had been facilitated to consider this holistically. Where they had not fully completed the paperwork there was not a record to show staff had followed up on how to gather this information. There was minimal detail in these plans. For example, one person's advance wishes document was completely blank, and another's just stated it was important that they had "companionship" and "music." The music was not specified.

The above issues with care plans, reviews and end of life care are a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● People's communication needs and any adjustments they may need to ensure information was accessible to them were not well described within care plans. It was not clear that information was made accessible for people.
● Care plans were handwritten and were not in a format that was easily accessible to the people they related to. The provider told us the move to an electronic care planning system would provide the opportunity for people to have easier access to their care plans.
● Relatives told us it would be helpful to have pictorial information about the staff on duty on each floor. We saw this was on display at reception, but this was not an area of the home people living on upper floors could easily access.
● The provider sent us a pictorial menu and activities timetable for people who could not read.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People were able to maintain their relationships with their families. The relatives we spoke with told us they were able to visit whenever they wished, with no restrictions on the time they visited. However, feedback about how welcome they felt varied. Some told us they always felt welcomed, but others told us they were not always confident staff were pleased they were there.
● Some relatives told us they found their relationships were affected by their perception that they had to visit regularly to ensure their family member's needs were met. Several people told us they did not find care plans were followed unless they visited and reminded staff. One relative explained their family member needed a calm environment which staff did not always respect. Another relative said, "We feel we have to visit, we can't ever take a day off and it affects all of our relationships."
● The provider had increased the resources available to the activities staff, but feedback from people suggested more work was needed to embed activities and engagement opportunities for people.
● Feedback from people about activities included, "No entertainers come here" and, "There are not many activities here, we just sit about and chat." We noted people were using sewing boards in one area. When we asked people about these, they said together, "We have never seen these before today."
● Records showed staff facilitated a range of group activities, including ball games, quiz nights and various arts and craft activities. We saw staff delivering a massage and sensory session during the inspection. However, given the feedback from people further work was necessary to ensure all people living in the home benefited from the activities on offer.

Improving care quality in response to complaints or concerns

● Some people and relatives told us they knew how to raise concerns and make complaints. However, others told us they did not know how to raise concerns. The complaints policy was on display in each area of the home.

● Records showed the provider investigated and responded to complaints in line with their policy. However, people and relatives did not always feel they were able to raise concerns. One relative said, "I haven't found any one person I can turn to with concerns." Another relative said, "We make complaints, and they fix it for a while but then we have to complain again to keep it going." Other people told us complaints were resolved.

● The provider held meetings for relatives so they could give feedback about the home. Relatives told us they appreciated that the timing of these meetings varied as it allowed relatives who had other commitments to attend.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection the provider had failed to notify us of incidents as required by law. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations.

At this inspection we found the provider was now meeting this regulation.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The CQC sets out specific requirements that providers must follow when things go wrong with care and treatment. This includes informing people and their relatives about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The registered manager understood their responsibilities.
- The provider had submitted notifications to CQC as required by law.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The systems in place to monitor and improve the quality and safety of the service were not operating effectively.
- The registered manager and deputy manager completed audits of care plans, medicines records and other aspects of the experience of people living in the home. The medicines audits had not identified the lack of detail in guidance for staff, inaccuracies in MAR charts and covert administration guidance. The care plan audits had started to identify that care plans were not personalised.
- The group quality and compliance manager also completed audits of the service. The provider submitted four months of their audits. These did not include any review of care plans or risk assessments. These audits had not identified the 'as needed' guidance for medicines was insufficient. The only actions identified by these audits related to the transition to the electronic records system.
- In response to our feedback about the systems in place to manage medicines the provider conducted an audit of their medicines. They sent us a document which stated they believed the information included in the prescriber's instructions was sufficient. This meant they had not understood the requirements of the regulations with regard to the safe management of medicines.
- The provider showed us their centralised audit system. The registered manager inputted the results of their audits into a central spreadsheet which allowed the regional manager to monitor the service. However,

this relied on internal audits which had failed to identify issues found during the inspection. Therefore this system was not working effectively to identify issues with the quality of the service.

The above issues are a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People, relatives and staff gave us mixed feedback about the culture of Acacia Care Centre and the visibility of the registered manager.

● Some people and relatives told us they knew who the manager was, and said they could give feedback and this would be acted upon to improve things for people. One person said, "The manager is very approachable. We can see them if we want and when we want."

● However, other people told us they did not think the manager was visible, and this meant they weren't aware of issues in different parts of the home. One relative said, "You occasionally see [registered manager] around." Another relative said, "I don't think the manager is up here on the top floor enough to see what is going on." A third relative said they felt the manager focussed more on the premises than the quality of the care.

● Staff gave us mixed feedback about the culture of the home. Some staff told us they were happy in their work, and felt the home was person-centred and supportive. However, other staff told us they felt there was too much focus on systems and not enough on the care. As one member of staff explained, "There is a lot of pressure on paperwork and it doesn't feel that they [management] look at the care side of things. They could be more supportive for the residents I think."

● People and relatives told us they found staff inconsistent in their approach to person-centredness. One person said, "The day staff seem happy, but not the night staff." Another person said, "Staff are ok, sometimes some of them are a bit moody."

● Meeting records showed providing person centred, holistic care was discussed in staff meetings.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● There was a regular schedule of meetings for relatives and different staff groups to involve them in the service. Volunteers and community groups were involved in supporting different activities.

● Records showed meetings were used to cascade information to staff to ensure they were up to date on issues within the home and the expectations of their role.

● People and their relatives had been invited to tasting sessions as part of the work the home was doing to improve the menu. Relatives told us this had been a welcome development to the home.

● Records showed volunteers from the local community had kept in touch with the service and stayed involved with supporting people who lived in the home with a range of activities.

Continuous learning and improving care; working in partnership with others

● The provider had implemented a new approach to developing the service and this was an ongoing piece of work.

● The provider was introducing an electronic care records system to improve care recording and care planning. They had introduced this for records of care, and this had increased the level of detail recorded. They had not yet implemented this for care plans although there was a plan in place to review and input the information.

● The provider described working with other services, including the local hospice, CCG, and a university to help develop practice in the service. They were working with a university on a project around staff

recruitment and retention. We will review the impact this has on people's experience at our next inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not receiving person-centred care, care plans lacked detail on people's needs and preferences. Regulation 9(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not followed the principles of the Mental Capacity Act 2005 and had sought consent from people who did not have legal authority to give consent. Regulation 11(1)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Risks faced by people had not been appropriately identified or mitigated. Medicines were not managed safely. Regulation 12(1)(2)

The enforcement action we took:

We issued a warning notice requiring the provider to meet this regulation by 13 January 2020.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems and processes had not operated effectively to identify and address issues with the quality and safety of the service. Regulation 17(1)(2)

The enforcement action we took:

We issued a warning notice requiring this regulation be met by 13 March 2020.