Devaglade Limited

Two Acres Care Home

Inspection report

212-216 Fakenham Road
Taverham
Norwich
Norfolk
NR8 6QN

Tel: 01603867600
Website: www.twoacres.co.uk

Date of inspection visit:
05 September 2017
06 September 2017

Date of publication:
12 March 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Two Acres provides accommodation for up to 115 people who require nursing and personal care. The home consists of four separate units, named Iris, Lily, Rose and Fern, set in landscaped grounds. At the time of our inspection Fern unit was closed for refurbishment and there were 69 people living in the home within the other units.

This comprehensive inspection included two visits to the home, which took place on 5 and 6 September 2017. The first visit was unannounced. The second visit was arranged with the registered manager to complete the inspection.

This home requires a registered manager as a condition of its registration. 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 home is run. There was a registered manager in post who had been in post since April 2017.

We had previously inspected this service on 1 and 10 August 2016. We found that the provider was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was in breach of two of the regulations which were for staffing and good governance.

At this inspection we found that the provider had taken action to ensure there were enough staff to keep people safe and provide them with basic care, therefore they were no longer in breach of this regulation. However, we found that although there were enough staff to keep people safe, there were not always enough staff to provide people with individualised care.

The provider had not taken the necessary actions to meet the requirements of the regulation relating to good governance. They had not adhered to their action plan they had sent us since the last inspection and were still in breach of this regulation.

We also found that the provider was in breach of a further two regulations during our most recent inspection. These were in relation to mental capacity and safe care and treatment. We found that people's mental capacity assessments (MCAs) had not always been fully completed detailing specific decisions. There were no records of best interests meetings having taken place with regards to people's care when they lacked capacity. Mental capacity assessments and DoLS applications had not always been reviewed and the conditions of DoLS were not always met.

People's risk of developing pressure ulcers and the subsequent treatment of these pressure ulcers was not adequately recorded, monitored and understood. The ongoing risk assessment process when people had a pressure ulcer was not always thorough.

The systems in place for monitoring the service in order to identify areas for improvement and take action were not effective. We saw that where audits had been carried out and identified concerns, no further action had been taken. The registered manager and the provider had insufficient oversight of the effectiveness of the service.

People did not always receive person-centred, individualised care. There were not always plans in place to fully guide staff on people's individual needs and preferences, and staff did not always have time to deliver person centred care according to these needs.

We found that most people's medicines had been administered as prescribed, however we found that not all medicines had been managed safely. We found that medicines errors or omissions had not always been reported, and that there were not effective systems in place for ensuring the correct stock counts were in place. There were no actions taken when concerns had been found.

We found that staff did not always record people's fluid intake where they needed full assistance to have drink, so the registered manager could not be assured that people received enough to drink across the home. People received enough to eat and on most units, where people could choose, they were offered a choice of meals. In other cases, care staff knew people's preferences and provided this with regards to their meals. Meals took a long time because most people required full support with them.

Staff were supported to undertake qualifications in health and social care and further training if they wished. They also had supervisions and appraisals where they could discuss their roles.

People were supported to access healthcare, and staff were responsive to emergencies and worked well as a team.

Staff were caring and compassionate, building positive relationships with people and their families. They respected people's privacy and dignity, and where possible, encouraged people to maintain their independence.

People were supported to engage in a range of activities and follow their interests where possible. However some people were not always able to choose how they spent their time and did not always receive the level of care they preferred.

The staff team who worked well together and communicated well. They found the registered manager approachable and the registered manager maintained visibility throughout the home.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed and recorded safely.

Risk assessments were carried out according to people's needs, but these were not always done in a timely manner.

Risks to the environment were mitigated appropriately.

Staff knew about safeguarding and how to report concerns.

There were enough staff to ensure people were kept safe and they were recruited with systems in place to minimise risks.

Is the service effective?

Requires Improvement

The service was not always effective.

People's mental capacity was not always fully assessed appropriately for specific decisions, and best interests meetings were not always completed or recorded.

People received enough to eat, but there were not systems in place to ensure that people always drank enough.

People had access to healthcare services.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were compassionate and reassuring towards people, but the systems in place did not always ensure that people received a caring service.

Staff fostered good relationships with people and their families.

Staff protected people's dignity and privacy as much as possible, and encouraged people to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were not always staff available to ensure that staff had time to spend with people in order to meet their needs and deliver individualised care.

Care records had plans in them of people's support needs, to guide staff on how to meet them.

People knew who to talk to if they had any complaints.

Is the service well-led?

Inadequate

The service was not well-led.

The provider has failed to make and sustain improvements, and had not fulfilled their action plan.

The registered manager had not always informed us of notifiable events.

Systems in place for monitoring the service were not effective.

Staff worked well together and there was a positive atmosphere within the home.

Two Acres Care Home

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.

The inspection was carried out by three inspectors, one pharmacist inspector, a specialist advisor in nursing and two experts 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 This was an unannounced inspection.

Before the inspection, we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. Prior to the inspection, the provider also completed a Provider Information Return (PIR). This 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. Before the inspection, we also obtained feedback from the local authority.

During the inspection, we spoke with six people living at Two Acres and seven relatives. We spoke with three nurses, a team leader, the registered manager, two kitchen staff and three care staff. We also spoke with a visiting healthcare professional.

We looked at care records and risk assessments for 14 people. We reviewed 15 medicines administration records (MARs) as well as a sample of people's daily records and other information associated with people's medicines and care. We also carried out observations throughout the day of how staff interacted with people and how support was delivered.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection on 1 and 10 August 2016 we found the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were not always enough staff available to ensure people's safety. This key question was rated as 'Requires Improvement' at our last inspection. At this 2017 inspection, it remains with this rating.

We found during this inspection on 5 and 6 September 2017 that there were enough staff on duty to meet people's basic needs and to ensure their safety. Staff we spoke with told us that they felt there were enough to keep people safe, but not always to spend extra time with them. One said, "I feel we are understaffed but it's manageable." The registered manager told us they were using a dependency tool which assessed the staffing levels required according to people's needs. During our inspection visit, we saw that staff were available to meet people's needs in all three units of the home. Consequently, the provider was no longer in breach of this regulation. Despite this, we still had concerns that there were not always enough staff available to be fully responsive to people's needs and spend time with them.

For one person who had a pressure ulcer, we saw that repositioning was completed every two hours as recommended. However, the person's pressure ulcer had not been re-assessed since it had been initially recorded on 11 August 2017. We looked at the daily records for this person and found that a dressing was recommended to be changed every three days. We saw that a dressing was recorded as applied on 6 September 2017, and no further records that this had been completed. The pressure area had not been adequately reassessed to ensure the person received the most appropriate care for this. Therefore the provider could not be assured that the area was healing or ascertain and mitigate the level of risk to the person. There had been no root cause analysis or review, so the provider could not assure themselves this person did not suffer avoidable harm.

When we spoke with the registered manager about this following the inspection, they told us that two pressure areas had been incorrectly recorded. We asked the registered manager for records of competency checks which the nursing staff had undergone in relation to pressure care, and they told us these checks were planned for October 2017. We were concerned that the competencies of the nurses in this area had not been properly assessed and monitored. This had resulted in incomplete risk assessment taking place in order to ensure the appropriate treatment plan for people with pressure areas. The lack of swift reassessment of high grade pressure areas meant that staff did not always respond quickly to changing needs and review risk assessments when needed.

These concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that on one unit pressure areas had been reviewed and recorded regularly. Where people had pressure relieving equipment, this was in use.

The pressure areas had not been reported to safeguarding authorities. However, due to the confusion in the

records we were unsure whether safeguarding notifications should have been made or not with regards to people's pressure areas. We found that staff had good knowledge of how to keep people safe and report concerns. We also saw that numbers for the local safeguarding team were posted around the home, and that any incidents between people living in the home were appropriately reported to safeguarding authorities.

Risks to individuals had been assessed and plans were in place to mitigate these. Risks included those associated with individual health conditions, use of equipment such as bed rails and risks associated with people's mobility. We saw that where staff supported people to change position to mitigate the risk of developing a pressure ulcer, they had recorded when they had carried this out, however this was not always as regularly as recommended. Whilst the majority of people across the home, who were deemed at high risk, were supported as recommended to reposition, it was not always recorded that people were repositioned as regularly as required. For example, it was recorded that one person who was recommended to have two hourly repositioning, was supported with this only after four hours on four occasions since 26 August 2017. We also found that another person was not supported to reposition as regularly as recommended. This meant that staff were not able to ascertain how appropriately people were supported when they were at high risk of developing pressure areas.

People's risk of falls had been assessed and mitigated, and where appropriate people had been referred to the falls specialist team to assist the staff to keep people safe. Where people had accidents such as falls, we found that these were reported so that action could be taken to further mitigate risks.

The environment was kept safe for people, and we saw that electric and gas appliances and lifting equipment had been recently tested. The registered manager was in the process of updating the home's fire risk assessment and taking action where needed. We saw there was a personal evacuation plan (PEEP) for each person living in the home. Although water temperatures were tested, there was no legionella risk assessment or maintenance plan.

All of the people we spoke with told us they felt safe. One person said, "I feel safe living here, staff help me out of bed, they get me up in the morning wash, dress and shave me. They are all nice people." Another told us, "I feel really safe here. The girls keep a close eye on me and really look after me." Another described it as "Safe and comfortable." This was reflected by all of the relatives we spoke with, one saying, "[Relative] is definitely safe here. There always seem to be enough staff around. They seem to keep an eye on her and I know they check her in her room."

Staff were recruited safely with checks in place such as DBS (Disclosure and Barring Services) and references. These helped to ensure the provider recruited staff suitable to work with the people living at Two Acres.

We looked at the management of medicines within the home and checked associated records. Staff had completed the medicines administration records (MARs), signing for medicines given to show when they were administered. However, we saw on one unit that medicines for two people, eye drops and a medicine for depression, were unavailable for two and three days respectively. This may have had a negative impact on people's wellbeing.

Medicines, including those associated with higher risk, were stored securely. The temperatures of the storage areas were recorded regularly and we saw in one area of the home that these were often higher than the recommended 25 degrees. This meant that not all of the medicines were kept within recommended temperature range to ensure they remained effective.

The medicines administration records (MARs) we looked at included information about allergies and a photograph of the person to make sure they were correctly identified. People told us they felt that staff administered their medicines safely.

Some medicines were prescribed to be taken when needed (PRNs), for example for pain. We saw plans were in place to guide staff on what the medicines were for and how much to give, and we saw that administration was clearly recorded.

Requires Improvement

Is the service effective?

Our findings

This key question was rated as 'Requires Improvement' at our last inspection in August 2016. At this 2017 inspection, it remains with this rating. 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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Mental capacity assessments were in place for people which recorded whether they could make decisions relating to day to day tasks. However, there were no further assessments in relation to any specific decisions that needed to be made that could restrict people's freedoms or were needed to ensure their welfare.

The service had not always reviewed peoples' DoLS applications to ensure they remained relevant, and ensured using the least restrictive methods possible. One person had an authorised DoLS application in place. This had expired in June 2016. The care record for this person stated that the mental capacity assessment was carried out last on 17 October 2015, and it had not been reviewed since then. For another person, the original DoLS application had been sent in October 2014 and this had not been reviewed.

The records we looked at did not demonstrate a thorough understanding of the MCA. There were no records of capacity assessments to determine whether people were capable of deciding for themselves whether to take their medicine, as required by the Mental Capacity Act 2005, and the provider had not involved the relevant people in the decision on whether it was in the person's best interests to have their medicines covertly.

Where people were receiving covert medicines, there was not always documentation included to show who had been involved in best interest decisions. For example, one stated 'family members' had been involved, however there was no further information about who they were. Decisions to administer covert medicines had not been reviewed. For example, for one person, the attached record stated the need for covert administration to be reviewed when new medicines were prescribed. The person had a course of antibiotics in August 2017 and there had been no update of assessment to decide whether they should be given covertly.

This meant that the provider could not be assured that they were making decisions in the best interests of people or giving the opportunity to make them themselves. We looked at the organisation's covert medication policy, and found that it stated that there should be a specific mental capacity assessment, an assessment of the person's needs and a multi-disciplinary best interests meeting. There were no records which showed that these steps had been taken.

As a consequence of these findings the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that staff gained consent from people where possible, before delivering support to them. A staff member stated, "I explain what I am going to do and obtain their consent and continue to explain as I am giving care. I stop immediately if the person becomes upset and ensure they are happy before I continue." The staff were observed to seek consent and explain to people what they were going be doing.

On Rose Unit, not everybody was regularly offered fluids consistently throughout the day and there was a lack of evidence of the recording of fluid intake in the records reviewed. There was no choice of drinks as only one was available throughout lunch time. We saw that during mealtimes where people were fully assisted by staff, people were not always offered sips to drink during the meal. People in most cases were supported to eat two courses, and then offered support to have a drink afterwards. Many people were not able to communicate their needs and were not able to ask for a drink. The majority of people on Rose Unit required support to drink, and there was not a way of ascertaining how much people had as it was not recorded, except for one person. On the other two units, we found people had access to drinks throughout the day.

During our inspection in August 2016, we found that fluid charts did not always indicate the amount of fluid offered or consumed. Where staff had recorded fluid intake, the amounts had not been totalled and the optimum fluid level for that individual had not been recorded. There were no instructions for staff on whether there was any action they needed to take and when. On this September 2017 inspection we found that this area had not improved and fluids were not always recorded sufficiently. For example, for one person, staff had recorded 250 millilitres of juice on their chart, however, the person had not yet consumed it. For another person, they had some drinks recorded with no amounts written on their chart, so the recording was not informative. There were no suggested amounts or targets.

People we spoke with told us they enjoyed the food, one saying, "I like the food. I never turn it down, I have porridge and bacon and two eggs for breakfast. I have put weight on since being here." Another said, "The food is very good, how much I eat depends on my appetite and how I am feeling." We saw that the staff were patient and assisted with meals at an appropriate pace unrushed and with dignity. A relative told us, "I think it is very difficult for staff at mealtimes as so many [people] need help. They seem a bit pushed to cope with everything then."

One person told us, "I didn't get a choice for my breakfast today. I get enough to eat." We saw that whilst some people who were able to choose, were offered a choice at lunchtime on two units, and others were not on one unit. Where people were not able to choose, staff told us that they knew what people preferred. We saw where people wanted second helpings, these were given.

There was evidence in the records reviewed that people were being assessed for their nutritional needs with completed nutritional assessments in their records and regular recordings of weights.

There was evidence of referrals to the speech therapy team and the dietician with people receiving fortified drinks and specialist diets if they were deemed at risk of not eating enough. We saw that people had put on weight accordingly after following dietician recommendations. Choking assessment risks had been completed and there was clear guidance in the records with regard to individual diets and nutritional requirements including positioning to reduce the risk of choking. We spoke with the kitchen staff and found they had a thorough knowledge of people's nutritional needs as well as their preferences.

Staff were supported to undergo training relevant to their role. This included the Care Certificate, a national qualification outlining the standards required in health and social care. There was a staff member dedicated to providing and organising staff training. Training included first aid, pressure care, dementia care and health and safety. One member of staff told us they had identified further training they would like to do and this had been arranged for them. The nursing staff demonstrated good knowledge and understanding in areas of diabetes, dementia and behaviour which some may find challenging, as well as nutrition and hydration.

The trainer was also responsible for undertaking supervisions and observations during staff's induction period. The registered manager told us this was flexible to allow for different levels of ability and experience. They told us new staff were paired with a more experienced team member, and they worked with them as well as attending training as part of their induction. They then started working independently when deemed competent and they felt confident to do so.

We saw some records of staff supervisions and found that they included discussions around aspects of care such as continence, pressure care and using lifting equipment. This meant that staff had the opportunity to raise any further training needs around a specific area. Staff told us they felt supported at work.

People were supported to access healthcare services. One person told us, "I saw an optician about a year ago. Someone comes round about every month to do your nails." Another confirmed, "The main nurse calls the doctor if needed, I visit every day so if they need to tell me anything they can when I visit." People and relatives confirmed that doctors, dentists, opticians and chiropodists visited regularly and were called in when necessary.

There was evidence in the records reviewed that referrals were being made to other agencies and that they were responding to changes in people's individual health status. For example we saw that one person with a specific health condition was seen by a chiropodist and optician in relation to this. There was also evidence of referrals within people's records to the dietician, speech therapist and the GP. The nursing staff reported that they also referred to the NHS dementia team for specialist knowledge and support.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in August 2016, this key question was rated 'Requires improvement'. At this 2017 inspection, this area remains 'Requires Improvement.' While we observed that individual staff were caring towards people, the provider's systems and processes did not always ensure that people were cared for in an individualised way. Some people told us that because of time constraints on staff, they did not always feel listened to, one saying, "I don't feel listened to all of the time, it's time, they have got to be prepared to spend with you and there are a lot of people to look after." Some staff we spoke with expressed regret about not being able to spend enough time with people to get to know them as much as they would like. One confirmed, "If [people] want to talk with you, you can't always do it." They commented that people did not always have social stimulation, "You don't want to be sitting there all day with nobody to talk to." We concluded that there were not always enough staff to provide social and emotional support to people.

The providers had not always ensured that there were enough staff available to ensure people's preferences were met and they received a dignified service. For example, one person told us that they felt staff did not always have the time to listen to them. They also said they had to wait for the toilet too long sometimes, and this impacted on their dignity.

All of the people and relatives we spoke with told us staff were caring. One person told us, "The staff are very kind, they come and sit here we have a little chat. We have a nice big room to spend our day in, I can have a nose out of the window, there is a little place out the back you can sit down, I am very satisfied with everything they are really nice people, they laugh and joke with you." Another said, "The staff are fantastic here. The lead nurse is so lovely and kind." This was reflected by a family member who told us, "I wouldn't want [relative] anywhere else. This is lovely, they (staff) are all wonderful to her."

Staff we spoke with told us they treated people how they would want their own family member to be treated. They also told us of the importance of getting to know people, and the difference this can make to providing good care to them.

We saw that staff spoke with people in a calm and respectful manner, and adapted their communication according to people's needs. A relative explained how staff supported their family member to overcome any upset, "The [staff] would jolly [relative] along and calm them down really well." We observed effective and positive interactions taking place between staff and people throughout the day. This included during mealtimes when staff supported people with their meals, and when staff supported people to move using equipment.

People's relatives told us that staff were responsive to people's emotions and communicated well with people. One said, "[Staff] visited [relative] before [relative] arrived and said they could help and they have been marvellous with [relative]. [Relative] is much calmer and seems happy." We saw that staff provided reassurance when needed and this had a positive impact on people.

People told us that staff respected their privacy, one person telling us. "The staff always knock." Another

confirmed, "The staff always make sure I am covered up and the doors closed when they help me to get washed and dressed." We observed staff knocking on doors before entering bedrooms or bathrooms.

We received some mixed feedback with regards to whether staff supported people to be as independent as possible. One person felt that staff could encourage them more, "I am not given the opportunity I am not asked, 'Are you able to wash yourself today?'" They felt this was due to time constraints on staff. However, we observed that on the other units staff encouraged independence, for example, we saw one staff member physically support one person to hold their own cup whilst supporting them to have a cup of tea.

Staff we spoke with demonstrated to us how they supported people to maintain their independence. One staff member told us, "We help a gentleman by helping him to walk everyday with his frame." We saw that this was carried out by staff. Another staff member said, "I encourage people to do as much as they can for themselves and help and guide them to wash and feed themselves. I give them choice as to what they would like to wear and what they would like to eat and drink when possible." Staff told us they encouraged people to maintain their independence, for example by supporting people to have their meals independently and washing themselves wherever possible.

One family member said they felt that staff kept them informed of anything important concerning their relative. They said, "The staff are very good, they tell you how [relative] is and how they're getting on. If [relative] has had a knock or anything they phone and tell you. They are very friendly in the office." We saw warm and caring interactions between staff and family members, and saw that staff were very supportive of them.

Some relatives felt they had been consulted over their family member's care plan but others could not recall a discussion. There was a lack of evidence in the care plan that people were being involved in their care plans, although many people may have lacked the capacity to participate in planning their own care. The records we reviewed lacked evidence that people's relatives were involved in the care planning process.

People and families confirmed to us that visitors were always welcome. One relative said, "The grandchildren come and visit. We are all made to feel welcome any time." Another told us that their relative came from the home to eat lunch at their house at times. During our inspection we saw that staff had fostered positive relationships with people's families, and that staff paid attention to their needs.

Requires Improvement

Is the service responsive?

Our findings

This key question was rated as 'Requires Improvement' at our last inspection in August 2016. At this 2017 inspection it remains with this rating. At this inspection, we found that it was difficult for staff to always be responsive to individual needs as staff were not always able to spend time with people and fit in various things that people wanted to do. We received mixed feedback across the home about whether the staff were responsive or not. On one unit, we found that for two people, they were not able to have a shower when they wanted. They told us they were not able to because staff did not have the time.

One person told us they felt that staff did not get to them in time to assist them to use the toilet. This impacted on their dignity. "They (staff) come and ask if you are ready to get up and all that, I would like a shower but I am told the shower isn't working, I haven't had a shower since being here." Another person told us, "I would like a shower every day, that is what I am used to but I can't, I have one a week because of time constraints. [Staff] say it is what's in my best interest, I could challenge it but I don't want to make them angry."

The provider had not always ensured that people had access to assessments for equipment which would assist them in their day to day lives. One staff member explained that for one person, who told us they were not able to shower, they were not able to use a shower chair safely. There was no further occupational therapy assessment made for further equipment such as a specialist chair, to enable this person to have a shower. The registered manager told us they would ensure this referral was completed.

People were not always able to choose where they spent their time. One person said, "I can't stay in my own bedroom as it is deemed unsafe to be left alone in there in case I have a fall, I have had one fall." Staff had told the person that it was better for them to be able to supervise them if they stayed in a communal area. We saw that this person stayed within a communal area all day throughout our inspection.

We observed lunchtime on the three units. We saw that many people required full support from staff with eating their meals, especially on Rose unit and Iris unit. As a result, some people were sitting in the dining room for periods of up to an hour before eating. They waited a long time for their meals as staff supported other people. One staff member said they could do with more staff during mealtimes to support people to eat. Two staff members on Rose unit told us they felt they would prefer to get to people quicker when they requested support, and to spend more time with them. We concluded with the above concerns that the service did not always deliver person-centred care that was based upon people's preferences and individual needs.

The home was not always responsive to people's ongoing healthcare needs. For example, a person recently admitted to the care home following a stroke had been assessed by a physiotherapist in August 2017 as requiring daily exercises. There was no evidence in the records reviewed that the person had been supported with these exercises.

People on one unit said they could have a shower when they wanted. They said, "I can have a shower every

day if I want to." People confirmed that they could get up and go to bed when they wished. "I can have a lie in if I want to. If I don't feel too well then I can stay in bed all day, [staff] don't mind." A relative also confirmed that people were able to access a hairdresser when they required.

On one unit, one relative told us, "If a call bell rings you may have to wait a few minutes but it hasn't caused [relative] any problems." Two staff gave us examples of when they had enjoyed spending time talking with people and finding out more about them. A staff member on another unit told us they felt they had enough time to deliver people's preferences with regards to showers and baths. All of the staff we spoke with said they did not rush people, and we observed this to be the case during the mealtimes, although this meant some people had to wait a long time.

There were comprehensive plans in place which guided staff on how to support people. They differed in content and quality across the home. Some care records contained more information about people's preferences and personal history than others. However, we found that they guided staff well on how to support people to move, and with any healthcare conditions as well as aspects of their support such as continence needs, pain and personal care. We found that some areas of people's care plans had been regularly reviewed so they remained relevant. However, there were other areas that were not always reviewed effectively, such as people's personal care preferences with regards to showers and baths, and pressure care. The registered manager told us they were in the process of reviewing and renewing the care plans. We found by talking with staff that they knew individuals' preferences, dislikes and needs well. One staff member told us, "We respect [people's] wishes and we are in the process of ensuring care plans reflect the persons' wishes and preferences."

We saw from records that staff responded in a timely manner in any case where people had needed emergency medical attention.

There was a variety of activities and entertainment on offer for people. One relative told us, "[Staff] are very caring, everything they do is good, they organised a couple of parties one at Christmas and a summer one." The registered manager also told us they were planning a Halloween party. Another relative told us, "We all went on a boat trip and they managed to get [relative] out so we could go." A staff member also told us people had enjoyed the recent boat trip.

Where possible, the home supported people to follow their spiritual interests and needs. On the day of our inspection there was a church service held in one lounge on a unit. These were monthly. However, one person told us, "I would like to go to church more it has been an important part of my life since I was a young boy, but I only get taken once a month as I have to be taken by car now as I can no longer drive it isn't enough." On another unit, a relative said, "[Relative] goes to church every week, the activities person takes [them]."

People, where possible, were supported to follow interests and hobbies. One family member said, "[Relative] responds to music so they make sure she goes to any of the music activities." Another said, "A singer was here yesterday and the [people] loved it. They were smiling a lot and you could see they were taking it all in and really enjoying themselves." Other activities included outings to the theatre, garden centres and shopping. We saw photographs of a variety of activities taking place within the home.

All of the people and relatives we spoke with told us they would speak to the head nurse or the manager if they had any concerns. One said, "If concerned we are encouraged to tell them." A relative said, "I would phone the office if I was concerned but I have never needed to." We looked at records of concerns and complaints and saw that these had been responded to appropriately, The registered manager told us they

were always available for people and family members to discuss any problems with, and we saw that they were approachable.

Inadequate

Is the service well-led?

Our findings

At our last comprehensive inspection in August 2016 we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have sufficient systems in place for monitoring and improving the service to ensure quality. This key question was rated as 'Requires Improvement' at our last inspection. At this 2017 inspection, it is rated as 'Inadequate'.

The provider sent us an action plan which told us the steps they were going to take to improve this area. They said they would have systems in place by February 2017. We found on this inspection in September 2017 that these actions had not been taken. The service therefore remains in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that audits had not been carried out consistently. For example, there were monthly infection control audits due which had not always been carried out. When they had been carried out, there were areas for improvement identified. However, no action plan had been made to show what corrective actions were required and when they were due to be completed by.

We found that nursing staff had carried out medicines audits in March, May, June and July 2017 and action had not been taken following the findings. These audits had consistently identified issues, and we found that no action had been taken and there was no plan of action. We saw that the same issues had been identified over a period of months. We found when medicines that were unavailable to be administered to people had been reported the registered manager was unaware of them. Concerns included incorrect medicines stocks and incomplete covert medicines records. The registered manager told us they had not been aware of these issues. Therefore they had not been in a position to review procedures to prevent the problem happening again.

All of the medicines audits we looked at had identified that no observations had been carried out as had been identified as a requirement within the provider's updates medicines policy. We concluded that despite the medicines audits occurring, there was insufficient oversight by the providers or the registered manager and a poor response to resolving issues found.

We checked the stock of some medicines, and found that although records showed they had been administered as prescribed, the stocks levels of people's medicines did not correspond with the records. This included medicines associated with high risk if not given correctly, such as those administered for blood-thinning and for aiding sleep. Therefore the provider could not be assured that they had been administered as recorded, as systems in place for keeping count of stock were not always effective. We had identified similar concerns during our previous August 2016 inspection.

There was not an effective system in place to gather information on whether or not people were provided with fluids regularly, and the registered manager could not assure themselves that people were adequately supported with fluids.

Contemporaneous and accurate records were not always kept for people. An example of this was that one person, who had developed a pressure ulcer, had an initial wound assessment recorded on 11 August 2017. We saw in the care file that the dressings were applied to the wound and changed every three days. However, there were no further reassessments of the wound so we could not be sure of its' current status. There were no checks in place of daily records to ensure that people were supported to reposition as recommended. The provider could not assure themselves that these were also kept up to date. Although we saw that audits of care plans had taken place, the action plans which were put in the folders for each unit had remained blank. These audits had also identified that covert medicines authorisations were not always fully in place, but no action had been taken and we found this to be the case during our inspection.

For the majority of the people on two units, they required full assistance with drinks, however only one person was on a fluid chart. Therefore the registered manager or the nurse in charge were not able to review records to assure themselves people were receiving enough to drink. We were concerned that with many people being deemed at risk of not drinking enough, and not able to get themselves a drink, there was no recording around people's fluid intake. Some people who were having food and fluid recorded were not having this recorded fully and the records were ineffective. For example, for one person we saw that there was no amount of fluid written and no target. There was no system for checking these records.

The systems for gaining meaningful feedback from people were not always fully effective. Where people told us they would prefer to have showers more often, this had not been identified within any quality assurance systems and acted upon.

We asked the registered manager if there were further audits carried out by the directors of the organisation, however they told us that the provider did not record any checks. Whilst some aspects of the care provided at Two Acres had improved and they were no longer in breach of one regulation, the service had not made and sustained enough improvements, including in areas which had been identified as needed by CQC over the last three years. We found again during this inspection that the providers had very little oversight into the running and the quality of the service provided because there were no checks or systems in place for this.

Consequently, the provider remains in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The inspection we carried out in July 2015 identified that the systems in place for monitoring the service were ineffective. Further to our findings in this home during this inspection and our inspection in August 2016, the provider has not made and sustained improvements in this area and is therefore rated as inadequate in this area.

We received mixed feedback about whether people felt involved in the running of the home. One person told us, "I think communication could be improved, it is to what detail we are informed, It is after all peoples' home. I think they are striving to improve but it would be nice to see the goals of the organisation and plans of how they intend to get there. Also we don't have a lot of say in what we like to do." A relative also told us, "We would like to go to [relative's meetings] but we have not been informed of any." There were surveys which gained feedback from family members and we saw that most of the recent feedback about people's care was positive.

All staff we spoke with said they worked well as a team, with one giving us an example of how they worked effectively with the team on duty to effectively deal with an emergency. There was a positive atmosphere in the home and we observed that the staff team worked well, communicating well with each other to ensure that people's needs were met as far as possible.

The registered manager was visible within the three units of the home that were currently being used. One person told us, "I have seen the new manager quite a lot. He comes round to check on things." A member of staff confirmed that the registered manager visited the unit daily. We observed that the registered manager had warm interactions with people living in the home and made an effort to get to know people. They also encouraged staff to approach them if they needed to communicate anything to them. Staff had regular meetings where they could discuss any concerns and keep informed about the running of the home. We saw that they had discussed important aspects of care provision within these meetings.

The home had some links to the local community and was involved in a research project working on improving care with regards to falls with the local university. The home had also kept close links with a local church. They had also recently held an event where they invited some local young people into the home to carry out supervised activities with people.

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 11 HSCA RA Regulations 2014 Need for consent Best interests decisions were not always made in line with legislation. DoLS conditions were not adhered to and MCAs were not completed in enough detail. MCAs were not reviewed.

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	Nursing staff had not always recorded and reassessed pressure areas consistently to ensure ongoing risk assessment and appropriate treatment

The enforcement action we took:

NoP to Impose positive conditions

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	The systems in place for monitoring the service were ineffective because no action was taken where concerns identified. The provider had limited oversight of the service.

The enforcement action we took:

NoP to Impose positive conditions