1st Care Limited

Acorn Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

The inspection took place on 13 February and 4 March 2015 and was unannounced.

At the last inspection on April 2014 we found the provider was meeting all the requirements of the regulations we inspected.

The Acorns is a 22 bed nursing home supporting people with dementia including working age dementia. At the time of our inspection 22 people were living there.

The registered manager resigned after the first day of our inspection and a new manager had been appointed when we returned to complete the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People that could tell us told us that they felt safe living at the home. Staff that we spoke with understood their responsibilities to protect people from harm and abuse. We found that the providers systems and processes had not ensured that risks were identified and that people were protected from the risk of harm.

Summary of findings

People had not always received their medicines as prescribed and appropriate medicine records had not always been maintained.

Staff had a limited understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. We found that the provider was not meeting the requirements of this legislation which serves to protect people's human rights.

Staff were caring and had some understanding of the needs of the people they were supporting. Staff had not received on- going training and supervision so that they had the knowledge and skills needed to meet people's needs.

People told us they could speak to staff and the manager if they needed to. We found that the provider did not have robust systems in place to ensure that concerns and complaints would be listened to and addressed quickly.

We found poor leadership. Systems in place to monitor the service had not been effective and failed to identify the failings that our inspection identified. We identified multiple breaches in the regulations. The action we told the provider to take can be seen at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People were not protected from the risk of harm and abuse.

Risks to people were not always identified and acted upon to prevent the risk of harm to people. People had not always received their medicines in a way that they had been prescribed.

Inadequate

Is the service effective?
The service was not effective.

Arrangements were not in place to ensure the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were understood and followed.

Staff had not received all the training and support they needed to carry out their role effectively.

Inadequate

Is the service caring?
The service was not always caring.

Staff were caring towards people but sometime their practice did not ensure people's privacy and dignity was respected.

People were involved in some discussions about their care but this was not always consistent.

Requires improvement

Is the service responsive?
The service was not always responsive.

People could speak with staff if they needed, however arrangements in place did not ensure that concerns were always listened to and dealt with robustly.

Requires improvement

Is the service well-led?
Staff had not been supported and supervised in a way that promoted a positive culture.

The home had not been well led. Systems in place to monitor the home had not identified failings which impacted on people's wellbeing.

Inadequate

Acorn 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 Act2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We received whistle blowing concerns in November 2014 and we shared this information with the local authority (responsible for monitoring the quality and funding many of the placements at the home) who visited the home in December 2014. In January 2015 we received additional whistleblowing concerns so we brought forward our inspection of this service.

The inspection took place on 13 February and 4 March 2015. Both days of our inspection were unannounced. On the first day of our inspection the inspection team included two inspectors 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 service. On the second day of our inspection the inspection team included two inspectors, including a pharmacist inspector.

We reviewed all of the information we held about the home. This included statutory notifications received from the provider about deaths, accidents and safeguarding alerts. A notification is information about important events which the provider is required to send us by law.

We spoke with ten people that lived at the home. We were unable to speak with some people due to their limited verbal communication so we also spent time observing people's care in the communal areas of the home.

We spoke with nine staff members including care staff, nurses, the provider's representative, the registered manager and the provider. We looked at five people's care records and other records that related to people's care to see if they were accurate and up to date. We also looked at medication records, staff employment records, staff training records, and quality assurance audits, complaints and incident and accident records.

Inadequate

Is the service safe?

Our findings

All staff spoken with knew about the different types of abuse. Staff told us if they had concerns then they would pass this information on to the nurse on duty or the manager. One member of staff said, "I have not seen anything that is abusive." Staff knew the different agencies that they could report concerns to should they feel the provider was not taking the appropriate action to keep people safe. Some staff spoken with on the first day of our inspection told us that they were not confident that the manager would respond appropriately to concerns they raised.

We saw from talking to people and staff and looking at records that the provider had not always followed safeguarding procedures where safeguarding incidents had taken place. They had not always notified the local authority and us of these events. In addition the provider had not learnt from incidents that had happened in the home and had not taken remedial action to protect people from the risk of harm. Arrangements in place had not ensured that people were protected from the risk of abuse. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at eight medicine administration records and found that people's medical conditions were not always being treated appropriately by the use of their medicines. For example we found that staff initials were missing from the administration record so we were unable to establish if the medicines had been administered. When auditing the medicines administration records we found they were not able to evidence that people had received some of their medicines as prescribed. We found administration errors had taken place with a person's blood thinning medicine. We also found the medicines administration records were not able to evidence that a person had received their inhaled medicine as prescribed.

We looked at the disposal records for medicines that were no longer required by people using the service. The records could not evidence that these unwanted medicines were being disposed of safely. We found that the information available to the staff for the administration of when required medicines was not always robust enough to ensure that the medicines were given in a timely and consistent way by the nurses.

Medicines were not being stored correctly so they would be effective. For example, the fridge temperature records showed that the fridge temperature had dropped below the minimum temperature and no action had been taken to ensure the safety of the insulin being stored in there.

We found that where people wished to chew their tablets prior to swallowing the service must ensure that these wishes do not place the person concerned at risk. We found people who were chewing their tablets were chewing medicines that on the label clearly stated "Swallow whole. Do not chew or crush". Arrangements in place did not ensure that people could be confident that they received their medication safely. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff spoken with knew some of the risks to people's safety and the actions they needed to take to manage this risk. However, they had not always received the information they needed, the support from the manager and the equipment to ensure that risks to people were well managed. For example, people who needed support to move did not have all the equipment in place to ensure this would be done safely. We saw staff support a person to move by lifting them under the arm which places the person and staff at risk of harm. We asked staff about what risks they needed to know about in relation to a person who had recently moved into the home. They were not able to tell us about some specific risks that the manager had told us about. We saw potential ligature points in a person's bedroom who was at risk of self-harm. Staff told us and we saw records of repeated incidents between people living at the home and there were no evidence that steps had been taken to minimise the risk of reoccurrence. We saw from looking at people's care records that known risk to people had not always been assessed so staff did not have all the information they needed to minimise risks.

We asked staff what action they took if there was an incident and a staff member was injured. They told us that they would report the incident to the nurse in charge or the manager and they would record the information on an incident form. A staff member told us, "I would tell the manager but an injury to staff would not always be recorded. We never received feedback following an incident or if we were injured". We asked to see the accident records that provider are required to keep of staff accidents and injuries however these could not be found.

Inadequate

Is the service safe?

We saw that accident and incidents that had been recorded on loose sheets were not analysed so that steps could be put in place to minimise the risk of a reoccurrence.

Staff gave us examples of how they would manage different incidents. They told us what they would do in the event of a fire and this included needing a key to open the front door of the building. Some staff were unsure how they would support specific people in the event of a fire, for example a person who was reluctant to leave their bedroom. Records showed that over half the staff had not completed fire safety training and first aid training. There were no individual plans in place to inform staff how to support people safely in the event of a fire. This showed that staff did not have all the knowledge and skills needed to ensure people would be supported safely in an emergency situation.

One person told us, “There seems to be enough staff on duty but there are quite a few temporary staff and I just get used to their strange faces and they disappear”. Most staff that we spoke with told us that things had been difficult because of the high turnover of staff particularly nursing staff. The provider told us that there had been a staff turnover of over 30 percent in the last six months. We were told that the employment of nurses was a particular problem and half of all shifts were being covered by agency staff. We saw adequate numbers of staff available to support people during our inspection. On the second day of our inspection the new manager confirmed that some progress had been made on recruitment so that a stable staff team would be provided. The provider told us that there had been no system in place to determine staffing levels.

All staff spoken with told us that employment checks were carried out before they started to work at the home. These included a police check and references so that the provider could assess their conduct in their previous employment to determine if they were suitable to work at the home. We sampled four staff records. Two staff records showed that the date of the reference was after their start date of employment. We saw that a DBS check had identified a criminal record for a staff member. However, there was an incomplete copy of the DBS check, with only page one of the check available to see. No risk assessment had been completed to demonstrate how the risk identified through the DBS check would be managed to ensure people’s safety. This did not show that robust recruitment procedures were in place.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) sets out what must be done to protect the human rights of people who may lack mental capacity to make decisions to consent or refuse care. Some staff told us they had completed MCA training however it was a long time ago or in another job role. We saw that some staff did ask people for their consent before providing care, which showed some understanding of the legislation. However, we met people and observed incidents during our inspection that identified people should have received a mental capacity assessment or that best interest meetings should have been held for people. For example, two people had refused medical treatment however no steps had been taken to assess the persons capacity and to provide the support they made need with making these important decisions. We asked the manager what action they would be taking in respect of the one person who they had made another appointment for and they told us, "They will go anyway". Records looked at showed that almost half the staff had not received this MCA training. Arrangements in place did not ensure that suitable arrangements were in place to ask and act on people's consent. This was a breach of Regulation 11of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for permission to deprive someone of their liberty in order to keep them safe. The provider told us on the first day of our inspection that they had made an application for two people where they believed that restrictions were in place. Some staff spoken with were unable to explain the principles of DoLS. Their limited understanding of DoLS showed us that staff may not always recognise a situation that could be a restriction on people. We saw restrictions in place that had not been considered as a deprivation of liberty. For example, many people were closely supervised by staff and people had restricted access to parts of the home. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people had been identified as needing weight monitoring. We found this had not been completed as often as required. In one instance significant losses had been recorded but staff had not identified this as a potential issue of concern. For other people we noticed steady decreases in weight over several months that had been recorded but there was no evidence and staff could not tell what action they had taken, for example bringing it to the attention of the doctor or keeping records of what people had eaten. When we asked the manager about people's weight loss she told us that she was not aware of the concerns. Weight loss can be an indication that people are unwell and may require further investigation. People had not been offered this.

We asked staff how they supported people with insulin dependant diabetes. Staff told us that they would look for changes in the person and report any concerns to the nurse. We looked at a person's diabetic care plan and saw that there was no detail about what signs and symptoms staff should look for, and how the person was supported to manage their diabetes. There was no involvement of a specialist diabetic nurse. The provider's clinical lead had identified problems with the management of people's diabetes in November 2014 and advised that the care plan should be rewritten and outlined what needed to be included. The care plan had been rewritten but failed to include the information that was needed to ensure effective management of this health condition.

People who could tell us told us that they were able to see the doctor if they were unwell. Staff told us that the GP visited the home weekly. One staff member told us that they were recently concerned about the health of one person and they reported this to the manager but nothing was done. When the new manager took over the person received emergency treatment. We looked to see if people had been offered regular appointments with the optician, chiropodist and dentist. People were unable to confirm if they had been offered these appointments and from the records seen it was difficult to establish if these appointments had been offered routinely to people. We looked at the specific healthcare monitoring offered to people with diabetes. We could not see that people had received the eye care or routine diabetes monitoring appointments that is recommended to ensure the condition is well managed. This showed that people had not received the support they needed to ensure their healthcare needs were met effectively. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Staff lacked guidance and training in specific areas so they understood how to care for people effectively. For example we saw that staff did not always communicate with people in a way that showed they understood people's needs, we saw staff did not always follow safe moving and handling procedures, we saw that staff found some incidents difficult to manage and unnecessary restrictions had been put in place such as locking personal toiletries away and locking bedrooms doors to manage behaviour. This showed a lack of training and skills and knowledge about supporting people effectively. Staff training records we saw showed that almost half the staff had received no training on challenging behaviour, dementia awareness and moving and handling. On the second day of our inspection the new manager told us that they had taken steps to schedule staff training and to ensure support systems were in place so staff were supported in their role. Staff that we spoke with confirmed that improvements had been made.

We observed times when staff provided support to people who were distressed. We saw staff varied in their ability and confidence to do this. We found this area of need was not always underpinned with written guidance and staff had not all been trained in techniques to support people when they were upset or distressed.

People who could tell us told us that they could have a drink when they wanted one. We saw people had access to a drinks trolley with cold drinks. Where people needed more support we saw that staff offered people regular drinks so that they remained hydrated.

We observed the lunchtime meal on the first day of our inspection and the evening meal on the second day. We saw people being offered choices about what they would like to eat. Feedback about the food was generally positive. One person told us, "The food is okay and we get enough to eat". Where people required support staff provided one to one support and we saw that people were not rushed.

Requires improvement

Is the service caring?

Our findings

People who were able to tell us said that they were mainly happy with their care and that staff were kind. One person told us, "Staff treat me with respect and observe my dignity". Another person told us, "Staff treat me with respect and observe my dignity, although I feel that a lot of staff approach it as a job".

We spent some time in communal areas and observed the care provided to people and their interactions with staff. We saw that at times staff were respectful and spoke with people kindly. However, we also observed a staff member turn over a television channel three times with no discussion with the people who were in the lounge at the time. We were told that some of the people living in the home needed one to one support from staff throughout the day. We observed on the first day of our inspection that staff did not engage with the person, ask their consent when appropriate or reassure the person. However, on the second day of our inspection we observed that the staff member supporting was caring and kind and spoke with the person and explained what was happening and when needed they reassured the person.

People who could tell us told us that they could decide what time they went to bed and got up, what they wore. One person said, "It would be nice for the staff to approach me every now and then and ask if I want anything, it always seems to be me approaching them".

A staff member told us, "We help each other out and learn from each other about people's needs". We found that staff were not fully aware of all the care and support needs of some people who had recently moved into the home.

Two people who had lived in the home several months told us that they had been asking to see their social worker and were feeling frustrated that staff were not listening to them. On the second day of our inspection one person told us that they had now seen their social worker and they were very pleased about this. The other person told us that they were still waiting to speak to a social worker however, staff were able to tell us about the progress they had made with making sure the person's request had been acted upon.

Each person had a single occupancy room so that they had their own private space. Rooms all had locks and where people were able they had a key to their room so that they could maintain their privacy. One person showed us the key to his room and told us he locked his room so only he could go in there. However, we saw that a staff member was sat on a chair that was propping open the bedroom of the person who they were supporting, who was lying on their bed. This did not promote their privacy and dignity. We also saw staff use another person's bedroom to support a person who was upset by another person's behaviour. This did not show respect towards the person who the room belonged to.

Requires improvement

Is the service responsive?

Our findings

One person told us, "I do have discussions with staff about my care". We saw that staff responded to requests from people to help with their care. However, we also saw people sitting for long periods of time with limited or no interaction from staff.

Staffs were able to tell us some information about people's individual needs, interests and how they supported people. We saw that information in people's care records was limited and difficult to follow. There was limited information about people's preferences.

We only saw one visitor during our inspection. A social event had taken place in-between our visits and people told us that some relatives and friends had attended the event. One person told us, "My relatives are made to feel welcome when they visit".

People told us that they attended meetings to talk about what they wanted to do. A meeting took place at the time of our inspection and we were invited to join the meeting. We saw that discussions took place about volunteers to clean the outside smoking area, people were asked for feedback about meals and people were informed that new table activity equipment had been purchased and about the activities taking place the following week. Records confirmed that the meetings took place on a regular basis. However, the minutes of meetings did not always show how suggestions made by people were acted upon.

People who could tell us told us that they could take part in some activities if they wanted to. We saw that some people did some drawing and colouring. There were two staff employed with designated responsibility for supporting people with their social activities and interactions. They told us there was a programme of different activities which included arts, crafts, games, computer work. There was also a domestic kitchen where staff supported people to prepare some snacks and meals with one to one support. We saw that some people were supported to bake cakes. One person told us that they went to the local shop with a staff member to purchase ingredients and would prepare a meal that was culturally appropriate and they enjoyed doing this. On the second day of our inspection a person had been supported to go into Birmingham City Centre to buy some personal clothing items. They told us, "I have had a great day today. I feel like part of the community and not like I am in prison".

People we spoke with told us they knew how and who to complain to. One person told us," I would speak with staff about any concerns I had. I had one complaint and management and staff responded quickly and positively". "Another person told us, "I have never had to make a complaint but I would speak with staff and they will help me out. We get to air our grievances at the regular residents meetings". Staff that we spoke with told us that they did not always feel confident and able to approach the manager about the running of the home or if they did raise concerns these were not responded to. We looked at the records of complaints. We had referred a complaint to the provider to investigate in January 2015, although we had received a reply, the complaint and any learning from the provider's investigation had not been recorded in the homes records.

Inadequate

Is the service well-led?

Our findings

The registered manager resigned shortly after the first day of our inspection. A new manager was promptly appointed by the provider and was in post on the second day of our inspection. A planned changed of nominated individual had also took place between our two inspection dates.

At this inspection we found a number of breaches with the regulations. The provider had not taken action to ensure the home was operating in a way that complied with the law. The provider's representative had completed a quarterly report on the quality of the service. The reports following these visits had identified no issues. We were concerned that the providers own assessment of the service did not fully or accurately reflect the findings of our inspection.

The provider's clinical lead had completed two reports about the service in October and December 2014. These had focused on medication practice and food provision. The reports identified a number of failings and an action plan of what needed to be done was also completed. However, the findings of our inspection were that the provider had failed to act on and follow up on these actions to protect people from the risk of harm.

We looked at the procedures in place to monitor the service and to ensure the safety and wellbeing of people that lived in the home. We saw some records of internal audits and these included health and safety, care records, infection control and medicines. However, the audits had not identified the failings we found during our inspection, they had not been robust. These findings did not provide evidence that effective systems were in place to assess and monitor the quality and safety of the service. Where incidents and accidents had taken place the systems in place to monitor quality had not been used to analyse the information so that themes and trends could be identified and action taken to manage the risk to people. The systems in place had not identified that suitable and safe equipment was not available. The systems in place had not ensured that MCA and DoLS was followed. The systems in place had not identified that staff were not suitably trained and supported to carry out their role effectively. It had failed to identify that people's health risks were not managed in a way that would prevent the risk of harm. It had failed to identify that not all staff were providing care in a way that was person centred to people so that their welfare was promoted. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regular staff meetings would provide staff with an opportunity to actively contribute to the development of the service. These would also provide a baseline from which to audit and check progress against agreed actions. Staff that we spoke with told us that meetings had been infrequent and had not been effective.

People who could tell us told us that they knew who the manager was [registered manager who had left]. One person told us, "I know who the manager is I see her quite regularly in the lounge and dining room. She spends an hour on a Wednesday with residents allowing us to speak with her about any concerns we have".

Staff that we spoke with told us that there was not always a good atmosphere in the home. On the second day of our inspection all the staff that we spoke with told us that the atmosphere in the home had greatly improved and staff told us that they felt listened to and supported by the new management team. A staff member told us, "Things are really improving now in the home we are being listened to and we are getting the equipment we need to care for people properly".

On day two of our inspection we spoke with the new manager, the new nominated individual and the provider. They told us that they had taken steps to improve the service and ensure people's wellbeing and safety. This included making sure staff had the information they needed to meet people's needs and manage risks, assessing people moving and handling needs, implementing weight monitoring, providing support and training to staff to ensure they have the skills to carry out their role and implementing a structured induction for agency staff. We were also informed that they had commenced recruiting to vacant posts. This showed a commitment to improve the service and minimise the risk of harm to people.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment We found that the registered person had not protected people against the risk of abuse. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not protected people against the risk associated with the unsafe use and management of medicines. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent We found that the registered person did not have suitable arrangements in place for obtaining and acting in accordance with the consent of people. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found that the registered person did not have suitable arrangements in place for to ensure that each person is protected against the risk of receiving care or treatment that is inappropriate or unsafe. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person did not have suitable arrangements in place for to ensure that each person is protected against the risk of inappropriate or unsafe care and treatment, by not having effective systems to regularly assess and monitor the quality of the service. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person did not have suitable arrangements in place for to ensure that each person is protected against the risk of inappropriate or unsafe care and treatment, by not having effective systems to regularly assess and monitor the quality of the service. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.