GB Care Limited

Acorn Hill Nursing Home

Inspection report

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Date of inspection visit: 15, 22, and 31 December 2014
Date of publication: 01/06/2015

Ratings

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

Overall summary

This inspection took place on 15, 22 and 31 December 2014 and was unannounced. The additional visits on 22 and 31 December 2014 were carried out due to concerns raised in relation to people's safety and well-being identified during our inspection on 15 December 2014 and information of concern we received from the commissioners of the service, who fund people's care.

Acorn Hill Nursing Home provides nursing and personal care for up to 49 people. There were 39 people receiving nursing care and one person receiving personal care at the time of our visit on 15 December 2014. A number of people had complex physical and mental health needs. Some people were living with dementia and others were receiving end of life care. The service is located in Leicester and accommodation is provided over three floors.

There was a registered manager in post at the time of our 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

Summary of findings

persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, the registered manager had resigned from their post at the time of our inspection and the service was being managed by the provider's clinical lead. A new manager was due to start on the day of our inspection on 15 December 2014, however, they did not arrive for work and the provider was unable to contact them.

At our last inspection on 13 May 2014 we identified a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2010. We found that people's care and welfare needs were not always being met. We asked the provider to take action to make improvements.

At this inspection we found that improvements had not been made and significant concerns about how people's care was being planned and delivered were identified. Due to the significant concerns we identified about how people's personal and health care needs were being met at Acorn Hill, we made five safeguarding alerts to the Local Authority in order for investigations to be undertaken. In addition, prior to and during the course of our inspection, a number of other safeguarding concerns had been raised from a range of sources about the care afforded to people at the home.

There were not suitable management arrangements in place when we inspected this service and this was having a significant impact on people using the service. There were not effective systems in place to monitor the quality of the service being delivered. The provider was failing to assess risks to people's safety and well-being and people were receiving unsafe and inappropriate care as a result.

At our first visit we found significant concerns in relation to staffing levels at the service and how people's individual needs were being met. All of the people we talked with were positive about the staff who cared for them but many of them told us there were not enough staff to meet their needs. We observed people having to wait for assistance and people being left to eat without support. We found that there was an insufficient number of staff working at the service.

Staff working at the service told us that staff morale was low. They described working in a negative environment and told us that they did not feel supported in their job roles. Several staff members told us that they wished to leave their employment at the service. Staff told us that they lacked any time to spend with people and that they struggled to meet people's care needs. We observed this to be the case.

We found that, although Deprivation of Liberty Safeguards (DoLS) had been applied for appropriately at the service, some of these DoLS had expired and no action had been taken to address this. There was a lack of staff training in relation to the Mental Capacity Act 2005 despite this being relevant to the people who used the service, many of whom lacked the capacity to make decisions about their care and treatment.

We found that people were not protected from the risk and spread of infection. We saw that the home environment was dirty and on occasion people's bed linen was dirty. This was undignified for the people concerned and put them at risk of acquiring a health care associated infection.

We found records were not completed accurately and that clinical charts contained gaps and omissions. Staff told us that this was due to them not having the time to complete them. Whilst this meant that we were not able to fully establish the actual care that these people were receiving, we identified significant concerns in relation to the care and support other people received.

People's care and treatment records were inaccurate, out of date and we found that they were not being stored securely. We found shortfalls with the arrangements in place for the management of medicines.

Staff treated people with kindness and we observed positive interactions between and staff and people using the service. However, due to staffing levels at the home people's dignity was, at times, compromised. There was a lack of activities on offer and a lack of evidence about systems in place to obtain people's views about how they spent their time. People were observed to be engaged in little or no activity during our inspection.

We found that staff were not adequately trained in key areas in order to deliver safe and effective care and that training about how to support people who may experience behaviour that was challenging had not been undertaken. We identified that there had been a number of injuries sustained by staff whilst working with people at the service.

Summary of findings

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond to a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

We also found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and have taken action to protect people using the service. We will report on this action once completed.

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?

Inadequate 

The service was not safe.

People were not protected from the risk of infection and medication was not being safely managed.

Risks to people's health and well-being had not been identified, assessed and managed in an appropriate way.

There were insufficient numbers of staff available to meet the needs of people who used the service. Safeguarding concerns were raised as a result of this due to people's needs not being met.

We found that one member of staff had not been recruited safely and did not have the required checks in place.

Is the service effective?

Inadequate 

The service was not effective.

Staff were not adequately trained to deliver safe and effective care at the service.

The provider was not meeting the requirements of the Mental Capacity Act 2005 to ensure that decisions about people's care and support were made in their best interests. DoLS were not being managed lawfully at the service.

People were not adequately supported to eat and drink and this meant that people were malnourished.

Is the service caring?

Inadequate 

The service was not caring

Inadequate staffing levels meant that staff lacked the time to spend with people and, at times, people's dignity was compromised as a result of this.

There was little evidence that people were involved in the planning and delivery of their care on an on-going basis. Care was not delivered to meet each person's needs and preferences.

Is the service responsive?

Inadequate 

The service was not responsive.

People's health needs were not being monitored and responded to appropriately. Care was not being delivered and planned to ensure people's safety and well-being.

The provider's complaints policy was out of date and contained inaccurate information. People told us that they were not sure how to complain.

People had limited opportunities to pursue their hobbies and interests.

Summary of findings

Is the service well-led?

Inadequate

The service was not well-led

There was no clear management leadership at the service and staff morale was low.

There were no systems in place to monitor the quality and safety of service people received.

Records were not being kept accurately and were not up-to-date. They were not being kept securely.

Acorn Hill Nursing 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.

This inspection took place on 15, 22 and 31 December 2014 and was unannounced.

The inspection team on 15 December 2014 consisted of three inspectors, an expert by experience and a specialist advisor who was a registered nurse. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service. Our expert by experience spent time talking to people who used the service and observing how care was being delivered. Our specialist advisor had expertise in relation to tissue viability, end of life care and nutrition. They reviewed people's clinical records and reviewed how their care was being delivered to them.

On 22 and 31December 2014 two inspectors visited the service.

Prior to our inspection on 15 December 2014 we reviewed the information we held about the provider. We looked at any incidents the provider had notified us about and reviewed what had been happening at the service over the last 12 months. We also looked at the statutory notifications we had received from the provider. These are notifications the provider must send to us which inform us of deaths in the home, and any incidents that affect the health, safety and welfare of people who live at the home. We spoke with the Local Authority to seek their views on the quality of service provided. We reviewed information provided to us from the commissioners who fund the care and treatment of people using the service. We also considered the inspection history of the service. We used this information to assist us in planning and focussing our inspection.

We did not obtain a Provider Information Return for this service due to the short time scale we had to plan this inspection in response to concerns raised. A Provider Information Return 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.

During our inspection we spoke with 13 people who used the service and observed the care and support being delivered to them. We spoke with the relatives of two people using the service. We spoke with 12 staff members including the clinical lead and the provider. We also spoke with one visiting health care professional and a social worker who were at the service.

Some of the people using the service had dementia and therefore not everyone was able to tell us about their experiences. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed six people's care and treatment records including care plans, clinical charts and risk assessments. We looked at staff training, supervision and appraisal records and staff recruitment records. We also looked at records in relation to the management of the service.

Inadequate

Is the service safe?

Our findings

We looked at the care and treatment plans for six people using the service to ensure they were receiving safe care. We found that the risk assessments in place had not always been adequately completed and that the care plans did not always take into account the risks which had been identified. There was insufficient detail in some of the care plans we looked at to ensure people were safe. We found people's daily records and clinical charts contained significant gaps and it was therefore not possible to determine whether people were receiving the care and treatment they required.

People who required regular turning due to risks associated with developing sore skin were not being turned as regularly as required. For example, for one person who required two to three hourly turns, we found that on the day prior to our inspection on 15 December 2014 there was no record of them being turned at all. Risk assessments were not being regularly updated during November and December 2014 and care plans did not contain sufficient information to ensure people were safe.

At our first inspection we attempted to access the fire door on the first floor. It appeared initially that the fire door was locked, as advised by the clinical lead who was managing the home. Neither the care staff nor the clinical lead knew how to open this fire exit. The maintenance person had to assist and explain that both door handles were upside-down and had to be depressed in order to open the door. Both the person in charge of the shift and the care staff were unaware of how to open this fire door and it was unclear as to how people would have exited the building in an emergency situation. Although a fire safety check had taken place at the service on 01 October 2014 the staff and management at the home were unaware of how to evacuate the building in the event of a fire. This meant that the fire risks at the service had not been assessed and planned for to ensure people's safety and welfare.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our first visit we found the home to be dirty, unhygienic and there were offensive odours throughout. Of the five people's bedrooms we visited, all were found to be unhygienic, with bedding and curtains found to be stained and dirty. We found evidence of urine, faeces and vomit on bed linen and floor coverings. Although there were cleaning schedules in place, these were not being carried out effectively as we found equipment, furniture, carpets and linen in bedrooms and communal areas to be worn, stained and dirty. This posed an infection risk to people using the service. The most recent infection control audit we were shown during the inspection was dated 13 August 2014. This did not indicate any concerns with the cleanliness of the home. The environment of the home was not being adequately monitored for cleanliness and measures were not in place to effectively manage and control the risk of infection.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At the time of our second and third visits we found that some improvements had been made to the overall cleanliness at the home and there were more domestic staff on duty. The provider had made some improvements to the cleanliness of the home following the feedback from our first visit.

At our first visit we spoke with people using the service about the staffing levels. One person told us, "I get sore waiting to go to toilet, but the staff are lovely and they have a lot to put up with." They went on to say, "Even at night I have to wait." Staff we spoke with all expressed concerns about the number of staff on duty. One staff member said, "You can't do everything. You don't get breaks. How are we supposed to give proper care?" Another staff member said, "I wouldn't like any member of my family to come here." This staff member also commented that, as a result of the lack of staff, "The residents are suffering." A senior member of staff told us, "I feel the main issue is staffing. If staffing levels were at a level staff were comfortable with things would be a lot better." Throughout our first inspection visit we observed the staff to be very busy and they told us that they were unable to meet people's individual needs. We saw that this had resulted in people's care and support needs not being met.

During all of our visits we found there to be a lack of sufficiently trained and skilled staff deployed at the service to safely manage the risks to people using the service. People's care records we looked at were incomplete as staff told us that they lacked the time to complete them and people's needs were not being met. When we spoke with the clinical lead at our first visit they told us that staffing numbers were determined by the provider and that no tool

was used to measure the dependency levels of people using the service against the numbers of staff available. As a result of this, there were not enough staff available to provide care and support at the times people needed them. This placed people at risk of harm.

At our first visit we spoke with a senior dietician who was visiting the service to provide staff training about nutrition. The clinical lead told us that this training was cancelled on the day of our visit due to inadequate staffing levels at the service. The training was re-scheduled for 16 December 2014, however, following the inspection the dietician informed us that this training was again cancelled due to an incident at the home which required staff to deal with. Staffing arrangements were not sufficient to facilitate this training to take place. The dietician had significant concerns about the service's ability to manage people's nutritional needs safely but was unable to deliver key training due to staffing levels.

Throughout the inspection we observed that staff were not available at the times people needed them. At our first visit one person was served their lunch late at 14.35hours and this was not their preferred choice. This person was in bed and was left unsupervised to eat their meal. We observed that staff had placed this person's plate directly onto their body and they were trying to scoop food from their bed clothes as they were unable to find their plate due to their mental health condition. This person was in some distress and was calling out for assistance. As no staff were available to intervene and support this person, we made staff aware of this. The staff member we spoke with in relation to this incident told us that they were being asked to assist three people with their meals at the same time and that this was not possible for them. This person was unable to eat their meal due to a lack of staff support.

At our second visit we again observed that staff were not always available at the times that people needed them. This posed a risk to their safety. For example we observed one person in a communal area to be unsteady on their feet. There was one staff member in the communal area at this time and nine people using the service were present. The staff member, employed by an agency, was providing care to another person on a one to one basis and was therefore unable to assist the person who was unsteady on their feet. This person was at risk of falling and had to steady themselves into a chair unaided. During this visit, we found that staff continued to be rushing to respond to people's needs and we found that there continued to be insufficient staff to meet people's needs.

At our third visit we found that one person was not receiving the care and treatment they required. This was because their care plan lacked the detailed instructions for staff to ensure their care needs were being met. The clinical lead told us that this was because an agency nurse had been asked to write the care plan due to a lack of permanent nursing staff employed at the service. The agency nurse had not been familiar with this person's specific care and support needs. We discussed these issues with the provider and their clinical lead at the time of our third visit.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at how medicines were managed at the service. At our first visit we observed that the medication trolley was left unlocked and unattended on several occasions as staff were distracted and trying to attend to people's needs whilst administering medication. This put people at risk as medication for people was left unattended in communal areas of the home.

Staff administering the medication told us it was difficult to manage the process safely, without interruptions. They said that this was due to the numbers of staff on duty and the needs of people using the service. One nurse told us, "You don't have an uninterrupted medicines round. I feel that if there was more staff, particularly around meal times it would work a lot better." We observed this staff member being asked to assist with people's care and nursing needs whilst undertaking a medicines round and as a consequence were unable to safely administer medication to people using the service.

We saw that controlled drugs were stored correctly in a fixed, locked container. These are medicines that are required to be stored and administered under special conditions. Controlled drugs were recorded in a register. We found that the stock level for one controlled drug was not accurate. We made the registered nurse on duty aware of this during our inspection. They were not able to give an explanation as to why this was during our visit.

Inadequate

Is the service safe?

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.

The home had an appropriate fridge to store drugs that required to be kept cool. This was locked, the drugs were stored correctly and the fridge's temperature had been properly and regularly recorded.

We looked at staff recruitment records to see if the provider had recruited new staff safely. We found that, in most cases, the required checks had been carried out on staff prior to them starting work at the service. However, we found one nurse to be working at the service without the required employment history or references in place. The provider had failed to ensure this person was safe to work with people who used the service as they had not obtained a full employment history or references from the relevant employers.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to the significant concerns we identified about how people's personal and health care needs were being met at Acorn Hill, we made five safeguarding alerts to the Local Authority in order for investigations to be undertaken. In addition, during the course of our inspection, a number of other safeguarding concerns had been raised from a range of sources about the care afforded to people at the home.

We spoke with people using the service during our inspection and asked them whether they felt safe living at the home. One person told us, "We are and do feel safe here, it is not too bad." Another commented that, "All staff seem to be thinly spread but they do take care of me."

Staff had received training in safeguarding and knew how to report abuse.

Inadequate

Is the service effective?

Our findings

Acorn Hill specialises in the care of people living with dementia so we looked at how staff were trained to meet the needs of this group of people. Training provided included 'Dementia', 'NAPPI' (Non-Abusive Psychological and Physical Intervention) and 'Managing Challenging Behaviour'. Records showed that less than half of the staff team had undertaken training in 'Dementia', and less than a quarter had undertaken training in 'NAPPI' and 'Managing Challenging Behaviour.' There were a large number of incidents reported at the service which involved injuries sustained by staff from people using the service. We did not find that staff were trained in dealing with this effectively. We also noted there had been limited training provided in other key areas, for example nutrition, end of life care, and tissue viability. These are areas in which we identified shortfalls in people's care throughout our inspection.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed staff training with the clinical lead at the home, who had recently been put in charge of staff training. They said they were aware that improvements were needed, and were in the process of reviewing all staff training. They said some staff had already attended one training session in nutrition, and a further one was planned. They also said they were in the process of sourcing training in dementia and end of life care.

The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards set out the requirements to ensure where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. This includes restrictions on people's freedom if this has been assessed as being in a person's best interests. The clinical lead told us that in the last 12 months, staff had made 14 applications to the local authority DoLS team to deprive people of their liberty. We checked the records of four of these people and found that two of them had up-to-date DoLS authorisations in place. However, the other people's authorisations had expired, even though they continued to be deprived of their liberty. This meant the provider was not complying with the MCA and we could not be sure that people's liberty was being lawfully restricted. Training records showed that staff had not undertaken training about the Mental Capacity Act 2005, and less than a quarter had undertaken training about the Deprivation of Liberty Safeguards (DoLS), despite this legislation being relevant to the people who used the service.

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.

We spoke with people using the service about the meals provided at the home. Two people told us that they were not given much to eat and said "We do not starve, but there's not a lot of food." Another person said, "I do get food, late or not."

During our inspection we spoke with a senior dietician who was working with the provider in order to improve people's nutrition. The dietician told us that they had significant concerns about people's nutritional needs not being met at the service. The dietician reported six people at the service to be malnourished. The dietician reported to us that they had serious concerns about the service failing to monitor people's weights and nutritional risk. Nutritional risk assessments did not include accurate weights for people and nutritional charts indicated that people were not receiving sufficient quantities of food and drink.

We found that the service was failing to monitor people's weight and when we asked for people's weight records for 2014 we were told by the clinical lead that these were unavailable due to them not being carried out accurately.

During our first visit we observed the care and support people received at lunchtime . We saw that people who were able to sit in the dining room were assisted to eat their meals where required. We found that people were given a choice of meals. However, the eight people who were being nursed in bed were served their food late. We found that one person who had not received staff support to eat their meal in a timely manner had lost a significant amount of weight over recent months and had been referred to the dietician. We raised this concern with the clinical lead who told us that the lack of support for this person was due to staffing levels at the home at that time. As a result of a lack of support and monitoring, people were

Inadequate

Is the service effective?

not protected from the risks of inadequate nutrition and dehydration. Following the inspection the provider sent us information about actions taken to improve the support people received at meal times.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that referrals were made to relevant health professionals when an issue with a person's health was identified by the service. We found the referrals had been made, for example, to the tissue viability nurse and the dietician. However, we found that people's skin integrity was not being effectively monitored due to failings with documentation in place in relation to people's health and care needs. The service was failing to identify and monitor risks to people's health and welfare and there was a reliance on health professionals coming into the service to do this for them.

Inadequate

Is the service caring?

Our findings

We spoke with staff about how they ensured people's dignity whilst delivering care at the service. They all expressed concerns about the number of staff on duty and the impact that this had on the quality of care people received. We found that, at times, the staffing levels at the service were having an impact on people's dignity as the lack of staff support meant that people's needs were not being met and their dignity was not promoted.

We saw that some people looked unkempt in their appearance with unwashed hair. One person had faeces on their hands and fingernails. We asked a member of staff about this. They told us this person would be having a bath or a shower later that day. This person's care plan identified that they should have a bath or shower twice a week however care records showed that this was not the case. This meant that people's dignity was being compromised and that their personal hygiene needs were not being met at the service.

There were other instances when we found that people's dignity was being compromised at the service due to staff failing to adequately meet their needs. At out second visit we observed that one person was wearing a skirt which did not fit them properly. This person was very unsteady on their feet and their skirt fell off them a number of times exposing their continence pad. Whilst we observed, no staff intervened and repositioned this person's clothing in order to maintain their dignity. We also saw a similar example at our third visit when a person was leaving the toilet with a staff member. Again we had to point this out before action was taken to maintain this person's dignity.

Staff told us that all personal care and support was delivered by two members of staff. This approach did not focus on the person and their individual needs. While some people would require two people to support them other people may only require and prefer one. The service was not consistently ensuring care and treatment was delivered which met people's preferences, respected people's privacy and maintained their dignity.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the shortfalls we found during our inspection, people we spoke with told us that staff were kind to them and that they treated them with respect. One person said, "Not bad staff, they are polite and nice and I do my own personal care."

We observed staff speaking kindly and respectfully to people who used the service during our inspection. One member of staff warmly greeted each person as they came into the lounge area and offered people an activity to take part in. We saw a staff member engaging people in reminiscence using a book about Leicester years ago. People were relaxed speaking to staff and asking them for assistance. We spoke with a member of staff about protecting people's privacy and dignity. They told us they always used signage to alert other staff that personal care was being delivered so that privacy could be protected. They said that people were shown choices of clothes and encouraged to choose for themselves. We spoke with people about how they spent their time at the service. Some people described being given choices and being able to remain independent. One person told us, "We love going outside, but have not been recently and like to watch the animals."

We saw some evidence that people's personal preferences were respected by staff at the service but this was not consistent throughout our inspection.

We spoke with staff about how they got to know people's individual preferences and needs. They told us that information was recorded in each person's care records. There was also a verbal handover of information between each shift. We looked at care records for six people who used the service. Some people had information recorded about their life history and the things that were important to them but some people did not. This meant that staff would not get to know the person if they were not able to verbally express their preferences. Care plans did not provide the detail staff required to meet people's individual needs or to take account of their individual preferences. As there was a number of agency staff working at the service during our inspection this lack of information about people's preferences and care needs impacted on the quality of care they were receiving. Care was not being delivered to meet each person's individual needs and preferences and we found that staff were focussed on undertaking care tasks rather than delivering care in a person focussed way.

Inadequate

Is the service responsive?

Our findings

At our inspection on 13 May 2014 we found that the service was failing to ensure people received care which met their individual needs.

The provider sent us an action plan outlining how they would make improvements.

At this inspection we found that improvements had not been made. We found further significant concerns about the way in which people's care was planned and delivered.

Effective systems were not in place to ensure that people received personalised care that was responsive to their individual needs. We found some care plans which had not been reviewed for a number of months, despite changes in people's care needs. It was therefore not possible to determine whether people were receiving the care and treatment they required.

At our first visit we spoke with a social worker who was visiting a person at the service. We observed the care records for the person they were visiting to be in a state of disarray. We made a further safeguarding referral to the local authority due to the concerns we had about this person's care. Care and treatment was not being delivered to ensure this person's safety and welfare.

At our third visit we found that one person was not receiving the care and treatment they required to meet their complex health care needs. We found that their care plan lacked the detail to ensure their care needs were being met. An assessor from the Clinical Commissioning Group visiting this person to carry out an assessment of their needs at the time of our visit told us that they was unable to continue with this assessment due to the lack of detail and clarity in this person's care notes. We discussed these issues with the provider and the provider's clinical lead during this visit. Care and treatment could not be appropriately delivered to this person due to their needs not being assessed and documented by the service.

This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's complaint's procedure was displayed in the entrance hall. We saw that information included within it was incorrect. For example the contact details of the Local Authority were incorrect and it gave instructions for people to contact us to investigate their complaints if they wished. People we spoke with told us that whilst they would feel comfortable complaining, they were not always sure how they would do this.

We observed people in the communal lounges. Many of the people we observed were asleep or engaged in very little activity. We observed people sitting for periods of time with little or no stimulation. However, we did observe some positive interactions from staff.

Inadequate

Is the service well-led?

Our findings

Prior to our inspection a number of concerns had been raised with us about the management of the service and the lack of quality assurance systems in place. These concerns had been raised by both the Local Authority and the Clinical Commissioning Group. They told us that they had significant concerns about how people's health and personal care needs were being met as a result of lack of leadership and management at the home.

At the time of our inspection the registered manager had recently resigned from their position at the home. On the day of our first visit a new manager who had been recruited by the provider was due to commence their employment at the service. However, this person did not arrive for work that day and nobody at the service was able to get in touch with them. We were subsequently informed that this person would not be coming to work at Acorn Hill. The home was being managed by the clinical lead at the service with support from the deputy manager. There was an expectation that both of these undertook nursing duties as part of the staff team, in addition to their managerial roles. During our second visit we observed the nursing staff to be extremely busy and unable to fully meet the needs of people using the service. This included the deputy manager who did not have time to undertake managerial tasks. The provider had not ensured that suitable leadership or management cover was in place in the absence of a registered manager.

We spoke with the clinical lead during our first visit and they told us they were, "Managing the situation." Staff told us that morale was low and we found the service to be disorganised with staff rushing from person to person. We observed call bells to be going off constantly and the home to be dirty and unhygienic. At our second visit we again found the service to be disorganised and chaotic. At this time the provider had appointed a consultancy firm to try and assist them with the running of the home at that time. Staff were still observed to be rushing from person to person and there remained no clear leadership within the home.

The provider was failing to identify, assess and manage people's needs and risks. These serious failing had not been identified or addressed prior to, or during our visits to the service. Staff we spoke with at our first visit told us that staff morale was low and that they were not being sufficiently supported to carry out their roles. One member of staff told us, "Sometimes we can't get people out of bed. It's affecting the carers because we are getting really stressed." Another care worker said, "Everybody wants to leave, including myself. The way we are spoken to is not good. Staff don't know if they are coming or going. Some days it's absolutely manic." We observed instructions being shouted to staff within the corridors of the service by the management on duty and found no clear structure in place as to who was responsible for what tasks. As a result of this we found that people's individual needs were not being met.

At our second visit we spoke with staff including the registered nurses on duty, the clinical lead and the care staff. All of the staff spoken with expressed concerns about their ability to do their jobs effectively and to meet the needs of people who used the service. They told us that this was because there were not enough staff on duty and that they were not supported in their job roles. We observed staffing levels having a direct impact on people using the service and that this meant people's needs were not being met.

There was no evidence that the provider had suitable monitoring procedures in place to identify, assess and manage the risks to people using the service arising from the concerns relating to staffing identified above. There were no systems in place to effectively monitor the quality of care people were receiving and as a result people's needs were not being met. We spoke about our concerns relating to lack of quality monitoring at the service with the clinical lead who was managing the service at the time of our initial inspection. They told us that no tool was being used to measure staffing levels and that staff were struggling to meet people's needs at that time. The provider had failed to identify, assess and manage risks relating to the health and welfare of people using the service, particularly in relation to staffing levels and the deterioration in condition of people using the service we identified during our inspection.

We observed call bells to be activated constantly during all of our visits to the home. We observed staff struggling to respond to these in a timely manner due to staffing levels at the home. We asked the clinical lead whether call bell response times were monitored in any way. We were told that they were not and that there were no systems in place

Inadequate

Is the service well-led?

to monitor how people's needs were being responded to in relation to call bell response times. We found that call bells were not being responded to promptly and that people were being left for long periods of time.

Effective systems were not in place to ensure that risks to people were being assessed and managed. Care plans and risk assessments covering October 2014 to December 2014 were reviewed during the inspection. The inspectors found that these records had not identified changes to people's care needs and these had not been updated where appropriate. Some care plans had not been reviewed at all during this time, despite significant changes in people's care needs. Care plan audits were not taking place at the service. We found that the provider was failing to assess, monitor and manage the risks to the safety, health and welfare of people using the service.

We found the home to be dirty and unhygienic when we visited on 15 December 2014. Of the five people's bedrooms we inspected, all were found to be unhygienic, with bedding and curtains found to be stained and dirty. Although there were cleaning schedules in place, these were clearly not being carried out effectively as we found equipment, furniture, carpets and linen in bedrooms and communal areas to be worn, stained and dirty. This posed a risk of infection to people using the service. We found that there were not effective systems in place so as to identify, assess and manage risks relating to the exposure of infection as a result of an inadequate cleaning and infection control regime at the service.

We found that although incidents were being recorded at the service no analysis or review of these was being undertaken. We found a high number of staff injuries recorded at the service with 11 recorded assaults on staff over a three month period. Some of these were very serious, for example, 'punched in throat', 'head butted', 'scratched hard and skin broken'. It was not clear from the review of these records what action had been taken by the provider as a result of these incidents to protect staff. We found gaps in staff training in relation to managing challenging behaviour and caring for people with dementia. Systems were not in place to effectively manage and monitor these risks.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our first visit we found piles of people's care records in one of the communal areas of the service. These records could be accessed by anyone using the service or visitors to the service. Records were not being kept securely. At our third visit we found that again the provider was failing to keep records securely. We visited the home's new 'high dependency' unit on the first floor. In the foyer of this unit a temporary nursing station had been put in place comprising of a table and chair and a lockable filing cabinet. This area was unattended and we saw that people's records had been left open and accessible on the table. These records contained sensitive personal information about the people who used the service.

We found people's daily care records including food, fluid and turning charts were kept in a number of different locations throughout the home which did not facilitate accurate and timely recording. This was because staff we spoke with during the inspection were unable to locate the charts we needed and told us that they were unsure where they were kept. We also found that information was being recorded by a number of staff in a number of different places. Food and fluid charts were hard to locate and staff were not always clear on where this information was. This was causing confusion and staff we spoke with were unclear about what care had been delivered to which person as a result.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People were not being protected from the risks associated with the unsafe use and management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **People were not being given a choice of suitable and nutritious food and hydration, in sufficient quantities to meet people's needs. People were not supported, where necessary, for the purposes of enabling people to eat sufficient amounts for their needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People's privacy, dignity and independent was not ensured at the service.**

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 **Where people did not have the capacity to consent, the service had not acted in accordance with legal requirements**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Recruitment checks were not operated effectively.**