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Acacia Lodge - London

Inspection report

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Date of inspection visit: 12 November 2015
Date of publication: 12/01/2016

Ratings

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

Overall summary

We carried out an unannounced inspection on 12 November 2015.

At our last inspection in August 2015 we followed up on two warning notices served on the provider in June 2015 for breaches of regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to care records kept and maintained for people who used the service and management of medicines. Records were not always updated following a change in people's needs, and medicines were not managed safely. This put people at risk of receiving inappropriate or unsafe care and treatment. The provider was required to make the required improvements by 31 July 2015. We found the provider had complied with the warning notice relating to medicine management. However, although there had been some improvements to records, further improvements were required.

At the last comprehensive inspection in May 2015 this provider was placed into Special Measures by CQC. This

Summary of findings

inspection found that there was not enough improvement to take the provider out of Special Measures. CQC is now considering the appropriate regulatory response to resolve the problems we found.

The provider had appointed a new experienced manager who started with the service two weeks prior to our inspection and was in the process of applying to become the registered manager. 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 2008 and associated regulations about how the service is run.

During this comprehensive inspection on 12 November 2015 we found that the provider had made some improvements. We found medicines were managed safely. People were treated with dignity and respect by staff who were caring. The environment was safe and the provider had improved the general appearance of the home which had been recently decorated, with further improvements planned. The provider had introduced person centred care plans which documented people's personal histories and preferences for care. Staff had received recent training in areas such as, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), medicine management and dementia.

We observed some good interactions between staff and people who used the service. The provider had submitted DoLS applications for people where their liberty had been restricted, we saw evidence in people's care files that these had been authorised by the local authority. Staff told us they felt things had improved since our inspection in May 2015 and since the new manager was appointed.

People's nutritional needs were met by the service and we observed that people were given choices at mealtimes. People's risks were assessed, however duplication of records made it difficult to know what was current and up to date.

We saw improvements to the way records for people at the service were maintained, such as individual diet care plans for people with diabetes, seizure chart in place for people with epilepsy, some care delivered in accordance with people's care plans. However, we noted some inconsistencies with care records. The new manager told us that further work was required to ensure all records were up to date and relevant. This is an area she told us she will be focusing on over the next month.

We have made recommendations about how the service responds to people who may lack capacity to make decisions.

We found the provider in breaches of Regulations relating to risk assessing and quality assurance systems.

You can see what action we have asked the provider to take to address these concerns at the end 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?

Inadequate

The service was not consistently safe. We found medicines were safely stored and administered and people received their medicines as prescribed.

People's risks were assessed, however we found actions taken to mitigate risks were not always documented.

People were protected from the risk of abuse because staff knew what action to take should they suspect abuse.

Is the service effective?

Requires improvement

The service was not consistently effective. Staff received relevant training and support. Although staff had received training in the MCA, we found this was not applied to all aspects of care.

People's nutritional needs were met by the service and people were given choices at mealtimes

Is the service caring?

Good

The service was caring.

We observed that staff were caring and kind when interacting with people using the service. People were treated with dignity and respect.

Care plans included people's personal histories, but we found some care plans were incomplete.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People participated in some activities at the home, however, these were not always relevant to what people liked to do.

The service had a complaints policy in place and relatives told us that they knew what to do if they had any concerns. However, one relative felt their complaint had not been fully addressed by the service.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

There had been a number of changes to the way the service was managed and a number of managers had joined and left the service within the last six months. However, the service has since appointed a permanent manager who was making improvements to service delivery.

Although audits were in place, these were not always effective in identifying issues found on the day of our inspection, such as inconsistencies in care records.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced comprehensive inspection of the service on 12 November 2015.Our last inspection in August 2015 was carried out to check that the provider had addressed the legal requirements of warning notices served in June 2015 for breaches of regulations relating to medicines management and records for people who used the service. Prior to the August 2015 inspection we inspected the service in May 2015 and found a number of breaches of regulations.The inspection team consisted of two inspectors, including a bank inspector, inspection manager and specialist advisor in dementia care and pharmacy.

Before the inspection we reviewed information we held about the service in our records. This included information about safeguarding alerts and notifications of important events at the service. We also spoke to the local authority quality team who worked closely with the service to improve the quality of the service.

Before the inspection the provider 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.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We reviewed care records for nine people who used the service, medicines administration records (MAR), and spoke with five staff, including the new manager, the provider, senior care workers and care workers. We spoke with two relatives and a friend of people who used the service. We also spoke with two healthcare professionals

Inadequate

Is the service safe?

Our findings

People and their relatives told us that they felt safe and happy living at the home. One person told us, "I feel very safe', I like it here, I have been here for some time and I am very happy, staff are very kind."

Records showed that staff had received recent safeguarding training and knew what signs to look for if they suspected abuse. Most staff knew the external authorities to report their concerns to and said that they would report any concerns in the first instance to the team leader or manager.

We found medicines were managed safely. The medication room was clean and tidy and medicines trolleys were locked and immobilised. All medicines were stored securely. Controlled drugs were stored securely and a controlled drugs register was in place. There was evidence that the room and medicines fridge temperature were monitored and recorded regularly and both were within the recommended ranges for the safe storage of medicines. There was a system in place to order supplies of medicines and all prescribed medicines were available. Medicines no longer required were disposed of, and collected by the supplying pharmacy. We saw paperwork documenting items that had been returned.

We counted a sample of medicines in stock and checked these against medicines records, and there were no discrepancies. This assured us that people were receiving their medicines as prescribed. Medicines were supplied by a community pharmacy which also supported the home with ongoing training. Medicines were dispensed in biodose trays where appropriate and the trays were found to be tidy and clearly marked. Medicine administration records were up to date.

Medicines requiring a date of opening such as eye drops were labelled to ensure that this was not used beyond the expiry date. Protocols were in place for medicines prescribed on a 'when needed' or 'PRN' basis. We saw that the senior carer on the day of the inspection took time checking records after their medicine round to ensure people had been offered their medicine.Staff responsible for administering medicines told us they felt more confident, understood more and felt the process for medicines were safer than at our previous comprehensive inspection.

Training records showed that staff had completed training in medicine management in June 2015 and October 2015. However, the provider could not evidence that staff competency to administer medicines had been assessed. Files seen contained a statement completed by the previous manager stating staff were competent with no documentation to demonstrate how staff had been assessed.

We found the provider did not always follow their medicines policy in respect of people who regularly went on home visits. This stated that discharged medicines should be given in their original packs. On the day of our inspection we noted that medicines had been separated from the original blister packs and were given to relatives unlabelled. Staff told us that they were unaware of the home's policy. Therefore we could not be confident that people had been given their medicines as prescribed whilst on leave.

Risk assessments were in place and covered areas such as, risk of pressure sores, poor nutrition, falls and choking. One person's risk of pain was assessed which showed that risk monitoring was undertaken appropriately.

However, we noted that actions required to mitigate risks were not always recorded, for example one person's care plan detailed the risk of falls as the person got up at night. The instructions recorded were for staff to 'monitor' the person, but this did not state how the person would be monitored and the actions required to minimise the risk of a fall. For another person at risk of choking no actions were detailed as to what staff should do other than for staff to be trained in first aid. Another person who had a specific risk assessment drawn up as they were at risk of high blood pressure and high cholesterol levels did not set out actions to mitigate these risks. We also noted that some identified risks were recorded in various places within the care plan. The main risk assessment dated September 2015 for each file reviewed did not contain details of people's risks. Therefore people were put at risk of unsafe or inappropriate care because information about risks was placed in different places within the care plan and information about the actions to be taken to keep people safe were not detailed.

In addition to risks specific to the care of each individual, information about risks commonly shared by all people living at the home were included within each person's risk assessment (such as risk of general abuse). Risks

associated with evacuation requirements were not person centred. This could lead to staff not reading the information properly because some of it appeared to be general concerning all the people in the home. Instructions for how to support individuals in the event of an evacuation did not take account of individual circumstances. Following our inspection we asked the manager to provide further evidence in respect of advice provided by another regulatory body, and awaiting further information concerning this.

We found a number of inconsistencies in MUST (a tool used to calculate overall risk of malnutrition) calculations in relation to people's weight. In one example it had been recorded in August 2015 that the person's risk of malnutrition was low. In another section it showed that the person had been taken to the GP as they were not eating.. In the same month a GP referral was made in relation to poor appetite. The person's monthly care review document stated that the person had a good appetite. The new home manager confirmed that only seniors and managers would be completing and calculating the scores. When shown the MUST chart she agreed the MUST scores were inconsistent and the weight calculations were incorrect. She was able to explain how the MUST should be used. Therefore we could not be assured that people's nutritional risks were effectively monitored or the risk of malnutrition managed appropriately.

For another person we saw that although staff were aware of their health condition and risk of entering in to a coma, staff was not able to describe the signs to look for as instructed by the GP and documented in their plan of care. For another, person with complex needs and physical disability, we found no evidence that the person had been repositioned despite them using pressure relieving equipment to meet their needs. Current National Institute for Health and Care Excellence guidance states that repositioning should be encouraged for adults who have been assessed as being at risk of developing a pressure ulcer to change their position frequently and at least every six hours. For people assessed as being high risk the frequency should be at least every four hours. If they are unable to reposition themselves, offer help to do so, using appropriate equipment if needed. Document the frequency of repositioning required. This put the person at risk of developing a pressure sore. For a third person we saw that their food and fluid intakes were not monitored in line with their plan of care. Staff told us that a fluid chart was not in place despite the care plan stating that they required a fluid intake of 1.5 litres a day. Therefore people were put at risk of unsafe or inappropriate care.

We concluded the above issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed staff personnel files for two staff members who had joined the service in the last four months. We saw that these contained information to show that checks had been undertaken before staff joined the service. This included, proof of identity and address and references from previous employers. Disclosure and Barring Services (DBS) checks were kept by the administrator in a separate file which we reviewed. Following our inspection we requested information about all staff and confirmation of their DBS checks. This information showed that 19 out of 25 staff had their DBS completed in October 2015 and four staff had renewals were pending.

We observed improvements made to the general environment, this included redecoration of the communal areas and refurbishment of a ground floor toilet. Window restrictors had been fitted on the upper levels of the building and the provider had employed a handyman to carry out minor repairs to the home. We saw that pictures had been put up in various places around the home. The provider told us that this gave the home a more homely feel. However, there was a smell of urine when we entered the building and in the dining room area. This had slightly reduced in the dining room throughout the day of our visit. The provider told us that this was a temporary smell due to an incident. We saw that fire equipment was checked and serviced regularly. The fire alarm was tested at all alarm points on a scheduled basis and fire drills were carried out. We saw that the stair lift had been regularly serviced.

Requires improvement

Is the service effective?

Our findings

We saw evidence of training for 12 staff in safeguarding, infection control, Mental Capacity Act 2005, Deprivation of Liberty Safeguards, dignity and dementia. The training matrix provided to us on the day of our inspection was out of date and covered training up to July 2015. However, additional training had been completed in October 2015.

Staff told us that they had received regular supervision. Records reviewed showed that supervision and appraisals were carried out for all staff in October 2015 and for some staff supervision was previously in July 2015. The supervision policy states that supervision should take place every two months.

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 decisions made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We observed that people were able to move about the home freely and people who were mobile were able to spend time in their room as they chose. One person chose to have their own key and preferred to keep their room locked. We saw that there was a coded lock on the main door. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found applications under DoLS had been submitted and authorised and relevant documentation maintained on people's files along with a mental capacity assessment completed as part of the DoLS authorisation. Although staff had been trained in MCA/DoLS some staff did not understand about consent in relation to the MCA and best interest decisions and how this may impact on the people they cared for. The newly appointed manager was aware of the requirements related to DoLS and told us that further work was required to ensure that mental capacity assessments were in place for all aspects of care and additional practical training for staff.

Care files reviewed showed little evidence that people, or their representatives, had provided informed consent about their care. We saw that many people had signed to give permission for their photographs to be used within their care plans, but most had not signed their care plan. Where people, or their representatives had signed, it was unclear whether they had been involved in the drawing up of the plan or where simply agreeing to it. On the day of our visit we saw staff asking relatives to sign these plans. One relative we spoke with had refused as they felt they were being hurried to sign and had not had the opportunity to read the plan. The relative later told us that they had not been involved in the discussions which led to the formation of the plan. Therefore we could not be assured that people's relatives were always involved in their plan of care.

We observed a staff member administering medicines approached a person without explaining what they were about to do and in front of other people using the service and applied eye drops without any warning. Following our visit the manager told us that the person was aware as this was explained to them before they entered the dining room. The manager said that the staff member should have explained this again to the person before administering the eye drops.

People had their nutritional needs met. The food was of high quality and well presented. The chef was aware of people's preferences and special dietary requirements, including sugar free jam and cakes served to people with diabetes. We saw that the food was served hot and people with a need for pureed food had this well presented. We saw that people had jugs of water in their rooms and were provided with snacks mid-morning and in the afternoon. We noted limited space available for people to be seated during lunchtime. The chef told us that this was due to the number of people living at the home, however, they also had use of another area on the first floor should this be necessary.

We observed people being offered a choice during breakfast. We saw that there were pictorial menus on each table. At lunchtime we saw that the tables were set with table cloths, cutlery and various sauces. Throughout this time people were also offered drinks. We saw staff asking people whether they wanted sugar on their cereals before adding sugar and asking people how much milk they wanted. For example one member of staff poured milk slowly saying to the person 'say when, when it's enough.'

Requires improvement

Is the service effective?

Sandwiches for people with diabetes had been prepared using low sugar jams. We saw that these had been prepared using white and brown bread taking account of people's preferences which the chef was aware of. People were offered bibs if they wanted to use these. These were taken from a drawer containing freshly laundered bibs. Staff told us that all bibs were returned to the laundry after each meal.

We saw that one person who was a diabetic had an individualised diet support care plan which stated that they should be provided with a well-balanced and sugar free diet. This information was also available to the chef who had the information in the kitchen. The chef was able to describe people's dietary requirements, including recommendations from the speech and language therapist relating to the texture to be presented.

The care plan stated that this person preferred their breakfast in their room and on the day of our inspection staff were seen supporting the person in accordance with their care plan. The care plan also recorded that the person should have yearly eye examinations relating to diabetes management, we found this had been completed in March 2015 and a further check had been booked for April 2016.

We saw evidence of letters and recommendations from healthcare professionals, such as the speech and language therapist for people with swallowing difficulties. Files contained records of visits from GP, dentist and opticians. For example we saw records about appointments for eye care for one person and care of a shoulder fracture for another. This showed that people saw the health care professions they needed to in a timely manner. This was confirmed by healthcare professionals who told us that staff contacted them if they had concerns about people's health. One person who was seen by the occupational therapist (OT) to prevent stiffness in one hand required regular exercise to prevent stiffness. We asked staff about this and they confirmed that the OT guidance was not being followed. Although we observed this person receiving exercise from the activities coordinator, we did not see any evidence in daily records reviewed between September 2015 and November 2015 that this activity had taken place. The provider showed us a copy of the guidance, however there was no record of the OT visits in the care plan or communication diary. Therefore we could not be confident that the service always acted on recommendations from healthcare professionals.

We recommend that the service finds out more about current best practice, in relation to staff working with people who lack capacity to make decisions.

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Good

Is the service caring?

Our findings

One person told us, “I like being here. I like having people around me. Staff are kind.” Another person told us, “I like it here, and I am well looked after.” A relative said, “The home is good. Dad seems comfortable and he is well looked after.”

Care plans showed that an assessment of needs had been undertaken which informed the development of care plans. The care plans started with a pen picture about each person clearly setting out their personal history and background, family connections, careers and interests. These were well-written and provided an excellent overview of the each person. They assisted carers in appreciating each person as an individual and promoted meaningful staff interaction and engagement with people living at home. One relative confirmed that they had been asked about their relative’s history and involved in developing this.

People were treated with dignity and respect. We observed some good interactions throughout the day which demonstrated that staff were kind and treated people with consideration and respect. People seemed to be comfortable with staff. One care worker had learned a few words of two or three of the native languages spoken by people in the home.

Care plans reviewed provided a good level of information and detail about people's preferences and how they needed to be supported. Information about the times people usually woke and got up and details of their morning routine were set out. For example one care plan advised staff to offer the person a hot drink when they woke at seven, stated the person’s preference for a male carer and their need of just one member of staff for help with personal care except when bathing where two staff were needed . Another care plan noted the person’s need of their glasses and support with their dental care. Whilst some people’s care plans gave information about how people communicated, others did not provide sufficient detail for staff about this. For example one file stated ‘staff to communicate with the person in his preferred way.’ There was no information about what the preferred way was. Therefore, this person may receive care which was not suited for their needs.

We saw that some staff had signed to say that they had read the care plan although it was not clear if all staff were required to read each plan. The staff we spoke to said they had access to the care plans and took time to read them where possible.

Requires improvement

Is the service responsive?

Our findings

People's interests and hobbies were noted in their care plans. For example we saw that one person liked classical music and reading, another had liked to knit and sew. Care plans indicated that one to one activities for some people in their rooms should be provided. One person's care plan stated specifically that the person needed to be engaged in stimulating indoor and outdoor activities. The activities coordinator worked each afternoon Monday to Friday. We saw that the home had a weekly activities programme displayed on a notice board situated in the dining room, although this did not reflect people's specific interests detailed in their care plan. This included activities such as, ball games, singalong to music, bingo and afternoon tea.

On the day of our inspection we saw the activities coordinator encouraged people sitting in the dining room through movements and coordination using a ball and was able to engage some people in this activity. We later saw the ball being used in the lounge with three people who lived at the home. Music was being played in the afternoon in the dining room after lunch which was used to encourage people to reminisce and to sing. We saw the activities coordinator and other staff engaged people living in the home in joining in by clapping their hands. One person who was able to get up, danced a little with the activities coordinator. A newspaper session was also held in the afternoon. This consisted of giving each person a copy of a newspaper to read. Some people given a newspaper were not able to engage with this activity. We asked the activities coordinator about the provision of one-to-one support to people in their own rooms. The activities coordinator was able to tell us about people who stayed in their rooms and the time that was spent with them. We did see the activities coordinator spending time with one person on a one-to-one basis in the lounge, encouraging them to maintain the movement they had in one arm through the squeezing of a small ball. However, we saw that some people were left for long periods of time seated in the dining room area without any stimulation. We spoke with the new manager who told us that she would be addressing this with staff and she felt that it was important for staff to encourage people to move around and take part in activities.

We saw that relatives and friends were able to visit the home at any time and to take people out. We saw one person going out to lunch with their friend. The person told us they often did this and enjoyed going to lunch and meeting up with people from their community. We saw that relatives spent time with people either in their rooms or in the lounge or other areas available in the home. People had access to the conservatory and in good weather they were able to use the communal garden. One person using the service told us that they used the garden when the weather was good.

We saw the service was responsive to some people's needs, For example, we saw that one person's care plan recorded they liked to have breakfast served in their room and required adaptive cutlery all of which was in place on the day of the inspection. The carer taking the person their breakfast was seen to be supportive and respectful. Healthcare professionals told us that they felt the service was responsive.

We saw that there was a complaints policy displayed in the main reception area. The provider told us that they had not received any complaints in the last 12 months. Relatives told us that they knew what to do if they had any concerns.

Requires improvement

Is the service well-led?

Our findings

The provider and the newly appointed manager told us that they were working on improvements to the service and had already implemented a number of these. The newly appointed manager was a dignity champion and was planning to develop senior staff to become dignity champions for the service.

The provider told us that they had been working closely with the local authority quality improvement team. This was also documented in the provider's PIR which stated that managers had been working alongside the local authority quality team to improve the running of the home. When we asked the new manager what they thought was special about the service, she told us that the size of the home and atmosphere. She also said that people feel at home, comfortable and there is a good relationship between staff and people using the service.

The service had experienced some instability in the last six months. The registered manager was absent for a long period of time and there had not been a registered manager managing the service since September 2014. This had led to a lack of leadership. There had been several changes which contributed to some of the issues relating to record management with various managers implementing different systems.

We saw evidence of monthly staff meetings for September 2015 and October 2015, but noted that these were brief and focused on information to be cascaded to staff. Staff confirmed that they had attended team meetings. Staff told us that there had been improvements since the new manager joined the service and healthcare professionals were positive about the new manager's approach.

We reviewed the action plan and saw that the service had taken action to address issues raised at the last comprehensive inspection. These included staff supervision and appraisals, the safety of the environment, people treated with dignity and respect and the way medicines were managed.

We saw that environmental monthly audits took place and involved a walk-through of relevant areas noting actions needed, for example, decorating. We saw that there had been improvements were made, such as redecoration of communal areas and refurbishment work to a downstairs toilet. The provider told us that further improvements were planned, including refurbishment of communal bathrooms.

We saw that the provider had also completed audits in areas such as care plans and the environment. We noted that the care plan audit did not provide any details of findings and was mostly a checklist of areas covered. These also failed to identify concerns found with records on the day of our inspection, as care records were not completed consistently and daily records were often unclear. For example, where staff had limited space to record information this was written along the side of the daily record sheet and in some instances not legible. Therefore these audits were not effective.

Incident and accidents records were insufficient and actions taken and outcomes were not documented, therefore we were unable to evidence any learning from these. The provider's PIR had indicated that staff would be provided with health and safety training and training in how to complete incidents and accident reports. However on the day of our inspection this training had not been completed, although staff knew what action to take in the event of an accident. The new manager told us that these were still areas for improvement.

During the inspection we were provided with a folder containing a number of policies and procedures. We noted that these policies had been purchased by the provider and had not been tailored to suit the service being provided. For example there was a restraint policy which the provider told us was not relevant to the service. The provider told us that they would be reviewing the policies and procedures to ensure that these reflected the way service is delivered by them.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered provider failed to assess the risks to the health and safety of service users of receiving care or treatment and doing all that is reasonably practicable to mitigate any such risks.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered provider failed to ensure that systems or processes were effective to assess, monitor and improve the quality and service and maintain up to date records of care and treatment provided to service users and decisions taken in relation to the care and treatment provided.**