Regency Healthcare Limited

Acorn Nursing Home

Inspection report

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04 February 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 26 January and 04 February 2016 and was unannounced. There were 29 people living at the home at the time of the inspection.

Acorn Nursing Home is a thirty-four bedded care home, which provides both residential and nursing care. The home was formerly a vicarage and it is less than one mile from Bradford City centre and close to St Luke's Hospital. The home is well served by public transport and there is adequate parking to the front of the property. Bedroom accommodation consists of both double and single rooms situated on the ground and first floor of the building.

The last inspection was carried out on 7 May 2014. At that time there were two breaches of regulations which related to the safety of the premises and the systems in place to assess and monitor the quality of the services provided. The provider sent us an action plan and assurances that the concerns about the premises had been addressed. During this inspection we checked to see if the required improvements had been made. We found the specific issues relating to the premises had been addressed. However, we found the systems for monitoring and assessing the quality and safety of the services provided had not improved. There has been a change to the regulations since the last inspection and therefore we have mapped the continued failure of the quality assurance processes to the new regulations.

There was a 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.

People who used the service and relatives did not raise any concerns about safety however we found a number of issues which led us to conclude the service was not safe. We found risks to people's safety and welfare were not always identified and managed properly. For example, we found risks to people's safety due to unlocked storage areas and uneven floor surfaces had not been acted upon until we brought them to the attention of the registered manager. We identified problems with the way the disposal of clinical waste was being managed.

We found people's medicines were not managed safely.

There were enough staff deployed to meet people's needs. However, we found the required checks were not always done before new staff started work and this meant people were at risk of being cared for by staff who were unsuitable to work with vulnerable people. We found the records of staff training and support were not properly maintained and therefore could not be assured staff had received the training and support they needed to carry out their duties effectively.

The service was not working in accordance with the requirements of the Mental Capacity Act 2005 and

therefore people's rights were not always protected.

We found people were not always treated with respect, dignity and compassion. Some of the language used by staff when speaking about people who lived at the home was not appropriate or respectful.

People were offered a varied range of food and drink and special dietary needs were catered for. However, we found the meal service was rushed and chaotic and people missed the opportunity to enjoy the social aspect of meal times. When people's dietary intake was being monitored we found the food and fluid charts were poorly completed.

We found people and their relatives were not consistently involved in making decisions about their care and treatment. Many of the care plans we looked at did not provide information about people's individual needs and preferences.

Information about the complaints procedure was not easily accessible to people and the providers procedures for dealing with complaints were out of date.

People were given the opportunity to take part in a range of social activities in the home but for most people opportunities to go out were limited.

There were systems in place which were designed to assess, monitor and improve the quality of the services provided but they were not working properly which meant that the service did not have effective governance.

Records relating to the care and treatment provided to people and relating to the day to day management of the home were not properly maintained.

We identified eight breaches of regulations. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'.

The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 told us they felt safe and staff knew how to recognise and report abuse. However, the right procedures were not always followed and this put people at risk. People were at risk because all the necessary checks were not always done before new staff started work.

Medicines were not managed safely and this meant people were at risk of receiving unsafe care and treatment.

Risks to people's health, safety and welfare were not always identified and managed properly.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's rights were not always respected because the service was not working in accordance with the requirements of the Mental Capacity Act 2005.

People were offered a varied range of food and drink which took account of their preferences and any special dietary needs. However, when people needed to have their dietary intake recorded the records were not completed properly.

Staff were supported through supervisions and appraisals and for the most part received the training they needed to help them carry out their duties effectively. However, this was not always reflected in the records.

Is the service caring?

Inadequate

The service was not caring.

Some staff were kind and caring and we observed some positive interactions. However, other staff were brusque and bossy and people were not always treated with respect, dignity and compassion.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Peoples care records did not always provide an accurate and up to date record of their individual needs and preferences. People and/or their relatives were not consistently involved in making decisions about how their care and support needs would be met.

A range of social activities were provided in the home but people had limited opportunities to take part in social activities outside of the home.

Information about the complaints procedure was not readily available to people.

Is the service well-led?

Inadequate

The service was not well led.

The systems in place to assess, monitor and improve the quality and safety of the services provided were not working well.

Risks to the health, safety and welfare of people who used the service and others were not dealt with effectively.

Acorn 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 26 January and 04 February 2016 and was unannounced.

The inspection team consisted of three 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 care service, in this case services for older people.

We asked the provider to complete 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. The PIR was not returned, the only information provided was a list of contact details. We reviewed all information we held about the provider and contacted the local authority to ask for their views on the service.

During the inspection we spoke with seven people who lived at the home and four relatives. We spoke with the registered manager, the deputy manager, one of the nursing staff, four care workers and the cook.

We observed how people were cared for and supported in the communal rooms. We used the Short Observation Framework for Inspectors, SOFI, to help us gain an understanding of the experiences of people with complex needs and limited verbal communication. We looked at six people's care records, medication records, staff files and training records and other records relating the management of the home such as maintenance records and meeting notes. We looked around the inside and outside of the home and in addition to the communal living areas we looked at bathrooms, people's bedrooms and the kitchen.

Inadequate

Is the service safe?

Our findings

Visitors we spoke with told us they felt confident that their relative was safe and well cared for.

Relatives of one person said "She's always clean and well dressed. Are there enough staff? There are quite a lot of them, but there's a lot of need. We're happy that she's safe and well cared for."

Another person's relatives said, "They're very good. Very caring: She can get very agitated and she fell out with (another resident) and started staying in her room, but we asked them to insist that she comes down to the lounge. She's in the lounge regularly now. We feel happy that she's well cared for. They really are very good. The people here could really do with one to one attention, but they'd have to have more staff for that, and it's all money isn't it?"

The staff we spoke with told us they had received training about safeguarding. They were able to give us examples of abuse and knew how to report any concern both within the organisation and to external agencies.

When reviewing the accident/incident records we saw a record of an incident on 01 January 2015 in which one person who used the service punched another person causing them to fall onto the floor. The records did not indicate this incident had been reported to the Local Authority safeguarding team. The registered manager told us they believed it had been reported. Following the inspection we checked the notifications we had received from the home and found no record of a notification about this incident. We spoke with the Local Authority safeguarding team and they told us a safeguarding alert had not been received. They told us they had a record of a similar incident involving the same two people in May 2014. Our records showed we had not been notified about the 2014 incident.

Systems and processes were not being operated effectively to make sure people were protected from abuse; this was a breach of Regulation 13(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We spoke with the registered manager regarding the procedures and practices for the handling of people's personal money. They told us no money was held at the home on behalf of people who used the service.

We looked at how people's medicines were managed. No one who lived in the home had chosen to administer their own medicines and this was recorded in their care plans. Where it appeared people may not have the mental capacity to make choices about who should administer their medicines we found no evidence of specific mental capacity assessments.

Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled medicines. At the time of our inspection a number of people were receiving controlled medicines. We inspected the contents of the controlled medicine's cabinet and controlled medicines register and found all drugs accurately recorded and accounted for.

Our scrutiny of the medication administration records (MARs) and our observations of the administration of medicines demonstrated medicines to be administered before or after food were given as prescribed.

Drug refrigerator and room temperatures were checked and recorded. However, we found medicines incorrectly stored in the fridge. For example, on one medicine the instructions stated the medicine should be stored at room temperature and on another the instructions stated, "Once opened do not refrigerate".

Our observations of the medicine round showed medicines were administered with sensitivity. We saw nursing staff spoke quietly to people when asking if they needed medicines prescribed as and when required (PRN). However, we also observed medicines on two occasions being administered with no regard for the prescriber's instructions. We were informed one person received their medicines covertly and found the correct process had not been followed.

Medicines prescribed to be taken as necessary (PRN) were not supported by written instructions which described situations and presentations where these medicines could be given. This fell short of good practice guidance and increased the risk of inconsistencies in administration. We also observed the prescribers intentions for the administration of PRN medicines were not adhered to. For example, one person was prescribed a tablet to be taken in the morning but we found it had also been administered at night between 13 and 25 January 2016.

We stock checked seven medicines which had been dispensed in individual boxes. On five occasions we found inaccuracies in accounting for medicines. For example, in the case of a medicine to be taken at night we found a new box of 28 tablets had been opened on 13 January 2016 and the MAR showed 13 had been given. However, there were 16 tablets still in the box which suggested it had not been given, but had been signed for, on one occasion. In another example, we found 14 tablets had been received on 13 January 2016, three had been signed for as given but there were only eight in stock leaving three tablets unaccounted for.

We saw one person had been prescribed an anti-biotic to be taken twice a day for seven days. The instructions stated another type of medicines, statins, should be stopped until the course of anti-biotics was completed. The MAR showed this instruction had not been followed and the statins had been given at the same time as the anti-biotics. Although a medicines audit had been carried out during this period of time the error was not identified until it was brought to the attention of the registered manager by the inspectors. On the advice of the inspectors the registered manager reported this to the Local Authority safeguarding unit.

We looked at the provider's medicines policy. The policy took account of current legislation and good practice guidance. However, as demonstrated above the policy was not being followed. The policy contained specific information to allow for the creation of a legal framework to allow medicines to be administered covertly. We found the policy had not been followed.

Medicines were not managed safely; this was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the home looked and smelled clean. We saw posters in the home advising staff about infection prevention and control measures. The posters pictorially demonstrated nails should be kept short, nail varnish not chipped, wrist and finger jewellery not to be worn and for staff to be bare below the elbows. We observed staff with long finger-nails, wrist bracelets and dress rings being worn and four members of care staff not bare below the elbow.

On the second day of the inspection we had concerns about the disposal of clinical waste. On arrival in the car park we saw the clinical waste bin was overflowing with yellow bags, it was not possible to close the bin there so many bags piled on top and therefore it was not locked. It was chained to the wall. We asked the registered manager about this and they told us several calls had been made to the contractor earlier in the week because the bin was full. The registered manager made a number of phone calls during the inspection, however, when we left at approximately 4pm the bin was still overflowing.

Appropriate action had not been taken to deal with the risk; this was a breach of Regulation 17(1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection we spoke with the infection control team at the Local Authority. They told us they had arranged to visit the service on 01 March 2016 to carry out an audit and would look at the arrangements for waste disposal. They told us the last audit had been carried out approximately two years ago and at that time the service had achieved a compliance score of 91%.

The kitchens were inspected by the Local Authority Environmental Health Department in November 2015 and given a score of 3, (Generally Satisfactory).

We completed a tour of the premises on the first day of the inspection. We looked at three people's bedrooms, bath and shower rooms and various communal living spaces. All radiators in the home were covered to protect vulnerable people from the risk of injury. We saw fire-fighting equipment was available and emergency lighting was in place. During our inspection we found all fire escapes were kept clear of obstructions. We saw upstairs windows all had opening restrictors in place. Floor coverings were of good quality and were well fitted posing no trip hazards.

However, on the second day of the inspection we observed one of the outside areas, close to a fire exit, was cluttered with furniture and other items for disposal which could have presented a hazard to anyone walking outside. We brought this to the attention of the registered manager who arranged for the maintenance person to tidy it up. On entering the home at approximately 9.30am we saw the floor in the entrance hall had been skimmed prior to a new carpet being laid. We were told this had been done overnight. However, someone had obviously walked in the wet skimming which had then dried leaving uneven edges around the footprints. This was in the main thoroughfare between the two lounges and presented a trip hazard to anyone who was unsteady or had a shuffling gait. Nothing had been done to attempt to minimise or reduce the risk until we brought it to the attention of the registered manager.

In addition, we found on both days of the inspection the door to the dining room had been left unlocked. This room was being used for storage during the refurbishment; it was full of items of furniture and other items such as ladders, on the second inspection day there were metal strips with screws protruding upwards lying on the floor. This posed a potential risk to anyone walking in there. On both days the door was locked after we brought it to the attention of the registered manager.

In the records of one person who had recently moved into the service we found the Personal Emergency Evacuation Plan (PEEP) had not been completed. The records showed the person needed help with mobility and would therefore have required help in the event of an emergency.

Appropriate action had not been taken to identify, assess and to deal with the risks to the health and safety of people who used the service and others; this was a breach of Regulation 17(1)(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

West Yorkshire Fire & Rescue Services issued an enforcement notice on the provider on 17 March 2015 and the notice was still in force at the time of the inspection. The timescale for meeting the requirements of the notice was June 2016.

We looked at a selection of maintenance records and they showed checks on equipment such as hoists and lifts were carried out in line with manufactures guidelines. We saw hot water temperatures were monitored, Legionella checks were done and portable electrical appliances were checked annually. The service had an electrical wiring certificate to show the hard wiring had been checked and was satisfactory. We saw the gas appliances had been checked and found to be in a satisfactory condition in June 2015.

The registered manager told us they did not have a staff recruitment and selection policy and procedure in place although the procedures manual referred to staff recruitment and selection policy. However, they told us as part of the recruitment process they obtained two written references and carried out Disclosure and Barring Service (DBS) checks for all staff before they commenced work. These checks identify whether staff have any convictions or cautions which may prevent them from working with vulnerable people.

We looked at the employment files for four members of staff had found the process followed was not robust and did not ensure only people suitable to work in the caring profession were employed.

For example, we were told that on occasions references were not requested by the registered manager but people were interviewed and allowed to take the reference request form with them. We saw one successful applicant had only put one referee down on their application form and this was a close friend who already worked at the service. However, we found a second reference on file which stated it had been completed by a previous work colleague. There were no contact details, or business stamp on the reference and when asked neither the registered manager or administrator knew who had sent the reference.

We found a reference had also been accepted for a second applicant which did not cross reference with the referee listed on the application form. The reference again had no contact details or business stamp. This was discussed with the registered manager and administrator who were unsure who had sent in the reference or in what capacity they knew the applicant. The registered manager told us that if they were unsure about the authenticity of references they would ask for contact details and contact the referee by telephone. However, we found no evidence this had happened in the examples above.

We saw the registered manager had started to audit the recruitment files and a list of missing documents had been placed on the front of individual recruitment files. However, all relevant information should have been received by the registered manager prior to an applicant being employed.

We saw there were job descriptions in place for all grades of staff and an employee handbook was available. The registered manager told us all new staff were employed for a six month probationary period following which they competency was assessed and if appropriate they were offered a permanent position.

We asked the registered manager about the process for checking the registration status of nursing staff. Nurses must be registered with the Nursing and Midwifery Council, (NMC). The registered manager told us this was done by the providers head office. They confirmed they had no documentary evidence to show the nurses employed in the home were currently registered with the NMC.

People were at risk because the recruitment procedures were not robust; this was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living in the home and the people's relatives did not raise any concerns about the availability of staff. Staff we spoke with told us they believed there were enough staff to meet people's needs. At the time of the inspection there was one registered nurse and six care workers on duty during the day. Overnight, there was one nurse and three care workers. In addition, there were three students on work placements. Separate staff were employed for housekeeping, catering and maintenance. The registered manager told us staffing levels were reviewed and changed to take account of people's changing needs.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager told us five people were either subject to an authorised DoLS or an application had been submitted for an authorisation or a renewal of an expired authorisation.

The care plans we looked at showed one person had a DoLS in place which was subject to three conditions. Our observations and further discussion with the registered manager showed the conditions were not being fully met. One condition required staff to support the person in their own room away from the noise and other stress factors in the rest of the home. We found the person was being taken to their room after becoming distressed and exhibiting untoward behaviour. However, another condition requiring the home to provide one-to-one support to access the community was being fully complied with.

During the morning we saw two people asking staff for cigarettes. On both occasions staff gave people six cigarettes. We enquired with the registered manager why this practice took place. On one occasion the person had a long history of a chronic respiratory condition. The person had capacity to make their own decisions and had asked staff to help them curtail their cigarette consumption. The second person was diagnosed with an illness which indicated they may be lacking in mental capacity. Staff had found the person would smoke a whole packet of cigarettes very quickly if not controlled. Whilst we agreed staff were acting in the person's best interest there was no specific mental capacity assessment to underpin the decision. The registered manager assured us they would conduct a mental capacity assessment and reflect the outcome in the care plan.

The nurse on duty told us one person was being administered their medicines covertly. We witnessed a nurse administering Clopidogrel 75 mgs during the morning medicine round. The persons care records showed there to be no credible legal framework in place to support the giving of medicines without their knowledge. The provider's medicine policy made specific reference to the giving of covert medicines quoting the document 'Managing medicines in care homes - National Institute for Health and Care Excellence (NICE) guidelines [SC1] – para. 1.15.3. Published date: March 2014'. A GP had written a letter stating the medicines could be crushed and added to water to aid swallowing the medicine. However, there was no suggestion this should be to give medicines covertly. Furthermore we observed the medicine being crushed and added to porridge rather than dissolved in water. There was no evidence that a best interest

meeting had taken place or that a pharmacist had been involved. The care plans did not record an agreed method of managing the administration of covert medicines nor was there a list of medicines approved to be administered covertly. There was no review process described or enacted. The manager assured us the correct procedure would be undertaken as soon as possible. Before we finished our inspection we saw evidence a pharmacist had been contacted which confirmed the medicine could be crushed without any harmful effects.

The service was not operating in accordance with the requirements of the Mental Capacity Act 2005; this was a breach of Regulation 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at a sample of care plans for people who we saw had bed-rails attached to their beds. Assessments of people's needs demonstrated bed rails were used only to prevent people falling out of bed or where people were anxious about doing so. We saw families had been included in discussions prior to bed-rails been used. We saw risk assessments were carried out to ensure the potential risks of using bed rails were balanced against the anticipated benefits to the user.

Nutritional risk assessments had been completed which identified if the person was at risk of fluid imbalance or malnutrition and reflected the level of support they required for eating and drinking. We saw prescribed food supplements were administered to people and staff supervised people when food supplements were consumed over a period of time. Whilst prescribed products were administered correctly we found some people were taking food supplements not prescribed for them.

We saw people's weight was monitored and when people had lost weight we saw other professionals such as GPs had been consulted. In the case of two people who had lost weight we saw they had underlying medical conditions which had contributed to their weight loss. In both cases there was evidence their GPs had been consulted about how to best support them to meet their nutritional needs.

We saw some people had food and fluid charts in place to monitor their dietary intake. However, they were not completed properly and did not give a clear picture of people's dietary intake. For example, one person's food and fluid chart for 22 January 2016 showed their total fluid intake for 24 hours was 455mls. On 21 January 2016 the total fluid intake was recorded as 430mls and on 20 January 2016 it was 235mls. In another person's records the food and fluid chart for 21 January 2016 showed a total recorded intake of 360mls, on 22 January 2016 it was 850mls and on 23 January 2016 it was 550mls. The Hydration Best Practice Toolkit for Hospitals and Healthcare published by the Royal College of Nursing and NHS National Patient Safety Agency in August 2007 recommends at a conservative estimate older adults should have a daily intake of fluids of at least 1.6 litres.

Similarly it was not possible to get a clear picture of the amount of food people had eaten because there were gaps in the records.

The food and fluid charts did not provide an accurate record of people's care and treatment; this was a breach of Regulation 17(1)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they had started to monitor the food and fluid charts on weekly basis to make sure they were being completed properly and we saw evidence of this in the records. However, there was no process in place to monitor the charts on a daily basis so that action could be taken to either encourage people to eat and drink more or to check the records were being completed correctly.

At lunch time we observed people were offered a choice of main meals. One person had curry and they told us, "I like my curry, but it's not spicy like I like it. They don't let me have too much spice because of my tummy. My tummy gets funny." The person was being supported by staff to eat, they said, "They [staff) are very good. It's good. I like it."

The food was served from a hot trolley and looked good; there were fresh vegetables and good portion sizes. Despite the fact that we found the meal service rushed people told us they enjoyed their lunch. Most people in the dining area, in the back lounge, ate independently and we saw the cook cutting up food for people so that they could maintain their independence.

People had plentiful drinks throughout the day and either biscuits or homemade cakes in the afternoon. There are also bowls of fresh fruit in various places. During the afternoon several people asked for fruit and we saw staff peeled and separated oranges for them or cut apples and served them on plates.

We spoke with the cook who had a good understanding of people's likes, dislikes and dietary needs. They told us they obtained Halal meats from a local supplier and Halal products were cooked separately. They told us how they fortified food for some people by adding cream and cheese and for people who required a diabetic diet they baked using sweetener instead of sugar.

Records showed arrangements were in place that made sure people's health needs were met. We saw evidence staff had worked with various agencies and made sure people accessed other services in case of emergencies, or when people's needs had changed. This included GPs, hospital consultants, psychiatrists, community mental health nurses, social workers, opticians and dentists.

The registered manager told us that all new staff completed induction training on employment and always shadowed a more experienced member of staff until they felt confident and competent to carry out their roles effectively and unsupervised.

We saw individual staff training and personal development needs were identified during their formal one to one supervision meetings. However, the records showed staff supervision was inconsistent. While some staff had received supervision on a regular basis others had not, for example in the files of two of the nursing staff we saw the last recorded supervisions were in November 2013 and September 2014. The registered manager told us they held regular group supervisions but this was not reflected in the records.

The registered manager provided us with a copy of the training matrix. This showed the majority of care workers were up to date with mandatory training such as moving and handling, fire safety, safeguarding, infection control and approximately 50% of them had attended training on dementia and challenging behaviour. Staff we spoke with told us they received the training they needed to carry out their roles.

The training matrix did not show what mandatory training nursing staff had undertaken. This information was in their individual staff files which meant it was not easy to locate. One of the nurses we spoke with told us they received annual updates on safe working practices and also had the opportunity to attend more specialist training on topics such as diabetes and wound healing.

However, on the first day of the inspection we were unable to find any evidence that nursing staff had undertaken recent training on the safe management of medicines. This was arranged for 29 January 2016 but this was in response to a medication error identified by the inspectors.

One person who used the service required a particular rescue medicine when they had seizures. One of the

nurses and the registered manager told us the nursing staff had been trained in the use of this medicine but there were no records to support this.

The records did not provide an accurate and up to date record of the training undertaken by staff; this was a breach of Regulation 17(1)(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

We observed many of the staff were very caring and pleasant and spoke kindly to people living in the home. These staff were attentive and alert to people becoming agitated and tried to divert them to different topics or take them somewhere where they felt calmer and happier. However, we observed some were brusque and bossy.

The registered manager escorted one of the inspection team to the bedroom of one person who used the service. Before leaving the bedroom the registered manager said to the person, "You've put tea in your waste bin. You shouldn't put tea in your waste bin." The registered manager took the bin away. The bin had not been returned 20 minutes later when we left the person's room. The person was anxious about where the bin was and started throwing tissues about.

At approximately 9am on the first day of the inspection we observed a person who used the service sitting in the reception area. They asked for and were given a cup of tea. We heard staff asking them to go into the lounge for breakfast; the person did not want to go into the lounge. We asked if they could have their breakfast where they were, as people were eating in both the lounges nearby. The care worker said they didn't think this was possible and the person would have to go into the lounge if they wanted breakfast. Later in the morning at approximately 10.45 we saw the person in the lounge and heard them say in a loud voice that they had not had their breakfast. Staff responded with raised voices telling the person that they had been given their breakfast. The registered manager came into the room and told the person they would have to go to their room if they did not stop shouting. The person stopped shouting and was given toast, they had been asking for a cooked breakfast.

On the same day at around 11am we spoke with a person who lived at the home. They were agitated and worried about bread; they kept asking the staff about their bread. After a few minutes a member of staff brought out toast that the person had not eaten for breakfast which had been reheated in the microwave. It was all floppy and very unappetising. The person was very upset and kept saying, "Where's my bread? This is all wet. This is disgusting, this is. I want my bread." Staff told the person it was what they hadn't eaten at breakfast. Eventually the person ate it but kept saying, "I'll get my mum and dad to get you. They'll get you."

During the lunch service we saw one person repeatedly ask to go to their room, they said they felt ill. They were sat at a dining table with a sick bowl retching. A member of staff said "He's making himself sick again." The person again asked to go to their room. Another member of staff said, "After your lunch. Have your lunch first and then we'll take you to your room." The cook intervened and said, "He's not well. If he's not well, he's not well." The person was then taken to their room.

We heard staff referring to people who needed help to eat as "the feeds", for example at breakfast one of the care workers said to another, "There is Weetabix for the feeds" and later we heard another care worker say, "The feeds are finished." We also heard staff speaking about people who lived at the home in an inappropriate way. For example, one said "She's not a very nice lady; she gets very agitated and angry. She can be very non-compliant and not nice."

We observed some staff standing over people while supporting them to eat at breakfast and lunch time.

We saw most of the cups, beakers and plates were of bright coloured plastic. We asked the cook why they were using so much plastic crockery, they didn't really know. They said there had been occasions when some people had thrown crockery and the plastic crockery had just been delivered one day. They said there were some ordinary crockery if people wanted it but most of the crockery we saw in use was plastic.

We observed the meal service at lunch time on the first day of the inspection. One of the dining areas was closed due to the refurbishment. People had their lunch in one of the two lounges or in their bedrooms. There were dining tables in the back lounge; in the front lounge people had their meal while sitting in their chairs with small tables in front.

There were eight people in the front lounge at lunch time. Knives, forks, spoons and plastic beakers were put on the tables in front of them. The cook served the meals from a hot trolley and at the same time staff were serving hot drinks from another trolley. At one point there were seven different staff milling around and the noise level was high because the TV was on and was loud. We heard the cook shout, "Feed" and hand a plate of food to one of the care workers to take to a person who lived at the home. While the food smelled and looked good and the portion sizes were good the meal service was chaotic, noisy and rushed.

People were not treated with dignity, respect and compassion; this was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

A person who lived at the home said, "I don't like it. I don't like anything about it. I don't like the food. I'm bored. I just watch telly. If I press the buzzer they come, but they're not really nice. I don't like it. I don't talk to anyone about my worries. I'm not bothered."

We found some people's bedrooms were personalised and people had their own possessions, photographs and personal mementos. Other people's bedrooms were sparse with little evidence of personal belongings. In shared rooms there was a curtain between the beds for privacy. We found signage to help people living with dementia find their way around the home was patchy, some parts of the home had picture signs, and others had no signage at all.

During the first day of the inspection we observed some staff were sitting talking to people but they were often called away for other tasks in the middle of the conversation. We observed one person was a keen football supported and we heard staff talking to them about this.

Whilst all people at the home had the support of families and friends our discussion with the manager showed they had a good insight into the requirements to provide unsupported people with lay advocacy. However, there was no information about advocacy services displayed in the home for the people who lived there.

We looked at three people's care plans which recorded whether they had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. On two occasions the correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form. A third DNACPR form, which had been completed when the person was in hospital, contained information which conflicted with parts of the current care plan. The form recorded the person was lacking mental capacity and the decision had not been made known to the individual. The care plans recorded the person had some degree of impaired cognition but had insight into

their medical condition and merely required help from relatives to make bigger decisions. It is considered good practice to review DNACPR decisions when people are transferring from a hospital to a community setting. The registered manager assured us they would speak with the GP and review the situation. We spoke with staff who knew of the DNACPR decisions and were aware these documents must accompany people if they were to be admitted to hospital.

The registered manager told us there were no visiting restrictions and family and friends were encouraged to visit their relatives at any time and join in the social and leisure activities.

The door at the back of one of the lounges led out to an enclosed garden and we observed people used this door to go outside to smoke. On the first day of the inspection it was cold and windy outside and the door kept blowing open, staff did not seem to notice despite the bitter wind that blew in and made the room cold for the people who were sitting there.

Requires Improvement

Is the service responsive?

Our findings

Visitors we spoke with had different experiences of engagement with discussions about their relative's care plans. One person said, "We used to be involved in discussions when she first came in, but we don't really get involved now. We used to come for the reviews, but haven't been for a long time. She's been here a long time now."

Another said, "Oh yes, they talk to us about her care and how she's been. We're involved in discussions about her care. She can get very agitated but they talk to us and they listen because they bring her down to the lounge like we asked." "We went to look at other places before we chose here – they can be beautiful on the outside, but there isn't the care. We know the staff well here. They're very good. Very caring."

The records we looked at confirmed what people had told us. Evidence of involvement by people who used the service and relatives in planning and reviewing care was inconsistent.

People's needs were assessed before they moved in so that the home could be sure they had the right resources to meet the person's needs. However, in one person's records we saw the pre-admission assessment had been carried out on the day they moved in. The assessment record did not state who had been present during the assessment although other information in the person's records indicated they needed support from family members to make complex decisions.

The information in the initial assessment stated the person had no dietary problems. However, the care plan for nutrition stated the person had a poor appetite and was prescribed a dietary supplement. The medication administration records showed the person was receiving their dietary supplement. A nutrition risk assessment had not been completed; the person's weight had been recorded three days after admission as 44.9kg. The daily care notes recorded the person's dietary intake as 'poor'.

In the same person's records the pre-admission assessment stated they had a skin tear on a pressure area, however, another assessment document stated their skin was intact. A pressure sore risk assessment had been carried out which showed the person was at 'medium' risk of developing skin damage. We asked the nurse in charge about this and they said they were not aware the person had any problems with their skin, they said they would check.

In the same person's records the falls risk assessment had not been completed although the information in the assessment stated the person's mobility was poor.

In another person's record we saw a care plan for nutrition which stated they should have their fluids thickened to the consistency of custard. However, information from the Speech and Language therapist following an assessment in May 2015 stated their fluids should be thickened to the consistency of syrup. This information was not in their nutrition care plan which had last been reviewed in December 2015. We saw the correct thickening powder was being used and the nurse in charge was aware of the correct consistency. However, because the care plan was not up to date there was a risk the person would not receive

appropriate care.

In another person's records we saw a review meeting had taken place on 11 December 2015 which identified the person's care plans had not been reviewed since August 2015. This meant there was a risk they did not provide an accurate and up to date record of the persons care and support needs.

At lunch time we observed one person did not have their teeth in although they were able to eat their meal without help. We looked at their care records and saw a care plan entitled 'oral hygiene care'. The care plan stated the person had top and bottom dentures and brushed their own teeth, it said they refused to take their dentures out at night. There was no information to explain why the person was not wearing their dentures.

The shortfalls in the records put people at risk of receiving care and treatment which was not appropriate, met their needs and reflected their preferences; this was a breach of Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

While some care plans had information about people's individual needs and preferences we found others were not person centred. For example, they contained phrases such as 'bath/shower at least once a week' and 'ensure prescribed medication is given'. The registered manager told us they had already identified this as an area which required improvement and said they discussed it at recent staff meetings.

We observed on person being supported to move with aid of a hoist and two members of staff. The transfer was calm and unhurried and staff spoke with the person throughout explaining what happening and reassuring the person.

A couple of times during the first day of the inspection we observed a member of staff attempting to get an activity going in the front lounge. A game of catch with a soft ball in the morning met with moderate success, several people were nodding off in their chairs, but they threw the ball to them anyway. The game proposed in the afternoon was not so successful and the member of staff soon gave up and left people watching TV. Another member of staff was playing connect four with a person who lived at the home during the morning. This person was quite agitated at other times of the day, but completely calm when playing the game. The home had an activities organiser but they were on leave at the time of the inspection.

The activities records showed the majority of activities were in house and included entertainers for special occasions such as Christmas and Easter. A small number of people went out to the local shops on a regular basis and one person went to a day centre twice a week. However, there had not been any organised outings for some time which meant for the majority of people there were limited opportunities to go out.

We asked people who they would talk to if they had a complaint or concern and most replied, "Any of the staff." One person's relatives said, "We can always talk to any of them if we're worried or concerned about anything." Records showed the service had received three complaints in 2015. The complaints had been dealt with by the registered manager within the timescales set out in the policy and there was an audit system in place.

We looked at the complaints procedure in the procedures manual. The procedures did not give a timescale for responding to complaints and did not have any information about providing feedback to the complainant. The procedure did not have any information about the next stage, what people could do if they were unhappy with the way their complaint had been dealt with. In addition, the procedure did not make any reference to how complaints were monitored by the provider. The registered manager confirmed

they did not submit a written report on complaints to the provider. They said they were held in a file for the directors to look at during their next visit should they wish to.

We asked the manager for the complaints policy and it took some time to find. When the policy was located it had timescales for responding to complaints however it was based on out of date legislation, the Health and Social Care Act 2008 (Regulated Activities) 2010. These regulations were replaced in April 2015 by new regulations, The Health and Social Care Act 2008 (Regulated Activities) 2014.

We observed there was no information displayed in the home to make people aware of the complaints procedures.

An effective system for dealing with complaints had not been established, this was a breach of Regulation 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service well-led?

Our findings

The registered manager told us the organisation had recently employed an external auditor who would visit every home they operated and carry out a full audit of service provision. They confirmed the external audit of Acorn Nursing Home had not yet taken place.

The registered manager told us as part of the quality assurance monitoring process the service sent out annual survey questionnaires to people who used the service and their relatives and on an annual basis. They told us the last survey questionnaires had been sent out in October/November 2015 and thirteen had been returned. We looked at the returned questionnaires and found that although the majority of people were happy with the care they received at the home, nine people indicated that regular outings did not take place and two people were unhappy with the standard of hygiene in the home. When we looked at the minutes of the relatives/residents meetings held on the 18 April 2015 we saw the registered manager had told people that because the service had recruited more staff trips out would be organised on a monthly basis. However, we found this had not happened.

The registered manager told us once returned the questionnaires were sent to the organisations head office and the information was collated. However, they told us they were unsure what happened to the information as they received no feedback, summary report or action plan.

The registered manager told us the organisation usually carried out an annual staff survey. They told us survey questionnaires were returned directly to the organisations head office and they were not made aware of the outcome of the survey unless staff raised specific concerns about their management style. The registered manager told us they had carried out their own staff survey in November/December 2015 but had not yet had time to collate the information.

The registered manager told us that a director from the organisation visited the service about every two months and looked at all aspects of service delivery. However, they confirmed they only received verbal feedback and therefore there was no documentary evidence to show the level of support the registered manager received from senior management.

During the inspection we identified a number of concerns about the effectiveness of the providers systems and processes for ensuring compliance with the fundamental standards and regulations.

These are detailed throughout the report and summarised as follows:

We identified a number of areas where risks to health, safety of welfare of people who used the service and others had not been identified or had been identified but were not being managed. For example, we found people were at risk during the refurbishment because nothing had been done to check the contractors had left the premises in a safe condition or secured rooms used for storage. We found risk arising from clinical waste not being stored securely had not been dealt with effectively.

We found people were at risk because safeguarding procedures were not working effectively and the required checks were not completed before new staff started work. In addition, we found medication errors which potentially had an adverse impact on people's health and wellbeing and which had not been identified by the provider's audits

We found people were at risk of receiving care and treatment which was not appropriate and did not meet their needs or take account of their preferences. This was because the care records were not person centred and accurate and people were not consistently involved in making decisions about their care and treatment.

We found people's rights were not always protected because the home was not acting in accordance with the requirements of the Mental Capacity Act 2005. In addition, we found the Commission had not been notified about the outcome of applications made under the Deprivation of Liberty Safeguards. This is a legal requirement. When we asked the registered manager about this they told us they had no knowledge of this requirement.

We found people were not always treated with dignity, respect and compassion.

When we looked at people's care records we found it was difficult to get a clear picture of people's needs and the care and treatment provided because information was recorded in so many different places. In addition to the individual care plan folders there were separate folders for day care notes, night checks, hygiene support, weights, food and fluid charts, nurses' communications and activities. We found these records were not always completed properly. We saw evidence of this in the food and fluid charts and in the night checks folder where we found no night checks had been recorded for one person since they had moved into the home six days before the inspection.

We found the service did not have an effective system for seeking and responding to people's views and the complaints procedures were not effective.

This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered persons were not working in accordance with the requirements of the Mental Capacity Act 2005. Regulation 11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not being operated effectively to make sure people were protected from abuse. Regulation 13(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints An effective system for dealing with complaints had not been established. Regulation 16(2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not operated effectively to ensure fit and proper persons were employed for the purpose of carrying on the regulated activities. Regulation 19(1)(2)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect. Regulation 10(1)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed properly and safely. Regulation 12(2)(g)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Complete and accurate records of care and treatment were not maintained. 17(1)(2)(c) Risks to the health, safety and welfare of people who used the service were not effectively managed. 17(1)(2)(b) Effective quality assurance processes were not operated. 17(1)(2)(a) Effective systems were not operated to ensure compliance with the requirements the fundamental standards and relevant legislation. 17(1) Complete and accurate staff records were not maintained. 17(1)(2)(d)

The enforcement action we took:

Warning notice