Regency Healthcare Limited

Acorn Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Acorn Nursing Home is a residential care home providing personal and nursing care to 34 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 30 people using the service.

People's experience of using this service and what we found
People were at risk of harm as systems were not in place to assess, review and monitor the risks relating to peoples' health, safety, and welfare. Medicines were not managed safely. Care records were not always person- centred and where monitoring was required this was inconsistent. There were a range of audits and quality checks in place but they were not always effective in identifying shortfalls.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. We have made a recommendation about improving how the involvement of people and their representatives in decisions are recorded.

People and relatives told us there was enough staff to provide care and support when they needed it. They said staff were caring and they felt safe. Recruitment was managed effectively. Staff had induction, training, and supervision to be able to carry out their role safely. The service followed safe infection prevention and control measures. Systems were in place to safeguard people from abuse and poor care.

The service worked closely with other health and social care professionals. Staff felt involved in the running of the service and said the registered manager was approachable and supportive. The registered manager was responsive to inspection findings and provided assurances they would make the required changes to improve safety and quality for people living at the home.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning

disability and or who are autistic.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 23 June 2021). The provider had completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last 2 consecutive inspections.

Why we inspected
We carried out an unannounced focused inspection of this service on 13 May 2021. A breach of legal requirements was found. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Acorn Nursing Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment and good governance at this inspection. We have made a recommendation in relation to how the service records how people and their representatives are involved in decision making.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Acorn Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The first day of the inspection was carried out by 2 inspectors, a Specialist Advisor 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. The second day of the inspection was carried out by 1 inspector. An assistant inspector spoke with staff on the telephone.

Acorn Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Acorn Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced on the first day and announced on the second day.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We looked around the building and observed care and support in communal areas. We spoke with 10 people and 3 relatives about their experience of the care provided. We spoke with 8 members of staff including the registered manager, nurses, care staff and the activity coordinator. We spoke with a visiting social care professional. We looked at people's care records and 2 staff files in relation to recruitment and induction. We looked at a range of management records including policies and audits.

Requires Improvement

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At our last inspection systems were either not in place or were not robust enough to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. This was a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17. Please see the well-led section of this report.

- People were at risk of harm because risks had not been adequately assessed and monitored.
- Care records did not always evidence people were receiving safe care. For example, where people's care plans specified they required regular repositioning to promote comfort and maintain skin integrity there were gaps in records which meant we were not assured they were being repositioned appropriately. This meant people were at risk of discomfort and the condition of their skin deteriorating.
- The provider had recently transferred records from paper to electronic care planning systems. Where care plans identified risks we found multiple examples where risk assessments were not in place. This included risks relating to people who presented with anxiety and complex behaviours and people who were assessed to need bed rails.
- The lifts to the first and second floor had not been available since the end of May 2023. This meant some people were unable to routinely access communal areas and outdoors. There was a general risk assessment in place but the risks to individuals had not been safely considered.
- There were a range of environmental checks in place but they were not always effective. For example, we found multiple examples where temperature checks in baths and wash basins exceeded the recommended safe temperature. There was no evidence action had been taken to respond to this. This exposed people to the risk of harm by scalding.

Systems were either not in place or robust enough to demonstrate risks to people's health and safety were

managed effectively. This placed people at risk of harm. The was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. This included ensuring robust water temperature checks and follow up actions were in place. They also confirmed they had updated risk assessments where we had identified concerns.

Using medicines safely
● Medicines were not managed safely.
● Robust systems were not in place to monitor and check the use of controlled drugs. Controlled drugs are medicines controlled under the misuse of drugs legislation due to being especially addictive or harmful. The provider told us controlled drugs should be checked weekly by 2 authorised staff but the checks had not been effective. The controlled drugs cabinet also contained other items such as jewellery and money which was contrary to regulations.
● Temperature checks of the clinic room and fridge were not robust. We found multiple examples where the temperature recorded was not within the required safe range. We also found medicines in the fridge that should have been stored at room temperature. This meant we were not assured medicines were stored safely.
● Fluid thickener, to thicken a person's drink to support safe swallowing was not always recorded when it was used. One person's care records contained contradictory information about the ratio of thickener to use. This meant the person was at an increased risk of harm through aspiration or choking.
● There were personal profiles alongside the medication administration records to inform staff how the person liked to take their medication. However, they were not in place for everybody and did not contain specific or person-centred details.

Systems were not in place to ensure the proper and safe use of medicines. This placed people at risk of harm. This was breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. Staff did have training to administer medicines and had their competency assessed but the registered manager liaised with the local pharmacy to plan refresher training and a full audit of medicines.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.
● Where people had been assessed as lacking capacity best interest decisions were in place. However, they did not always clearly evidence how other professionals and people's representatives had been involved in the decision. Records required more information to ensure the least restrictive options had been considered

by all relevant parties.
● Staff had received training and understood the principles of the MCA and promoted choice.

We recommend the provider reviews their recording systems to ensure where decisions are made in people's best interests there is detailed information about who was involved and how the least restrictive options were discussed and agreed.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong.
● Systems were in place to protect people from harm and poor care.
● People and relatives said they felt safe and trusted staff. One person said, "I feel safe because the staff look after me. The staff know what they are doing." Another person said, "I am well looked after. I feel safe."
● Staff had received training and understood how to recognise and report abuse. They were confident the registered manager would deal with any concerns appropriately.
● The registered manager had made referrals to the relevant authorities when required.
● Accidents and incidents were generally well recorded. The registered manager had a system in place to analyse events and identify action taken to mitigate the risk and learn lessons.

Staffing and recruitment
● Staffing levels were safe and there were enough staff to meet people's needs.
● Most people and relatives told us staff were able to respond promptly when they were needed. One person said, "There is enough staff and mostly staff I know. When I buzz, they come quickly."
● The provider used a dependency tool to assess how many care staff were required. However, this did not include the role of the nurse. There was one nurse on duty and they administered all the medication and had responsibility for a range of other clinical tasks. After the second day of the inspection the registered manager told us they were conducting a full review of the dependency tool and a decision had been made to increase the number of nurses from 1 to 2 on a morning shift.
● Recruitment was managed safely. The required checks were made before staff started work.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
Safe systems were in place to support people to maintain relationships with their families and friends. We saw people visiting flexibly and safely.

Requires Improvement

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection the provider failed to have robust quality assurance checks in place. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Shortfalls found at this inspection had not been identified by the provider's governance processes. Provider oversight was not effective at identifying and managing organisational risks.
- A range of audits were in place but they had not been effective in identifying the issues we found at this inspection. For example, medicines and environmental audits had been regularly completed but they did not identify the shortfalls we identified.
- The provider had recently transferred paper records to an electronic care planning system. A provider audit completed in May 2023 had identified some of the shortfalls we found in people's care records and had recorded all the findings required 'urgent action'. This had not been addressed promptly. The nursing team were partly responsible for reviewing and updating people's care records but over the course of the inspection we observed they were stretched in other key roles such as administering medication and daily clinical interventions.
- There continued to be a lack of robust systems to manage risks to people. This meant people were at a heightened risk of injury or their health and well-being deteriorating.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of

people using the service This placed people at risk of harm. This was a continued breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They told us plans were in place to recruit to a deputy manager position and there would be additional nursing staff on duty on a morning shift.

● The registered manager understood the requirements of the regulations to notify CQC about events and comply with the duty of candour requirements when things went wrong.
● People, relatives, and staff told us the home was well managed. One relative said, "It is well run and organised."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People's care records were not always up to date and person-centred and it was not clear how they and their relatives were involved in their care.
● Staff were involved in team meetings and daily handovers. They felt involved in the running of the home. One staff member said, "The manager is approachable and I can express my views."
● Several people and relatives commented positively on the ambience of the home. One person said, "It is a friendly and nice atmosphere."
● There was an activities coordinator in place at the home. When they were on duty, they supported people with a range of person-centred activities. This included one to one time where people chose to spend time in their own rooms. They had reviewed their programme to ensure people who were impacted by the lift being out of use had opportunities for one to one time.
● The provider sought people and their relatives' views through regular surveys. Forms were available in the foyer of the home which were accessible to visitors. We discussed the findings with the registered manager and they told us there were plans to collate and analyse the feedback provided and generate an action plan.

Working in partnership with others; Continuous learning and improving care
● There was evidence the service worked well with other agencies, including health and social care professionals. Care records showed staff contacted other professionals when needed. We spoke with a social care professional who told us the service communicated well with them. They described the registered manager as "responsive".
● The provider worked very closely with the local GP who routinely visited people living at the service weekly.
● The provider was working closely with the local authority on a service improvement plan.
● The registered manager acknowledged the findings of the inspection and demonstrated commitment to make the required improvements to the safety and quality of the service.

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems to ensure the safe and proper use of medicines were not effective. Reg 12(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to assess, monitor and improve the quality of the service were not robust. Reg 17(1)