HC-One Limited

Acres Nook

Inspection report

Boathorse Road
Kidsgrove
Stoke-on-Trent
ST7 4JA
Tel: 01782 773774
Website: www.example.com

Date of inspection visit: 17 October 2014
Date of publication: 13/03/2015

Ratings

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

Overall summary

We inspected Acres Nook on 17 October 2014. Acres Nook is registered to provide accommodation and nursing care for up to 72 people. Care and support is provided to people from the age of 18 years upwards. Accommodation and care was provided over two floors. People who use the service had physical health and/or mental health needs.

The registered manager had recently resigned from the service and was not present on the day. However, the provider had not notified us of the absence of 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 and associated Regulations about how the service is run.

Care was not always provided as planned and risks were not always managed to reduce risks to people.

Summary of findings

There was not always enough staff available to meet people's needs in a responsive manner. This meant we saw that people did not always receive the support they wanted when they needed it.

People were at risk of receiving unsafe care because staff did not feel they had the knowledge and skills to meet the needs of people who required specific care interventions in order to remain well.

We observed that care delivery was task-led and staff told us that they were always rushed and therefore people did not always receive the care and attention they required. People's dignity was not always maintained.

People's mealtime experiences were not always pleasurable because people who required support during meal times did not always receive they support when they needed it.

We found that safeguarding procedures were not always followed when people were at risk of abuse. Staff did not recognise and take appropriate action when people were at risk of abuse or neglect.

Effective systems were not in place to support people who wanted to make complaints about the care provided. Concerns or complaints raised were not explored and responded to effectively.

The provider did not have effective systems in place for managing complaints.

The provider did not have effective systems in place to monitor the quality of the service. Staff told us that they felt that the organisation was not open and did not feel that their concerns will be listened to or acted on by the managers. There had not been consistent day-to-day management and direct leadership of the service.

Medicines were ordered, stored and administered safely. People were supported to take their medicines independently and safely.

The provider supported people to maintain their faith and beliefs. People and their relatives were given opportunities to meet regularly to express their views about the service.

When people were unable to make certain decisions about their care, mental capacity assessments were carried out to decide what decisions could be made in people's best interest. The provider had not made any applications to deprive people of their liberties. The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) set out the requirements that ensure that where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. We were told and we saw that a majority of people who used the service were able to give consent to a variety of aspects of their care.

We identified that the provider was not meeting some of the Health and Social Care Act 2008 Regulations we inspect against and improvements were required. You can see what action we told the provider to take at the back of the full version of the 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?

Requires Improvement

The service was not safe. Staff did not report safety concerns when they felt that people were at risk of abuse.

People's care and management plans were not always followed.

There were insufficient numbers of staff to keep people safe and meet their needs.

People were supported to self-medicate safely.

Is the service effective?

Requires Improvement

The service was not effective. Staff did not always have adequate knowledge and skills to provide care.

People did not always get the support they required during meals, when they needed it. The provider did not adequately monitor that people received adequate amounts of food and drink in order to stay healthy.

Recommendations made by other health and social care professionals were not consistently followed in order to ensure that people stayed well.

When people did not have the ability to make decisions about their own care, mental capacity assessments were completed to ensure that decisions were made in people's best interests.

Is the service caring?

Requires Improvement

The service was not consistently caring. Care was rushed and people did not always receive the care and attention they required.

People's dignity was not always maintained.

People's faith and beliefs were respected and people were supported to go to church.

Is the service responsive?

Requires Improvement

The service was not always responsive. Effective systems were not in place to ensure that people's concerns or complaints were encouraged, explored and responded to appropriately.

People who used the service were given opportunities to provide feedback about activities that took place at the service.

Is the service well-led?

Requires Improvement

The service was not well-led. The quality assurance systems used by the service were not effective. The provider did not ensure that recommendations made following quality checks were acted on.

Summary of findings

People who used the service and staff told us that there was a lack of consistent management and leadership at the service.

Staff did not feel confident in raising issues of concern with the managers. They felt that their concerns would not be listened to or acted on.

Acres Nook

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 17 October 2014 and was unannounced.

Our inspection team consisted of two inspectors, a specialist advisor with specialist knowledge in rehabilitation, moving and handling, neuro-rehabilitation and complex needs; and an expert by experience who had experience of using mental health and physical health care services.

We reviewed information we hold about the service. This included notifications that the provider had sent to us. Providers are legally bound to notify us about any changes to their regulated services or incidents that have taken place in them. We reviewed information we had received from the public and the local authority and used the information to formulate our inspection plan.

We spoke with the local authority's safeguarding and commissioning teams to identify if there were any current concerns. The local authority sent us a written summary of safeguarding referrals that had been investigated or were in the process of being investigated between April 2014 and October 2014.

We undertook a thematic probe to gather information about how well providers handled complaints and staff concerns/whistleblowing. The thematic probe was launched in August 2014 to gather information, which will feed into a 'State of Complaints' report that will be published at the end of 2014.

We observed how general care was provided and carried out observations during breakfast and lunch to check if people who required assistance during meals received the support they needed. We also checked if people were supported to have adequate amounts of food and drinks during meals and throughout the day.

Sixty-three people were using the service on the day of our inspection. We spoke with 17 people who used the service, five relatives and reviewed five people's care records. We also spoke with two nurses, 12 members of care staff, four visiting professionals, the Quality Assurance Manager (QAM), a manager from another home owned by the same provider and reviewed records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People were not safe because staff did not recognise and take appropriate action when people were at risk of abuse. A staff member told us that a person's wound dressing was due to be changed two days earlier and this had not been done. We saw records that confirmed this. The person was admitted with pressure ulcers and guidance was available on how the pressure ulcer should be managed. Staff had failed to follow the guidance provided. The staff member we spoke with was concerned about the person's care but failed to identify and respond to the risk. Due to the concerns we identified we referred this as a safeguarding to the local authority because the person had been at risk of neglect.

Prior to the inspection, we received concerns from a relative of a person who used the service that appropriate care had not been provided to their relative and this had left in discomfort and pain. The relative told us that they had to call and remind staff to provide the planned intervention. We spoke with the person who used the service and they told us that they did not always get the care they required when they needed it. Staff we spoke with were aware that the person was at risk of severe pain and discomfort if care was not provided as planned and in a timely manner. We reviewed the provider's records of safeguarding referrals that had been made but we did not see a record of this incident. The local authority informed us that they had not received a safeguarding referral from the provider about the incident. This meant that the provider had not identified and taken appropriate action to respond to potential acts of omission that could impact on the care and welfare of this person.

The examples above showed that staff did not recognise abuse and had not responded appropriately to incidents when people were neglected. This was a breach of Regulation 11 of the Health and Social Care Act 2008.

We saw that there were not adequate numbers of staff to support people during meals. Thirty-three people lived in two units on the ground floor. We saw that a majority of the people were cared for in their bedroom and needed support at meals times. Each unit had one member of staff supporting people with eating and drinking during this time. We saw that meals were left on tables in their bedrooms whilst people waited for assistance with their eating and drinking. One person commented to staff, "It's cold", when a staff member we were with asked them if they had eaten their dessert. The staff member told us, "There are not enough staff; there are people waiting for their dinners". People who needed support during meals were not getting the assistance they needed when they needed it because there were not enough staff.

We saw that call bells or requests for help were not answered promptly. For example, we saw that it took over 10 minutes for staff to respond to a person who was calling out for staff assistance. We noted that staff were engaged in supporting other people and could not attend to the person when they needed their support. One person said, "Call bells are not answered immediately. That is the bugbear. It takes an eternity". Another person told us that they had to wait over an hour before they could get help when they needed it.

A staff member we spoke with told us that support with people's toileting needs was not always timely. The staff member said, "By the time you get to them, they've wet themselves and are upset". Another staff member said, "Some people get one bath a week because there aren't enough staff to give them baths".

All the staff we spoke with told us that the provider did not always have suitable numbers of staff on duty and staff were working long hours. A staff member said, "Staff are worn out to the point of crying. We have more help from the domestics". The QAM confirmed that there were not enough staff on the day to meet the needs of people and that the provider was in the process of recruiting additional care staff.

The examples above showed that there was a breach of Regulation 22 of the Health and Social Care Act 2008 because there were not enough staff to meet people's needs.

One person had sores to their body and their risk assessments indicated that their skin integrity was at risk of deteriorating if they did not receive their care as planned. The person needed to have prescribed creams applied on certain parts of their body regularly because their skin integrity was poor. We saw that the person was cared for mainly on their bed and was at a higher risk of developing pressure ulcers. There were no body maps in the person's care records to show staff where and how often the creams were to be applied. The nurse we spoke with told us that topical creams were to be applied by the carers who

Requires Improvement

Is the service safe?

provided personal care but they were not certain if the creams were applied regularly. The provider sometimes used temporary staff and there were risks that these staff may not always know where the creams should be applied if guidance was not available. We checked the person's care records and saw that records were not being maintained to show that the person received their creams as prescribed.

People told us that they received their medicines as planned and did not have concerns as to how their medicines were managed. One person who was prescribed 'as required medication' (PRN) for pain told us that staff gave them their medicines at a particular time of the day because that was when they needed it most. We saw that information was available to guide staff on when to administer the PRN medicines.

We spoke with a temporary staff member who was administering medication. They told us that they had been given adequate information about people and their care needs. They showed us summary information relating to the health care needs of people which they told us meant they had information to administer medicines safely.

People were supported to take their own medicines. One person who self-medicated told us, "I like to self-medicate because I have my meds on time and if there is an emergency, I can sort myself out if they [staff] can't get here on time". We saw that risk assessments and management plans were in place to ensure that they self-medicated safely. We saw that medicines were ordered and stored safely. Medicines were stored securely in locked cabinets in a locked room.

Requires Improvement

Is the service effective?

Our findings

One person needed to use specialist equipment to support them to breathe. The staff told us they were unsure of how to maintain and clean this as they had not received any training in this area. We saw a protocol had been developed to reduce the risk of any infection. This included the maintenance and cleaning of this equipment to ensure the person's welfare. A staff member who came to assist the person with cleaning the equipment commented, "I have not done this before" and apologised before leaving. The person who used the service told us, "There was still dirty water in the equipment after cleaning". The QAM told us the protocol had been put in place to ensure that staff provided suitable care and cleaned the equipment effectively, but we saw that staff did not have the knowledge of training to support the person.

Some staff told us that they did not feel confident carrying out certain specialised roles because they had not received additional training to meet the specific needs of people. One person who had a supra-pubic catheter (a hollow flexible tube inserted into the bladder through a cut in the stomach in order to drain urine from the bladder) did not always have their catheter changed as planned. A staff member told us that the person's catheter needed to have been changed two days earlier but this had not happened as they were expected to change the catheter but had not received specific training on how to change them. They told us that they did not always feel comfortable doing this. We brought this to the attention of the provider, who told us that catheter care management training has now been arranged and nursing staff will receive the required training.

Staff we spoke with told us that they did not have regular supervision; and this had been made worse with the absence of the registered manager. A staff member said, "Support wise, we haven't really had a lot from management". The supervision records we looked at showed that staff did not receive supervision regularly. Supervision also provides opportunities for staff to discuss their training needs and other concerns with their employers. The provider told us that regular staff supervision will be reinstated and staff meetings had been scheduled for the months ahead.

People who were unable to make important decisions about their health or wellbeing were protected. Staff we spoke with demonstrated some understanding of the legal requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA and the DoLS set out requirements that ensure that where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. Staff gave us examples of when they would apply these principles to protect people's rights. We saw them seeking and obtaining consent before they provided care and support to people. We saw records that where people lacked capacity to make certain decisions, mental capacity assessments were completed to identify what decisions should be made in their best interest.

One person was supported to have their food and water through a soft plastic tube that was put into their stomach. This is known as percutaneous endoscopic gastrostomy (PEG) feeding. The person's records for that week indicated that they had not received adequate amounts of water. There were no records to show that the person had received their PEG feed the previous day. We brought this to the attention of a nurse. They told us that the person had received their feed the previous day but the staff member who administered the feed had forgotten to record it. The dietician responsible for the person's care told us that accurate records had to be kept in order to ensure that the person received the right amount of PEG feeds and water at regular intervals.

Some people who used the service needed to have their weight monitored and records to be kept of what they ate and drank due to health concerns. We saw these records were not always completed. A staff member we spoke with told us, "Fluid balances are not being done because the new staff don't know". An investigation the previous year following the death of a person who used the service identified that inaccurate recording of the person's food and drink intake and lack of care may have contributed to the person's death. The QAM told us that the provider had made changes in the way food and drink intake was monitored following the investigation but we saw the changes made were not effective.

We carried out a lunchtime observation and saw that people who required support did not always have a pleasant experience during meals. We observed two people with physical disabilities struggling to eat their meals whilst in the dining area, which resulted in food being distributed on their clothing. We saw that staff in the dining area did not assist them to limit the food from being

Requires Improvement

Is the service effective?

distributed everywhere. However, we saw that other people who did not require support enjoyed their meal. They told us that they were happy with the quality of food and drink at the service. One person said, “The food’s excellent. That is one of the good things here”.

We saw that a variety of food was available during meals. One person told us that they had enjoyed their lunch and they had tomatoes, bacon and eggs for breakfast. A relative told us, “[their relative] always has a choice a meal time and there’s always a variety of sandwiches at tea time. They are eating better here than they did at home”.

People were able to access health, social and medical support when they needed it. A relative told us, “They [the staff] had the doctor in to see [their relative] straight away just to be sure because they had a bit of a cough”. We saw three visiting professionals at the home reviewing people’s care. hey told us they visited the home regularly and staff often contacted them when they had concerns about people’s health.

When people became unwell or their condition had changed we saw records of visits from doctors and other health professionals were requested. However, we saw that the staff did not consistently follow advice given by other professionals. This was because people’s food and drink intake were not monitored as advised, wound dressings were not changed as directed and catheter care was not managed according to guidance provided by professionals.

Requires Improvement

Is the service caring?

Our findings

We saw that care was rushed and enough time was not always taken to provide care in a compassionate way. We observed that care provision was task-led and staff did not always have enough time to spend listening to people. One person said, "It seems like the paperwork comes before us". A relative said, "We find [relative] most of the time sitting in their wheel chair. I don't think my [relative] is getting the care or attention they need. All I want is the best for them and not to come and see them slumped in a chair". Staff we spoke with told us that they did not always have enough time to talk with people. A staff member said, "We just go in and wash them, and it's a shame for the residents". This meant that the service was not consistently caring.

People's dignity was not always maintained. We saw one person walking around the communal areas with their clothes soiled and not properly dressed. We saw that staff walked past the person on a number of occasions without offering them assistance to get cleaned and dressed properly. One person said, "They [the staff] are awkward sometimes". Another person said, "They [staff] don't speak to you nice". We did not observe poor interaction between staff and people who used the service. However, we observed that care was rushed.

We saw one person who could not communicate verbally and who needed full assistance with their personal hygiene. However, there were no care plans in place on how the person would be supported with their personal hygiene. We found that other people who could not verbally communicate their wishes did not have care plans in place to indicate how they wished to receive care. They were at risk of not receiving care and support in a way that they preferred. This was because we saw that care was task-led and a staff member said, "They [people who used the service] are really just getting the basic care".

People we spoke with told us that their faith needs were respected. People told us that they were supported to go to church if they wished to. One person told us that staff knew that they preferred to have their care in a specific away and at a specific time and therefore provided the care in the way they wished. They said, "I think that the care is good, it can't be fabricated".

The provider had good links with the local community and volunteers came to the home to take people to their preferred place of worship. The provider had their own specialist vehicle they used to support people to access community facilities. A hairdresser came to the service regularly. One person said, "The staff are all very nice. I've had my hair done and they took me out".

Meetings took place regularly where people who used the service decided on what activities they wished to engage in. Where people had mental health problems, we saw records that staff spent time with them and supported them to access the help they required. One person told us that they had been supported to access advocacy support to put their views across to other professionals when they were being assessed for alternative accommodation.

Requires Improvement

Is the service responsive?

Our findings

The provider had designated staff responsible for ensuring that people were engaged in activities and hobbies of their choice. One person told us, "The staff are all very nice. I've had my hair done and they took me out". We saw that people were encouraged by staff to attend the cinema within the home, where we observed them engaging in a sing-along. Another staff member responsible for activities was observed visiting people in their bedroom to spend time with them and engage them in activities of their choice.

We saw some people were at risk of isolation. One person told us that they spent most of the time in their bedroom because staff did not always support them to access communal areas. The person told us that they had lost their confidence to use their walking stick to walk independently following a recent fall in their bedroom. The person told us that they could walk for short distances but they were not always supported by staff to leave their bedroom and often felt isolated.

The provider did not have effective systems in place for the management of complaints. We spoke with a person who had made a complaint and they told us they had raised the issue with staff several times about the care of their specialised health equipment but no action had been taken until they made a formal complaint. The person felt the complaint had not been handled effectively and appropriate action had not been taken initially to ensure their safety and welfare. The provider took steps to resolve the problem following the formal complaint but the complaint had not been recorded for the purposes of assessing, preventing and reducing the chances of it reoccurring.

The provider did not manage complaints in a consistent manner. A relative told us that they had made several verbal complaints to staff about the care of their relative. The relative said, "I've never put anything in writing but I've spoken to staff. I'm upset with the whole system". We spoke with a staff member who was aware of the complaints but we noted that no record had been made of the complaint. The complaints were not also shared with their manager. Staff were unaware of what constituted a complaint or a concern and how these should be handled. This meant that complaints and/or concerns were not always handled in a consistent manner.

The provider had a complaints procedure in the reception area of the home headed 'Feedback'. Two people told us they did not know there was a complaints procedure. They told us they would talk to staff if they were unhappy about aspects of their care. The examples above showed that staff did not always deal with people's concerns about their care and treatment or complaints effectively. People's concerns and complaints were therefore at risk of not being explored and dealt with effectively.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had resigned and had been absent from the service for over two months. The Quality Assurance Manager (QAM) informed us that the provider was in the process of recruiting a new manager. In the interim, the QAM and a manager from another service owned by the same provider came to the service regularly to offer management support.

We saw that the QAM carried out regular quality monitoring audits of the service. The audits included reviewing care plans, medication records, falls, infection control systems, residents' well-being, the environment, equipment and staff support. The provider did not have effective systems in place to monitor quality of medicine management and we found gaps in MARs which were not accounted for and had not been identified. We saw that people's care records did not always reflect the care people received or if they had consented to their care. Most of the care records we looked at did not reflect that people had consented to the care they received. We showed the QAM examples of such care records and they said, "That is one thing we do fall face down on. There is a form we are supposed to fill in to show that people have been involved".

We saw that an action plan had been developed to address any shortfall that been identified through the quality assurance process. The plans included dates for completion of the actions identified but no staff member had been identified to take responsibility for ensuring that actions were implemented. We saw that some audits had actions which had not been acted on and we had also identified further concerns in this area. These meant that the provider did not have effective systems in place for assessing and monitoring the quality of the service provided and this was a breach of Regulation 10 of the Health and Social Care Act 2008.

People told us that a monthly luncheon club had been established following discussions with relatives who were asking for greater involvement with the service. Relatives were invited to a meal with people using the service. It was a social occasion that provided relatives with an opportunity to meet together and to feedback their views. Staff told us that relatives of people from another home attended and were able to meet to discuss various aspects of the service. We saw the number of hours for 'diversional activities' had been increased over the weekend as a result of feedback received about activities not taking place. Some people told us that the provider had organised a day trip for them to another town, which they enjoyed.

People we spoke with and their relatives told us that the registered manager was not always around, or that they did not know who the registered manager was. One relative said, "I really don't know who the manager is. I don't know if it's a man or a woman". There had been intermittent absences of the manager in the months before our inspection. The QAM told us that they and the other manager present during the inspection were contactable and offered support over the phone or came to the home if required. Staff told us that it was not always possible for the managers to come to the service when they were needed. We saw that there was no agreed leadership arrangement in the absence of the registered manager.

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	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **Effective systems were not in place to identify, assess and manage risks to protect people against the risks of receiving inappropriate or unsafe care. The provider did not regularly assess and monitor the quality of care provided.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The provider did not respond appropriately to allegations of abuse.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **There provider did not take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons to provide care.**