Acorn Retirement Home

Acorn Retirement Home

Inspection report

Acorn Retirement Home
102 Birmingham Road
Walsall
West Midlands
WS1 2NJ

Tel: 01922624314

Date of inspection visit:
19 January 2016
20 January 2016

Date of publication:
17 March 2016

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**

Summary of findings

Overall summary

This inspection took place on 19 and 20 January 2016 and was unannounced. At our last inspection completed in March 2014 the provider was meeting the requirements of the law.

Acorn Retirement Home is a residential home that provides accommodation and personal care for up to 18 older people. At the time of our inspection there were 16 people living at the service, some of whom were living with dementia. A registered manager was in post. 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. The registered manager of this service is also the registered provider.

Risks to people were not always identified or actions taken to minimise these risks. People were not always protected from potential injury due to unsafe moving and handling practices. Staff could describe how to identify signs of potential abuse, however, concerns about people were not always effectively identified and reported to the Local Authority when required. People were supported by a staff team who had been recruited safely. People were happy with how they received their medicines.

People were supported by staff who had not received sufficient training and did not always have the required skills. People were not always enabled to consent to the care they received. Where people did not have capacity to provide consent, decisions were not always made in their 'best interests' in line with the Mental Capacity Act 2005.

People had access to sufficient quantities of good quality food and drink. People were not always enabled to make choices about their food and drink or provided with sufficient support where they were not able to eat independently. People had access to healthcare professionals when needed.

People told us that staff were kind and caring. People's privacy and dignity was not always protected and their independence was not always fully promoted. People were supported to maintain relationships that were important to them.

People were not fully involved in the development of their care plans. Care plans did not always reflect people's needs or the care they received.

People felt able to raise concerns and complaints where appropriate and we saw that the provider responded to concerns raised. The provider was developing ways of proactively obtaining people's views about the service.

People and staff spoke highly of the management of the service. The provider was visible in the service and supported an open culture within the staff team. Quality assurance systems were not sufficiently developed

to ensure that the quality of the service to people was continually improved and that care plans reflected people's individual needs.

We found that the provider was in breach of three regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

People were not always protected from potential risks to their health and well being. People were supported by sufficient numbers of staff who had been recruited safely. People were happy with how they received their medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported by staff who had been sufficiently trained and had the skills required to meet their needs. People's human rights were not always protected through the effective use of the Mental Capacity Act 2005. People weren't always happy with the food choices available. People had access to healthcare professionals when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

People were supported by a staff team who were kind and caring. People's dignity and independence was not always respected and fully promoted. People were supported to maintain relationships that were important to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always fully involved in planning their care . People's care plans did not always reflect the care they received and their individual needs. People were able to make complaints and raise concerns when required and they felt listened to.

Is the service well-led?

Requires Improvement

The service is not always well-led.

People felt supported by a management team who were open

and listened to them. Staff felt well supported by the provider. Quality assurance systems needed to be developed to ensure that areas of improvement and risk were identified and resolved.

Acorn Retirement 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 19 and 20 January 2016 and was unannounced. The inspection team consisted of one inspector, a specialist advisor and an expert by experience. The specialist advisor was a qualified nurse who has experience working with older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection we reviewed the information we held about the service. We looked at statutory notifications sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We sought information and views from the local authority. We also reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

During the inspection we spoke with 10 people who lived at the service. Some people who lived at the service were unable to share their experiences so we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the registered manager, the deputy manager, the cook, the hairdresser, four care staff, one visiting professional and two visitors who were relatives of people living at the service. We reviewed five people's care records, medicine administration records, three staff files and records relating to the management of the service. We also carried out observations across the service regarding the quality of care people received.

Requires Improvement

Is the service safe?

Our findings

We looked at how the provider identified and managed risks to people living at the service. We saw that risk assessments were not always in place and care plans did not outline how to safely minimise risks to people. Staff were aware of how to manage the risks to some people living at the service but this was not consistent. Risks for some people were not well managed or understood by all staff members.

We saw examples of members of staff moving people in a way that caused an increased risk of injury. While staff were supporting people to stand, we saw them being held under the arms which can cause an increased risk of injuries such as joint dislocation and skin tears. We also saw people falling back into their chairs and experiencing discomfort. One person was heard saying to staff, "Just let me do it my way". Another example was heard of this person shouting out, "It's killing me" as they were supported to move. Staff told us that one of the people we had seen struggling to move had arthritis in their hands which was impacting on the person's ability to grip objects. Staff were asking this person to support their own body weight when standing by gripping a frame, despite the fact they were struggling to grip. We observed this person falling backwards several times while trying to grip the frame and stand. The risks to this person had not been reviewed and guidelines were not in place to outline to staff how to safely support this person when mobilising. We saw that there were no risk assessments in place to outline how to safely support the other people we saw to mobilise. We asked staff how they should safely support people to mobilise and staff were able to describe safe practices, however, we saw these were not being applied in practice. We saw that these staff members had not received recent training in moving and handling. Peole were at risk of injury as they were not supported to move safely around the service.

We identified through observations and through speaking with staff that risks were not being managed relating to two people who were not eating sufficient quantities of food. We saw that one of these people was identified in their care plan as having a fluctuating ability to feed themselves. The care plan outlined that on certain days they may need additional support. We saw that this person was struggling to feed themselves during the inspection and insufficient support was provided by staff. Their meal was taken from them mostly uneaten. Staff were not following the guidelines that were in place to ensure the risks to this person of not eating were managed. We saw that another person was not eating during the inspection. Staff told us that this person had not been eating well for the last two weeks and we saw that the care plan did not identify and manage the risks to this person. The person's food and fluid intake was not being recorded and monitored, alternative methods of maintaining sufficient intake of nutrients had not been considered and the person's weight was not being monitored. We saw that staff had not recorded in daily care records that these people were not eating sufficiently.

We saw that risk assessments were not personalised to reflect people's individual needs. There was one person who stored and managed their own medicines, however, a risk assessment had not been completed by the provider. We also found an example of a person who was visually impaired and washed themselves daily. This person told us that they sometimes lost their balance as the wash basins are small and water splashes on the floor causing them to slip. The provider had not considered the risks to this person and worked with them to minimise these risks while still promoting their independence.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff that we spoke with were able to describe the signs of potential abuse to people living at the service and could tell us how they would report concerns about people. Staff told us that they knew how to 'whistle-blow' and report concerns to organisations outside of the service if necessary, for example to the CQC or the Local Authority (LA). We saw that the provider investigated and managed concerns about people within the service. We saw that some circumstances arose within the service that would require the registered manager to notify the LA. These circumstances had not been identified and reports had not been made.

People told us that there were sufficient staff available to meet their needs. One person told us "If I press the intercom, it's just a few minutes. I think there's enough." The provider told us that they used a formal staffing tool to identify how many staff were required on each shift. They told us that they did not use agency staff to cover sickness absence as they had a committed staff team who were willing to work additional shifts if required. Staff told us that they had effective contingency plans in place when required. They told us that the registered and deputy manager were very, "Hands on" and domestic staff were also trained to provide care. The staff files we looked at showed us that the provider was aware of how to safely recruit care staff to support people living at the home. We saw that pre-employment checks such as references and screening of staff members potential criminal history were completed prior to them starting work.

People we spoke with told us that they received their medicines when needed. Some people told us that they were given pain relief and they weren't certain why. We saw that these medicines had been prescribed by the doctor. Staff had not effectively explained to people why they were having these medicines or requested a review by the doctor if they were no longer required. While we saw that most medicines were stored securely, we did identify some topical medicines that were kept in people's rooms that were not secure. We checked the stock levels of medicines and found that they matched the quantities outlined in people's medicine records.

We looked at the medicines for people who were on blood thinning tablets and 'as required' medicines. We saw that protocols were not in place to describe to staff how and when 'as required' medicines should be administered to people. We saw an example of one person who had been prescribed blood thinning medicine. This medicine was not always being measured accurately. The provider could not demonstrate that the person was receiving the correct amount of medicine each day and therefore the risks to their health of taking the wrong amount was not effectively managed.

Requires Improvement

Is the service effective?

Our findings

We looked at how the provider ensured that consent was obtained from people prior to them receiving care. We saw examples of staff seeking consent prior to supporting people but this was not consistently done. We were told by one person that when staff supported them to shower, their consent was not always sought. They told us, "It was 'sit down, stand up, do this, do that'". We saw one person being supported to eat by a staff member without them describing what was happening or seeking their consent. We saw a staff member try to put a medicine into someone's mouth while they were refusing it. They were heard saying, "No, take it away". We saw another staff member asking a person if they wanted a drink. The person was shaking their head although the staff member continued to put the drink to their lips.

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. We saw that where people lacked the capacity to make their own decisions about their care or to provide consent, the principles of the MCA had not been followed. We saw that there were no assessments of people's capacity completed and decisions made on behalf of people had not been made and recorded in line with the MCA.

We saw that one person was receiving medicines covertly by them being crushed and added to their food. We confirmed through observations and by speaking to staff that this person was not always able to consent to this medicine due to their capacity. The principles of the MCA had not been followed in order to make a decision about this person's medicines in their best interests. We saw that the provider's policy around covert medicines also did not reflect the requirements of the MCA. We found that staff had not received training on the MCA and they were not able to describe the requirements of this Act when we spoke with them. The management team also did not have an understanding of the requirements of the Act.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found that one person's patio door had been locked since their capacity had reduced in order to protect their safety and well being. We saw numerous examples of people who were continually supervised when mobilising around the service. People's consent to these interventions had not been sought and where they were confirmed by staff as lacking capacity to make decisions about their care, applications had not been made to lawfully deprive them of their liberty while keeping them safe. We spoke with the registered manager who told us they would review how they would make improvements in the application of the MCA including DoLS immediately following the inspection.

Some people told us that they felt staff could benefit from further training and didn't always have the skills

required to support them. One person told us, "They're very nice but I think they ought to have more assessments." Staff views on training were mixed. Some staff told us that they thought they received sufficient training while others said this was not the case. One staff member told us, "Training could be a bit better". We were told by staff that their initial induction was good. Staff were aware of national induction standards and we could see that their induction was structured to meet the requirements of these standards. We looked at the training records for staff members and found that important training had not always been completed or updated, for example in areas such as moving and handling. We found that there were not adequate systems in place to ensure that staff had completed training and that their competency in their role was continually assessed and skills updated. Most staff told us that when they needed advice and support from management, this was available to them. We were told that they had received regular supervision meetings with a senior person until a few months ago. The provider told us that they were in the process of reinstating regular supervision meetings, however provisions were not in place to ensure that staff remained effective while these arrangements were made.

People gave us mixed views about the food they received. Some people told us they were happy with the food. One person told us, "The food is very good" and another said, "Oh, the food's ok. It's always fresh. Nothing out of a box." A third person said, "I don't have to worry about starvation during the day". Another person told us that they didn't receive a choice of what they ate although they thought the food was good. Other people told us that they were not happy with their food and that choices were not made available to them. One person said, "It's the same thing week after week". Another person said, "Dinners? They're not always good". A third person said, "The main meals vary – it depends who's on. There is a menu but they don't give me one". A staff member told us that they had options available for people but they only discussed alternatives with people that they knew wouldn't like the main choice. We saw that staff were not proactively seeking people's views around the food they wanted to eat and providing sufficient choice.

We saw that food was freshly cooked at the service and was well presented. We saw that where people had special dietary needs, such as a soft diet, these needs were met. We saw that one person had been identified as requiring adaptive plates and cutlery in order to eat independently and these were provided. We saw that there were other people struggling to eat with their knife and fork and sufficient support was not in place. We found that consideration had not been made to providing some of these people with items such as adaptive cutlery in order to promote their independence.

People told us that they were happy with the access they had to healthcare professionals when needed. We saw from people's care records that regular intervention was sought from professionals such as doctors, specialist consultants, the chiropodist and dentist. We saw that the service had varying levels of involvement with people's healthcare depending on the person's own capacity and the support they received from family members. One person told us, "I go to the hospital for treatment. I arrange the ambulance, but they would do it for me if I wanted them to." A visitor told us that healthcare professionals had been sourced to ensure that their relative had the equipment they needed to support their health. They told us, "They've (the provider) been really good about understanding [person's] health needs. They've put a new foot stool in place and have put a pressure mattress in". We were told by staff that this person's health was being monitored and that the GP and nursing team were regularly involved in their care. We saw that further assistance could have been obtained from professionals such as Occupational Therapists in order to promote people's independence. For example, where further assistance with mobility was required this had not been identified and referred to the relevant professionals.

Requires Improvement

Is the service caring?

Our findings

Staff gave us examples of how they would protect people's privacy and dignity, for example ensuring that doors were closed when people were supported with personal care. We saw that this was done throughout the inspection. We saw that people's dignity was protected by staff in other areas. For example, ensuring that people were supported with their appearance and personal hygiene where this was important to them. We did, however, see care practices that did not protect people's privacy and dignity. We saw that people were routinely asked about going to the toilet in public and staff discussed people's needs in communal areas. We saw one person's catheter bag exposed in the lounge area as they were supported to apply gel to their knees. We saw that staff did not always use dignified language when speaking with people; for example when one staff member supported someone with their food they were heard saying, "That's right, you do it yourself, you eat it. That's a good girl."

We saw that staff promoted people's independence in some areas but this was not consistently done. For example, we were told by staff that they tried to encourage people to do as much for themselves as they could. One staff member told us, "I try to look at what people can do for themselves and encourage them." They described how they would encourage someone to do up their own shirt buttons and described an example of how someone was supported to complete daily activities such as make their own bed. We saw some examples of staff encouraging people to eat independently themselves at meal times. Staff had, however, not promoted people's dignity by ensuring they had the required support and equipment.

People told us that they were not able to independently move around the service. One person told us, "I have to have a carer if I want to go anywhere". We saw that several care plans outlined that care staff should stay with people when mobilising, "at all times" and we saw staff supervising people when they moved around the service. One staff member was heard to say, "I'll walk down with you and make sure you're ok" when one person tried to move independently. We were told by staff members and visitors that people were not able to bath and shower without supervision. We saw that the provider was not promoting people's independence sufficiently through positive risk management and care planning.

People gave us mixed views about the choices they were able to make about their care. Some people told us that they were able to make choices about where they spent their time. One person said, "It's very nice in the lounge, but, in a nutshell, I like my own little room. It's my choice". We saw that people were involved in making choices about their bedroom environment and people's rooms had personal items decorating them. One person's relative told us that their relative had chosen to bring in their own bed and chair from home and the provider had supported this choice. Staff members told us they tried to offer choices. One staff member told us, "I ask them what clothes they want to wear and encourage them to make choices." Some people told us that they weren't given sufficient choices around things such as their personal care or the food they ate. We saw that staff could be more proactive in offering people choices about their day to day care.

People told us that they were happy living at the home and that staff were kind to them. One person told us, "I think they're very caring and kind. You're looked after well". Another person said, "Honestly, they've always

been kind. No-one has ever spoken to me out of turn." A third person said, "I find it very good. If I didn't I wouldn't be here. Everybody's been so kind". Visitors told us that care was, "Excellent". One visitor told us, "I like the way staff go down to her level and make eye contact" and "I like this home as it allows you to be yourself and it's like home". We saw some positive, caring interactions between staff and people living at the service. One staff member told us, "I like to go home at the end of my shift knowing everyone is happy". We saw that most staff would speak to people kindly and would go down to people's eye level to talk to them and ensure they were comfortable.

People were supported to maintain relationships with people who were important to them. We saw that visitors were able to see people without unnecessary restrictions and a private space was available if people wanted to use it. One person told us, "They always make visitors welcome. A cup of tea will appear." Another person told us, "My room's very nice. When I have visitors, I usually take them in there." We saw that the provider supporting family involvement in the service where people expressed a wish for this to happen. The provider also made information about advocates available for those who needed additional support in making choices or decisions.

Requires Improvement

Is the service responsive?

Our findings

People told us that they were not involved in the development of their care plans. We saw that care plans were often generic and similar to those of other people living in the service. People's care plans were not always reflective of the care we saw being delivered. We asked staff about the needs of people whose care plans we looked at and most, but not all, were able to describe people's care needs.

We saw that care plans were signed by a staff member as having been reviewed on a monthly basis. People were not involved in this review of their care plan. We saw that even when changes in people's needs were present, care reviews were marked as no changes being required. For example, we saw examples that included one person who staff described as having a recent change in their mental health and another who was having an acute period of disorientation which was impacting on their acceptance of some aspects of their care. This showed people's care plans had not been reviewed and updated to reflect people's needs. Care staff were not aware of how to manage these changes in people's needs. Care plans were not always reflective of people's individual needs and updated to reflect changes in the care people needed.

We saw there were very limited leisure opportunities available for people living in the service. One person told us, "There ain't much going on. We rattle between ourselves." Another person told us, "I haven't got any hobbies other than reading." We saw that a range of books, including audio books, were made available for people in the lounge and these were replenished regularly by a local library service. People told us that they used the books that were available. Some people told us that there were other activities available at times. One person said, "They take us out into the garden when it's sunny". Another person told us, "Just before Christmas, they took us to [a local school] for carols. That was nice" We saw that the provider kept an activities record in which limited activities were recorded. During the week prior to the inspection, staff had recorded 'chatting with residents in the lounge' and 'crossword with residents' as the activities that had been completed. We saw that staff had been developing personal histories that were in place in people's care plans. The provider told us that these were used to get to know people living at the service better and that they often did a "This Is Your Life" event for people's birthdays. This knowledge about people had not been used to create opportunities for people to pursue their own hobbies or areas of interest.

People told us that they knew how to complain if this was necessary. Most people told us that they hadn't had to complain about the service previously. One person said, "There's nothing to be critical about." Another person said, "Nothing here has upset me, but if you were upset, then you'd have to tell [Deputy Manager] and she would tell [Registered Manager]." We saw that feedback surveys had been completed by people and their relatives. Where negative comments had been raised these had been followed up by the provider and addressed. We saw that comment cards were made available in the reception area and the provider had recorded a number of comments received from completed cards. The provider told us how this was a new system that had been developed to assist in gathering people's views and allow them to be more proactive in responding to views people had about the service.

Requires Improvement

Is the service well-led?

Our findings

We looked at how the provider monitored the quality of care that people living at the service received. We saw that the provider completed a range of audits on the environment and various aspects of the service. We found that the provider had not developed sufficient systems and audits to monitor that people's needs were consistently met by the care they received. The provider's quality assurance system had not identified the issues that we had identified during our inspection. We saw that audits completed did not include sufficient analysis to identify trends and actions that could reduce potential risks to people. For example, we identified risks with people's mobility and nutrition that had not been identified in their care plans. Care plan reviews had not identified these gaps in people's care and their care plans. We found that systems had not been developed to ensure that staff were competent in their care practice and that people were protected from the risk of harm. For example, ensuring that staff were using safe practice when supporting people to mobilise around the service.

We saw that some policies did not reflect current legislation and best practice guidance. This resulted in processes used within the home not being compliant with current regulations. The provider advised us that they were in the process of reviewing all policies and procedures to ensure that processes and care practice were improved to raise standards in the service and the care people received. The provider had not developed systems to ensure that all incidents notifiable by law were identified by staff reported to the local authority and to CQC.

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

We saw that the provider sought people's feedback about the service they received and took action where issues were raised. People spoke highly of the registered manager who was also the provider. One person told us, "The manager, [name], and his wife, they're very nice, very helpful." People were supported by a team of motivated care staff who also spoke highly of the management team. One staff member told us, "He's visible and very approachable". Another staff member told us that the registered manager had been very supportive and that, "He's been brilliant". Staff members that we spoke with understood their role and responsibilities with the structure of the service and they also understood the role of the management team. There was however, a lack of leadership in terms of ensuring the staff team understood their responsibilities under the law.

People told us that felt listened to by the provider when they did raise any concerns. During the inspection, we saw the provider take time to speak to people living in the service. People appeared to be familiar with the provider and comfortable in their presence. Visitors also told us that they felt involved in the service and the care their relative received. One relative told us, "[Registered Manager] and [Deputy Manager] keep us posted re anything that needs to be done."

Most staff that we spoke with told us that they felt listened to and involved in the service. One member of staff told us, "I feel listened to". Another staff member said, "We all know we're very free to go to [the

registered manager] with any suggestions". Staff told us that they were committed to their role and they wanted to provide a good standard of care for people. One staff member said, "I'm not here for [the managers]. I'm here for the residents." We observed a positive, open culture amongst staff members and management. We found that the provider was open to discussing areas of improvement that were identified in the service.

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 11 HSCA RA Regulations 2014 Need for consent People's human rights were not protected through the effective application of the Mental Capacity Act 2005. People did not always consent to the care they received.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services were not sufficiently protected from the risk of harm due to inadequate risk management practices.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not in place to identify and address risks and areas for improvement within the service.