Mr Kevin Hall

Acorns Care Centre

Inspection report

Parkside
Hindley
Wigan
Greater Manchester
WN2 3LJ

Tel: 01942259024

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook an unannounced inspection at Acorns Care Centre on 01 November 2017 and returned for a second announced visit on 03 November 2017.

Acorn's Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home provides single occupancy bedrooms with en-suite facilities, across three floors, and is serviced by one lift. There is a communal lounge on the middle and top floor and a large dining area on the ground floor. At the time of the inspection there were 33 people living at the home.

Following our inspection in 22 and 26 February 2016 and 14 March at Acorns Care Centre, we took enforcement action and subsequently re-visited the home on 10 October 2016 and 12 April 2017, to ascertain if improvements had been made to the quality of care people received. At both inspections, we found the management had continued to make improvements to the quality of care people received and in April 2017, although there remained two breaches of the regulation in relation to staffing and governance, they were regarded to have little impact on people living at the home. As a result of the continued improvement observed, CQC withdrew the enforcement action we had previously taken.

Following our April 2017 inspection, we received anonymous information of concern regarding a mice infestation at Acorns Care Centre. The informant told us management were aware of the issue but had done nothing to address it. We passed this information to environmental health and they undertook a prompt inspection visit. Environmental health ascertained there was mice activity in several areas of the home including the kitchen and dining room. It was found, building repairs had not been made timely to prevent rodent access and pest control arrangements were ineffective in regards to the needs of the home. Environmental Health in collaboration with the provider put control measures in place to ensure people's safety and continued to visit the home for the proceeding four days to confirm appropriate action was being taken. Environmental health undertook a follow up visit in October 2017 and further concerns were identified. We have considered their findings in May and October 2017 to inform our judgements.

At this inspection, we found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regards to; safe care and treatment (two parts), safeguarding, environment and premises and continuous breaches of the regulations for staffing and good governance (two parts). We are currently considering our enforcement options in relation to these breaches.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within

this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

At the time of the inspection there were two registered managers in post. However, following the inspection we were told one of the registered manager's had stepped down and had submitted a notification to cancel their registration with CQC. 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.

All the people, relatives and visitors spoken with during the inspection said the home was a safe place to live. However, at this inspection, we found two people had not been protected from the risk of aspiration or choking. The two people had been assessed as having an 'unsafe swallow' but had been given foods that were not in keeping with their assessed needs which could have exposed them to the significant risk of harm.

Medicines were not managed safely due to processes being inconsistent, re-ordering of stock was chaotic and audits had not been conducted within required timeframes which would assist with re-ordering of medicines.

We found ineffective systems in place to safeguard people from abuse and improper treatment. During the inspection, we identified two events that had occurred which should have been referred to the local authority as safeguarding. However, neither incident had been referred; and one incident had been unknown to either registered manager.

There was a satisfactory recruitment process in place which included obtaining references and a Disclosure and Barring (DBS) check being undertaken before staff commenced working at the home. However, we identified the process of obtaining references required strengthening.

Staffing levels were no longer calculated using a formal calculation based on the needs of people using the service. We received mixed views from people, relatives and visitors regarding whether there were enough staff to meet people's needs.

Following the inspection, we received the infection control audit and the service was rated 100%.

We saw the mealtime experience was positive and people were complimentary of the food choices and quality of the food provided. People's nutrition and hydration needs were met but we found records to demonstrate this required strengthening.

The managers did not have an effective system in place to demonstrate compliance with the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS). The registered manager had no system in place to undertake mental capacity assessment and oversee Deprivation of Liberty Safeguard applications. Granted authorisations remained on the computer and were not with people's care files; the registered manager was unable to identify recommendations made and how these were being met to demonstrate compliance with the Act.

We found the system to oversee and schedule training was ineffective. Staff that weren't due refresher training had been prioritised to attend the moving and handling training prior to people that had never completed the training at all. This meant staff were working without the required competence and skills to fulfil the duties of their role. Staff had not been appropriately supported by the management as they had not received consistent support through supervision and appraisal.

People's biographical information, likes and dislikes was captured but had not been incorporated in to people's risk assessments or care plans to support person-centred care planning.

People living at the home and their relatives described the staff as kind, caring and always willing to help them when needed. We found the staff were friendly and engaging which made for a relaxed and pleasant atmosphere. Staff were knowledgeable about the people they cared for and expressed being proud of the care they provided.

People were treated with dignity, respect and were given privacy at the times they needed it. We observed staff knocking on bedroom doors before entering and providing explanation to people prior to undertaking care tasks.

Staff had not received end of life training and despite being a nursing home, nursing staff were unable to manage syringe drivers and would require support from community nurses if a person needed this intervention and wanted to remain at Acorns Care Centre to receive end of life care.

The home had equality and diversity policies in place and the registered managers were able to demonstrate when they had been sensitive and supported people or staff's cultural needs.

There was a complaints system in place and this was advertised throughout the home. All the people spoken with during the inspection expressed knowing the complaints process but informed us they had never had cause to make a complaint.

We found the operational structure had not been embedded and there was no oversight maintained in regards to managing the regulated activity. Audits were not completed in line with the regulations which meant issues were not being identified internally and addressed to ensure people were receiving safe and effective care. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Two people were at risk of choking or aspirating on their food as they had been given foods that were deemed unsafe by Speech and Language Therapy (SaLT).

The system to manage safeguarding was ineffective as we found two safeguarding referrals that had not been made in line with local policy.

Medicines were not managed safely as systems were chaotic and audits were not conducted regularly to support medicine ordering.

The environment had not been effectively maintained which had resulted in a mice infestation.

Is the service effective?

Requires Improvement

The service was not consistently effective

The system to oversee staff training was not effective. Staff had not received the training, support and supervision needed to enable them to fulfil their role.

The system to oversee the Deprivation of Liberty Safeguards (DoLS) was ineffective and authorisations were not kept with people's care records to demonstrate recommendations were being followed.

Fluid charts were not accurately completed, or analysed. People were not protected from the risk of dehydration.

The overall mealtime experience was pleasant and people praised the quality of food and choice available.

Is the service caring?

Good

The service was caring

People and their relative's spoke highly of the care provided.

People told us staff listened to them and provided the time for them to do the things they could do for themselves.

People were treated with dignity and respect.

People's confidentiality was protected. Personal information was appropriately stored.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

Care plan reviews were nurse led and did not involve people, their families or care staff who were responsible for undertaking the majority of the day to day care interventions.

People told us they received responsive care and staff demonstrated they knew people well.

There were social activities available that were flexible and adapted to meet the needs and wishes of people living at the home.

There was a complaints process in place which was advertised around the home which meant people and relatives had the relevant information required to make a complaint.

Is the service well-led?

Inadequate

The service was not well-led

There was a lack of oversight and scrutiny by the provider.

The management were not completing quality assurance checks frequently or effectively to ensure that they were able to effectively assess, monitor and mitigate the risks relating to people's health, safety and welfare.

The provider was not meeting regulatory requirements as we found breaches of the regulations.

The management had not sustained the previous improvements observed which meant the standard and quality of care had declined and the service has been placed back in to special measures.

Acorns Care Centre

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 checked 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.

Our inspection visit at Acorns Care Centre on 01 November 2017 was unannounced but we returned for a second visit on 03 November 2017, which was announced.

The inspection team was made up of one adult social care inspector, a specialist adviser (SPA) who was a Pharmacist and one 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 expert by experience had experience in caring for older people and people living with dementia.

Before the inspection we reviewed the information we held about the service, which included correspondence we had received and any notifications submitted to us by the service. A notification must be sent to the Care Quality Commission every time a significant incident has taken place; for example, where a person who uses the service has a serious injury.

We also spoke with the local authority quality performance officers, safeguarding, environmental health and infection control to ascertain if they had information to support our inspection planning.

During the inspection we spoke with nine people who lived at Acorns Care Centre and three relatives/visitors. We spoke with the compliance manager, registered managers, team leader, three care staff and kitchen staff. We spent time looking through written records, which included four people's care records, three staff personnel files and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

All the people, visitors and relatives expressed feelings that Acorns Care Centre was a safe place to live. Comments included; "I feel very safe as there are always lots of people around to look after me." "I feel safe because I can do things here with help that I can't do by myself. I have never had anything go missing, clothes sometimes get mixed up, but they always go and find them for me and bring them back." "Everyone is safe, because all the carers are so kind and nothing is too much for them. I felt happy here from the start." "[Relative] is very safe here. [Relative] shouldn't get out of the chair by herself so they always take her to the toilet etc. They look after her very well. I am really satisfied with the home. None of her belongings have ever gone missing and I know that can happen in some homes, but not here." "[Relative] is safe as the carers are always in and out to check on her. She has rails on the sides of her bed so I am happy about that as I know she can't fall out."

We found risks were not appropriately managed when people had been identified as having an 'unsafe swallow', as there was no effective system in place to ensure recommendations made by Speech and Language Therapy (SaLT) were being followed. This meant people had been exposed to the risk of choking or aspirating. Aspirating is when food or drink goes down the windpipe and enters the lung.

We looked at two people's care records that had been assessed as requiring a fork-mash diet. We saw risk assessments and care plans had been updated in a timely way following SaLT assessments. SaLT guidelines were available for both people, which meant staff had the required information to mitigate risks associated with the two people's dietary needs.

We cross referenced this information with both people's food and fluid records and saw both people had received foods that were not in keeping with their assessed needs, which had exposed them to the significant risk of harm. The foods given included: cooked breakfast; toast; sandwiches; crisps; and fruit salad, which contained grapes. On the second day of our inspection, we observed one of the people eating egg on toast and the other person was eating a cooked breakfast and toast. Neither person was deemed to have capacity to consent to their care and treatment and relied on staff to keep them safe.

We looked to see how accidents and incidents were monitored and what control measures were put in place to prevent further re-occurrence. We saw accidents and incidents were recorded and when people had experienced recurring falls; risk assessments and care plans had been updated as needed. We saw referrals had been made to people's GP for medicine reviews or the falls team for assessment and support. The registered manager calculated how many falls and incidents had occurred but did not undertake an analysis of the information to determine themes and trends.

We found medicines were not managed safely as there was an absence of procedures, which resulted in inconsistent approaches between nursing staff. The medicines policy and procedure documented; 'A formal procedure to organise prescription orders with each GP practice should be established'. We ascertained that a formal procedure had not been devised and we observed the registered manager making notes of stock shortages and required orders on the back of a napkin. The last medicines audit had been completed

8 September 2017, which meant a weekly system to manage stock levels were not in operation.

We found 'when required' (PRN) protocols in place were of a standard format and not personalised. The PRN protocol did not contain information to determine: how the person would let the care staff know that they needed pain relief; for what reasons the pain relief was given; and we saw one person had the wrong medicines strength documented on the PRN chart to what they were actually prescribed which was unsafe.

We observed nursing staff administering PRN with other medicines as standard without enquiring with the person whether they required PRN. Nurses were not consistent when documenting PRN as some nurses completed the information on the medicine administration record (MAR) whilst other staff signed a separate PRN sheet and didn't make a record on the MAR. We saw the homely remedies information was limited and didn't contain guidance as to who could be given homely remedies and in what circumstance.

We saw two people had frequently refused medicines but the nurses had not maintained notes on the reverse of the MAR to indicate why this had occurred. We noted one of the people did not have capacity to consent to their care and treatment which meant covert medicines should have been discussed with their GP and pharmacy.

This meant there had been a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; safe care and treatment because medicines were not managed safely and the provider was not mitigating risks associated with people identified as having an unsafe swallow.

Following our April 2017 inspection, we received anonymous information of concern regarding a mice infestation at Acorns Care Centre. We were told management had been informed but had done nothing to address it. We passed this information to environmental health and they undertook a prompt visit and ascertained there was mice activity in several areas of the home including: the kitchen, dining room, cleaning store and first floor of the home. Environmental health visited daily for four days following their initial visit and worked with the provider to ensure the premises were safe. We maintained contact with environmental and the provider throughout this period but found progress was delayed, which resulted in the kitchen being closed for four days. The food hygiene rating awarded in May 2017 was 0. A further visit has been undertaken by environmental health in October 2017 and further concerns identified. The food hygiene rating awarded following their October 2017 visit is 1. Environmental health is currently considering their regulatory response to their findings and we have used this information to inform our judgements.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, premises and equipment because the provider was not ensuring the premises were clean, secure and suitable for the purpose they were being used.

Following Environmental Health concerns regarding the kitchen, the infection control team (ICT) conducted an infection control audit on 13 November 2017 at Acorn's Care Centre to ascertain procedures and infection control was being effectively managed in the rest of the home. ICT updated CQC regarding their findings and the home had been awarded a score of 100%.

We looked at the system in place to safeguard people from abuse and improper treatment. We identified shortfalls at Acorn's Care Centre with regards to the identification of safeguarding incidents and reporting procedures. We found two incidents staff and management had failed to identify and raise safeguarding alerts when safeguarding incidents had occurred. These incidents included a person who was alleged to have hit another person, and a person that had gone outside unknown to staff and fallen face first out of their wheelchair. We requested these incidents were referred to the local authority following our inspection

and wrote to the provider following the inspection to determine that this had been done.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because systems and processes in place to protect people from abuse and improper treatment were not operated effectively.

During the inspection, we looked at how the provider ensured there were sufficient numbers of staff on duty to meet people's needs. We were told by the registered managers that staffing levels were no longer calculated using a formal method based on people's dependency. The registered managers told us there were two nurses and six care staff on duty in the morning. This reduced to five care staff and minimum one nurse in the afternoon. The registered managers indicated they had informally analysed the needs of the service by observing when staff were busiest and people most dependent. We were told shifts had changed to address this and two members of day staff commenced shift at 07.00 to assist night staff between 07.00 and 08.00.

We received mixed views from people, visitors and relatives as to whether they thought there were enough staff. Comments included; "They help me, the staff are very good. I shout out for their help when I am here in the lounge. Someone will come." "I find there are plenty of carers, they come to help me fairly quickly." "There are lots of carers and they attend to you very quickly. Once I was in the bathroom and I pulled the call bell twice. I didn't know that meant there was an emergency. Two carers came bursting in straight away to see if I was alright." "There is plenty of staff at the moment. When I have been here I have seen that [my relative] doesn't have to wait long if she requires support." "Sometimes I think there could be more carers as they are all rushed off their feet. When I ring the bell I've never had to wait more than three minutes." "Just at present the staff are run off their feet. They attend to [my relative] as soon as they can." "I am sure they could do with more staff. The ones they have are very hard working and if you ask them something they will always spare time to talk to you."

We recommend that the management employs a dependency tool based upon the needs of the people using the service to ensure there is consistently sufficient, effectively deployed staff to meet people's needs.

We looked at three staff personnel files for staff that had commenced work at Acorn Care Centre since our last inspection. We saw adequate checks had been carried out prior to new staff starting work. We found pre-employment checks had been completed; staff had confirmed their identity, completed application forms with any gaps in employment explained, had provided references and a Disclosure and Barring (DBS) check had been undertaken. However, we saw references were completed on a standardised form and management had not requested verification on the author's identify. This meant there was a gap in the recruitment process that needed addressing to strengthen the procedure.

We looked at the home's safety documentation, to ensure the service was appropriately maintained and safe for residents. Gas and electrical safety certificates were in place and up to date, hoists, lift and fire equipment was serviced within regulatory timeframes with records evidencing this. People's care records contained personal emergency evacuation plans (PEEPS) and there was a file containing copies of these in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, we found the induction had been aligned with the care certificate and at this inspection it was confirmed new staff continued to be signed up for the care certificate.

At the last inspection, we found the service to be in breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because as staff training was not up to date. The gaps in training included Health and Safety (63% of staff), Infection Control (65%) of staff, Fire (73%), Safeguarding (70%), Manual Handling (53%), DoLS (40%), Mental Capacity (38%) and First Aid (50%).

At this inspection, we found there were still gaps in the training and the registered manager could not demonstrate oversight or an effective system for scheduling training. For example, we found staff working at the service that had never had moving and handling training whilst other staff had attended the training before their refresher training was required. Eight care staff were working without basic first aid training, six staff without food hygiene training and no staff had completed nutrition or dysphagia training and there was no identified timeframe for completion. We also found significant issues with the management of people's dietary needs.

We checked to see if staff were provided with appropriate supervision and appraisal, as this has been raised as an area of concern at all our previous inspections. We found there remained no systematic approach for scheduling or providing staff with supervision and although we had raised appraisals at our previous three inspections on 01 November 2017, no appraisals had been completed. During our second visit on 03 November 2017, we saw 10 appraisals had been completed on 02 November 2017. However, these contained little detail or evidence that an informative discussion had occurred to support staff with continuing professional development.

The service was found to be in continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff had not received appropriate support, training, professional development, supervision and appraisal to enable them to effectively perform their duties.

We looked at how people were supported to maintain good nutrition and hydration. People living at the home had nutritional risk assessments and care plans in place. The registered manager had also implemented the malnutrition universal screening tool (MUST) since our last inspection. This meant there was a recognised assessment tool to guide staff as to when a referral was required to dieticians. These were reviewed each month or as people's needs changed.

All the people spoken with during the inspection told us the food served to them was of a good quality. People said there was ample to eat and a good choice provided. We were told if people didn't like a meal, they could ask for anything and it would be made for them. People's comments included: "The food is quite nice and there is a choice. I'm never hungry as I get plenty. If I want something else they will make it for me." "I like the food. Each day they come around to my room and tell me what choice there is for lunch, if I don't like it I get jacket potato." "The food is very good. I am very fussy but I can't fault the food." A relative said;

"[Relative] likes the food and has plenty to eat. [Relative] can also ask for a snack at any time."

We observed the mealtime experience was positive and staff were attentive to people's needs. People were offered a choice of breakfast cereals, cooked breakfast or breakfast sandwiches. Staff didn't rush people and when people required support, this was provided discreetly and staff spoke with the person throughout the meal. Lunch was homemade soup and sandwiches and the evening meal was another cooked meal with a choice of pork or barbecue chicken, potatoes and vegetables, which people chose earlier in the day. The chef advised us that this was just a guide for meal preparation but people could still chose the alternative meal at the time it had been prepared.

The home had documents which were used to record food and fluid intake; but we found the records we reviewed were not completed effectively. There were large gaps on the records as we noted there was no food or drinks documented as given after 4.30pm. This raised concerns that people were not being provided nutrition and hydration after this time but we confirmed with people that this was not the case and that drinks and snacks were provided in the evening. The records did not identify what the recommended daily fluid intake would be for the person, which meant that staff were not able to monitor whether this had been met. We saw some fluid charts only recorded people as having consumed 600mls of fluids but this had not been identified internally as a concern or that records ceased being completed after 4.30pm to address this.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found mental capacity assessments were not being consistently completed when people did not have capacity to consent to their care and treatment or make specific decisions. The registered manager had no system in place to undertake mental capacity assessments or oversee Deprivation of Liberty Safeguard applications. We found DoLS applications were not being made timely as one person's admission documentation in August 2017 indicated they did not have capacity to consent to their care and treatment. However, at the time of our visit, the MCA assessment and subsequent DoLS application had still not been completed.

We saw the DoLS matrix was not updated when required and contained inaccurate information and there was no process for pursuing applications once submitted to the local authority to determine assessment timeframes. We found granted authorisations remained on the computer and had not been incorporated in to people's care records. We asked the registered manager whether the supervisory body had made any recommendations for people subject to DoLS but the registered manager was unsure and could not demonstrate this had been determined or being considered in relation to care planning.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider was not maintaining a complete and contemporaneous record in respect of nutrition and hydration or deprivation of liberty safeguards. This meant they could not demonstrate people's needs were being met or the service was working in line with the Mental Capacity Act.

We saw people had access to health professionals as necessary. There was an ancillary visits record in people's care files detailing any appointments they had attended, if they had been referred for further

advice, or if they had been visited at the home. Some of the professionals involved with people's care included, GPs, district nurses, dieticians, podiatrists and the diabetic team.

We saw people had been involved with choosing the colour scheme and décor of the home. For example; the ground floor was painted Wigan Warrior's colours as tribute to the local team. There were pictures of Hindley town centre, local parks and train stations. However, there was a board in the dining room and the purpose of this was to inform people of the day, date, month, season and weather. The board was in the corner of the room so was not visible to people and did not display the correct date, day, season or weather. We observed there were no large clocks in the home or other means for people to orientate themselves to date and time. Signs that were displayed were placed at adult standing height and not in consideration of people in wheelchairs. This meant consideration was not being given to promote people's independence.

Good

Is the service caring?

Our findings

All the people we spoke with told us they thought the staff were kind and caring. Comments included, "They look after me very well. The carers are marvellous people and they spend so much time with me." "The carers are very good, they know exactly how to care for me and I have never felt there is anything they can't do for me." "They look after me well. I feel stuck in my room sometimes but a young woman comes in and takes me outside for a ride in my chair. She has offered to take me to Wigan and Southport." "They look after me well, there is nothing they could do better." A relative said; "[Relative's] care needs are met. She gets more support here than we could give her at home. We are very pleased with everything; very satisfied."

We observed staff were caring, patient and kind in their interactions with people. We saw when staff came into the communal areas they spoke with people, listened to what people had to say and gave them time to respond. Staff were knowledgeable about people and their families and demonstrated they cared. For example, we heard one person speaking about their family and expressed being confused about where they were. A staff member reassured them and spoke about their family member being in Australia. By the end of the conversation, the person and staff were laughing and joking and the person had visibly cheered up following the conversation and reassurance given.

There were also friendly and person focused conversations relating to offering drinks and biscuits. Staff we spoke with knew people well. We saw people were relaxed in the company of staff and laughed or smiled when chatting with them. Where people did not respond we saw staff remained animated and encouraging when talking to them.

Staff demonstrated they knew people well and engaged with people to get the best out of them and make them happy. We saw staff asking one person about their visit to the hairdresser and complimenting them on their hair and how nice they looked. Another staff member was joking with a person. The person was laughing and quick witted, joking back with the member of staff. The person told us, "They are cheeky with me and I love it."

We observed the registered manager with a person in their bedroom. The person had limited communication and mobility but they elevated out of their chair when they saw the compliance manager had returned from their holiday and signalled with their arms to hug them. The manager had returned with jewellery for them. The person was visibly delighted, throwing their arms in the air and clapping their hands. The jewellery was put on them and they continued to touch it on their person and hug the manager. We left them so not to intrude further as it was evident they had missed them.

We saw staff ensured people had their personal effects close to hand for example the ladies had their handbags and wore their own personal jewellery. The home celebrated people's birthdays and bought people individual gifts.

We saw staff knocked on people's bedroom doors before they entered when checking whether people needed anything. We observed staff treated people with respect and ensured their privacy and dignity was

maintained. For example, we saw staff were calm and considerate when assisting people with the hoist. We saw they explained what they were doing and reassured the person throughout the procedure. We saw staff ensured people's modesty was maintained by checking their clothing was not displaced. People looked well-groomed and were comfortably dressed. People and relatives told us; "Whenever I am in the bathroom they will shut the door when I am on the toilet and wait for me to call them. They cover me up when I am being washed as much as they can." When [relative] needs the toilet they give privacy. If she uses the commode in the room they will close the curtains." "They treat me with the greatest of respect. When I'm in the bathroom they leave me, and say shout when you are ready."

However, we saw there were isolated instances when we found staff were not always mindful of people's dignity. For example, at mealtimes we observed staff placing people in a queue at the lift in their wheelchairs waiting to go down in the lift to the dining room. We observed people were queued at the lift in excess of ten minutes as a staff member came up and down in the lift to collect people. We expressed our concern to the management who agreed that people should be taken to the lift one at a time when it was available to take them down rather than several people being queued up in the corridor waiting. They assured us they would address this at the next team meeting.

People told us their choices were respected by staff and their independence was promoted. We saw people had set places in the dining room but staff didn't assume and clarified with people were they wanted to sit. People told us staff never rushed them and gave them the time they needed to do things.

People's rooms were large and decorated in the way they preferred, with their own personal belongings. People could use their own rooms to meet with visitors if they preferred. Everyone stated they could have visitors at any time and that they could stay as long as they wished. A relative also told us; "When I come they chat with me and offer me drinks and something to eat."

People's right to confidentiality was now protected. Key code locks had been placed on nursing office doors which contained people's care records. Throughout the inspection visits we noted these remained locked unless staff were in the office.

Requires Improvement

Is the service responsive?

Our findings

We asked people whether they felt involved in planning their care. None of the people spoken with during the inspection could demonstrate how they had been involved in planning their care. The people we spoke with were also unfamiliar with the content of their care plan. However, relatives expressed feeling they'd had more involvement. Comments included, "When [relative] first came here I was involved in care planning. I have attended some review meetings. I feel in control of [relative's] care and they listen to my opinions and wishes." "When we first came here, we were involved in the care plan to a certain extent. They visited us at home and said they could look after [relative] and cater for their needs. We are happy with everything they do." "I feel my views are listened to and I have control of [relative's] care. I can talk to management at any time if I have any concerns or questions."

People told us their needs were met and they felt staff provided good care. They told us staff were responsive to their needs and they could choose when to get up and when to go to bed. We found staff had a good understanding of people's individual needs, which had developed from working at the home for a long time and the formulation of strong relationships with the people living there. Staff demonstrated they understood people's preferences and interests, how best to communicate with them to meet their needs, which meant the current people being supported were receiving support that was responsive to their needs. Despite this, we found care plans did not include personalised information about people's care and they had not been reviewed or updated with people to ascertain the information was reflective of people's current needs. Care plans and reviews were signed by nursing staff which meant the service was not including people in reviews of their ongoing care or supporting people to express and document their views or preferences following admission.

We found staff had asked people's relatives to complete their family member's life histories when people were unable to provide staff with this information themselves. We saw information in people's care files pertaining to people's life histories, background information, employment history, interests, likes and dislikes. However, this information had not been embedded in to people's care plans to provide personalised care. They focused on what had to be done and didn't account for people's individual needs and promoting people's independence. The care plans were not goal orientated and just detailed the interventions required. We discussed this with the managers who told us they had identified this and it was their intention to start addressing this and amend the care plans in order to make them more person-centred.

We recommend the registered manager seek advice and guidance from a reputable source, about person - centred care planning.

People's equality and diversity and protected characteristics such as race, sexual orientation, and disability were considered at assessment and management and staff demonstrated a good understanding of these considerations. People's cultural and spiritual needs were being met by religious events, and Holy Communion was held at the service on regular occasions. A person told us; "We can go to communion every fortnight which I like. We have it here."

We saw meetings for people living at the home had been arranged but the last meeting had been cancelled, so people had not formally been able to express their opinions or give feedback but they told us they felt confident to do this with the staff at any time. We saw relatives coming and going throughout the inspection. There was friendly chatter between staff, people and relatives, and it was evident that people's relatives were as familiar to staff as the people living at the home and had been made to feel welcome at the home.

Complaints and comments processes had improved and were advertised throughout the home so people and their relatives had access to the necessary procedure to make a complaint. We saw in the complaints file that there was only one complaint logged from some time ago involving the water temperature which had been actioned and resolved. We spoke with people to confirm that it wasn't just that complaints were not being recorded. All the people spoken with and their relatives confirmed they'd never had cause to make a complaint and informed us if they did have a concern that they would go directly to the managers which they named in person and raise the issue.

During our inspection, we saw few activities available for people as the activities coordinator was on annual leave. We saw upcoming events and activities displayed in the reception area and throughout the home. We were told the activities schedule had changed as people had requested more one to one activities and trips out. This was substantiated by people and their relatives that we spoke with. People said, "I did knitting a long time ago, but I can't do it now because of my hands. I go to the knit and natter meetings just to chat. I like people from outside coming in and entertaining us and I like the trips out." "I can do what I want. Sometimes I join in with things going on. I like books so I read in my room." "I am partially sighted but if I go to bingo or quizzes they always help me so I can take part." "[Relative] likes to go to knit and natter on Monday. Tuesday, she likes bingo and every Wednesday she has her hair done. They take [relative] on trips out in the local area -Tesco, but she enjoys that." "All my [relative's] needs are met. Every afternoon there is something going on and they help her to join in activities to stimulate her."

We looked what arrangements were in place to support people if they wanted to remain at Acorns Care Centre to receive end of life care (EoL). Relatives told us; "We have discussed end of life care with the manager. She knows my views on resuscitation and so everything is in place now." "EoL has been discussed with the manager. I was asked about resuscitation and they know my wishes. I have also expressed that I wish her to pass away here at the home." "I have told them I want [my relative] to be here at the end and not in hospital." We found people were making their own decisions regarding resuscitation or families had been involved in the decision in their best interest if the person was deemed not to have capacity. We found staff had not received end of life training and despite being a nursing home, nursing staff were unable to manage syringe drivers and would require support from community nurses if a person needed this intervention and wanted to remain at Acorns Care Centre to receive end of life care.

Inadequate

Is the service well-led?

Our findings

At our first inspection in February 2016 we found a lack of leadership and managerial oversight of the home. Following this inspection, we took enforcement action and the home was placed in to special measures. A nurse working at the home was promoted to the registered manager and registered with CQC to manage the regulated activity. We were told the previous registered manager would be the compliance manager and provide oversight to Acorns Care Centre and its sister home.

Following the February 2016 inspection, the home was rated as inadequate and was supported by Wigan local authority through a service improvement programme (SIP). This involved an action plan being devised to meet the regulatory requirements with the quality performance officers (QPO's) from the local authority supporting the home through the process. CQC attended regular SIP updates and the home continued to make good progress throughout this process.

At the October 2016 and April 2017 inspections, we found the management continued to make improvements to the quality of care people received and in April 2017, although there remained two breaches of the regulation in relation to staffing and governance, they were regarded to have little impact on people living at the home. As a result of the continued improvement observed, CQC withdrew the enforcement action we had previously taken.

The expectation would be that following the previous inspections and the April 2017 'requires improvement' rating, the provider would have ensured the quality of care received had continued to improve and attained a rating of either 'Good' or 'Outstanding' at this inspection. This had not been the case as we found the oversight provided had declined and the provider had failed to meet the regulations in respect of; consent, safe care and treatment, safeguarding, governance and staffing. In addition, the provider had consistently failed to sustain and make improvements where non-compliance and breaches of regulations had been identified at previous inspections. This meant the quality of service provided to people living at the home was not continuously improving over time and as a result of the regulatory breaches found at this inspection, the service will be placed back in to special measures.

At the time of the inspection there were two registered managers in place. 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. One registered manager was responsible for the daily management of the home and we were told the second registered manager had a compliance role and overseeing the regulated activity at both homes at provider level. We found the service remained inadequately led and there was no oversight from the registered provider. Neither the registered manager or compliance manager were fulfilling the requirements of their role which had resulted in regulatory breaches occurring that had not been identified internally.

We identified during this inspection that effective systems and processes were not in place to monitor and improve the quality and safety of the service. There were no robust quality assurance systems in place to

effectively monitor the service to ensure people's safety and mitigate risks relating to their health, safety and welfare. We asked to look at the auditing which had been undertaken since our last inspection. With the exception of two health and safety audits, two cleaning and kitchen audits and medicines audits which had not been completed for eight weeks prior to the inspection, management could not evidence what quality assurance they had undertaken or the actions they had carried out since our last inspection in April 2017. This included the review of people's care plans to ensure they reflected people's current care and support needs, robust analysis of incidents and accidents including witnessed and unwitnessed falls, safeguarding incidents, staffing levels, safe management of medicines, providing person centred care and the home manager conducting regular walks around the service to identify risks within the home's environment.

Improvements were also needed to record keeping as there were inconsistencies in the accuracy of information contained in people's care records, examples of these have been highlighted in the safe, effective and responsive sections of this report. Inaccurate or incomplete information in care records places people at risk of not receiving the care they need. This further demonstrated to us that there were ineffective systems in place to accurately assess and monitor the service. Moreover there was a lack of scrutiny and oversight on the provider's behalf regarding how the service was identifying areas for improvement and taking the appropriate actions. Significant improvements were required to ensure effective quality assurance systems were in place to drive improvements.

The management could not evidence how they were moving the service forward. It was apparent from our inspection that the absence of robust quality monitoring and lack of auditing processes was a contributory factor to the failure of the registered managers and provider to recognise breaches or any risk of breaches with regulatory requirements.

The above failings demonstrated a continued failure by the provider to ensure regulatory requirements were being adhered to. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An operational structure had been developed which included, the compliance manager, registered manager and team leader to support the daily running of the home and to provide staff with management support and guidance. The staff spoke positively of this, however we found there was no cohesion between the management regarding what their role entailed, their responsibilities or communication to manage the regulated activity.

We found the culture, leadership and management of the service were open and transparent. The management were honest regarding the current position and did not dispute our findings. Both managers acknowledged they had not been fulfilling the duties of their role and attributed this to covering nursing shifts and providing care rather than overseeing the quality of care provided.

The management had sent out surveys to people but there had been no identified timeframe for completion or consideration when the surveys would be analysed to use the information to drive improvements. There were no suggestion boxes to capture feedback on a regular basis.

We asked the registered manager how they met staff's cultural needs and saw the home had an equality and diversity policy. They also spoke of supporting a staff member's cultural and religious needs by enabling them to take regular breaks for prayer and providing a room to support them to achieve this in private with no disruption.

Following our inspection the compliance manager informed us the registered manager had stepped down

and was going to be the clinical lead. They told us they would manage the regulated activity in the interim whilst advertising for a registered manager. The compliance manager said they had contacted Wigan QPO's to request support to address the areas of concern identified during our inspection and that following our feedback they were in the process of reviewing all the systems and processes in place to ensure their audit and governance systems were safe and effective. However, due to the seriousness of our concerns we wrote to the provider on the 14 November 2017 requesting an update from them to tell us what they had immediately implemented following our inspection to ensure regulatory requirements are met. We are currently considering our enforcement action and will continue to monitor the service.