Acorn (Watford) Ltd

Acorn House - Acorn Watford Limited

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 7 February 2017 and was unannounced. Acorn House provides accommodation and support for up to ten adults with learning disabilities. Accommodation is provided over three floors in a large semi-detached Edwardian building located in a residential area. At the time of the inspection there were ten people living at the home. They had a range of learning disabilities and some people were also living with long term conditions such as dementia and diabetes.

We last inspected Acorn House on 15 December 2015 when we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because potential risks to people's health, safety and well-being were not being consistently managed. After the inspection the provider wrote to us to say what they would do to meet the legal requirements. At this inspection we checked to see if the required improvements had been made and whether the provider was meeting the requirements of the Health and Social Care Act 2008. We found that improvements had been made, however further areas of concern were identified.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of the inspection the registered manager was on maternity leave and the deputy manager was in charge.

Risks to people were not always identified, assessed and managed. This meant that suitable arrangements were not always in place to minimise risks to people and staff. Staffing levels were not always adequate to ensure that people's needs would be met safely. These issues were identified as areas in need of improvement. Since the inspection CQC have received confirmation that all these areas have been addressed.

There were safe recruitment arrangements in place to ensure that staff were suitable to work with people. Staff understood their responsibilities with regard to safeguarding people. Medicines were managed safely and some people were supported to manage their own medicines. People told us that they felt safe living at Acorn House. One person said, "I feel safe here, it's a very nice place to live."

Staff received the support they needed to carry out their roles effectively. Training was planned and included subjects that were relevant to the needs of people they were caring for. Staff understood their responsibilities with regard to the Mental Capacity Act. People told us that they had confidence in the staff, one person said, "They know how to look after me."

People were supported to have enough to eat and drink and they were able to choose the food that they wanted. Where risks and nutritional needs were identified, people were supported and monitored appropriately and advice was sought from dietary and nutritional specialist. People told us they enjoyed the

food and drink, one person told us, "The food is very, very nice, you can choose from the menu and I can get drinks when I want."

Staff supported people to access the healthcare services that they needed. People's records included clear health care plans and referrals were made quickly when people's health needs changed.

People said that staff were kind and caring and we saw that they had developed positive relationships with the people they were caring for. Staff knew people well and spoke of them warmly with affection. People were supported to express their views and to be involved in planning their care. One person told us, "I can choose what I wear and how to spend my time, I like to go out sometimes, it's up to me." People had been supported to make their wishes known regarding arrangements for end of life care.

People's care plans were personalised and included details of their personal history as well as their preferences and wishes. Detailed care plans guided staff in the most appropriate way to provide care for each person. People were supported to maintain relationships that were important to them. They were able to follow their interests and staff supported people with activities that were meaningful and stimulating to them. This included everyday activities and chores around the house that people wanted to take part in as well as organised leisure activities.

People, their relatives and staff spoke highly of the management at the home. There was clear leadership and staff were motivated and supported in their roles. There was a complaints system in place and people said they felt comfortable raising their concerns. When issues were raised this had been dealt with in a timely and sensitive way. People and staff were involved in developments within the service. One person told us about the recently refurbished bathrooms explaining that they had helped to choose the new bath. They said, "We wanted one that made bubbles and we have got one now."

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 consistently safe.

Risks to people were not always identified, assessed and managed effectively. There were not always enough staff on duty to ensure that people's needs were met.

Staff understood their responsibilities to protect people from harm or abuse and knew how to report any concerns.

People were supported to have their medicines safely.

Is the service effective?

Good

The service was effective.

Staff received the training and support they needed to carry out their roles effectively. They understood their responsibilities with regard to seeking consent from people in line with the Mental Capacity Act 2005.

People were supported to have enough to eat and drink.

People were supported to have access to the health care services they needed.

Is the service caring?

Good

Staff were caring.

People were supported to express their views and to make choices and decisions about their lives.

Staff knew people well and had developed positive caring relationships with them.

People's privacy and dignity were respected and promoted by the staff.

Is the service responsive?

Good

The service was responsive.

People were provided with care that was personalised and responsive to their needs.

Staff supported people to maintain relationships that were important to them. People were occupied with a range of activities and interests that were relevant and meaningful to them.

People and their relatives knew how to make complaints and felt comfortable to do so.

Is the service well-led?

Good

The service was well- led.

There was clear leadership and staff were motivated and supported.

There was an open culture and people and staff were included in service developments.

There were systems in place to monitor quality and drive improvements.

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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 7 February 2017 and was unannounced. The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed information we held about the service including previous inspection reports. At the previous inspection we had identified a breach of the regulations due to concerns that people were not consistently protected from risk of harm. We also looked at any notifications, (a notification is information about important events which the service is required to send to us by law) and any complaints that we had received. The provider had submitted a Provider Information Return (PIR) prior to the inspection. A PIR asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. This enabled us to ensure we were addressing relevant areas at the inspection.

We spoke to five people who use the service, one relative and one visitor. We spoke with two members of staff and the deputy manager. We looked at a range of documents including policies and procedures, care records for four people and other documents such as safeguarding, incident and accident records, medication records and quality assurance information. We reviewed staff information including recruitment, supervision and training information as well as team meeting minutes and we looked at the providers systems and processes.

The last inspection of December 2015 had identified one breach of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in December 2015 we found that the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because potential risks to people's health, safety and well-being were not consistently managed. Arrangements in place which could have potentially placed people at risk of harm had not been identified and managed. At this inspection we found that the provider had taken action to address this breach and systems were in place to ensure that people were safeguarded from the risk of abuse.

At the last inspection in December 2015 we found that standards of maintenance and hygiene in some areas of the home were not adequate and people were not always protected with infection control measures. At this inspection we found that the provider had followed their action plan and addressed most of the areas identified at the last inspection. The ground floor and first floor bathrooms had been refurbished to a high standard and infection control measures were in place to ensure the safety of people and staff. This meant that the breaches had been addressed.

Despite these improvements we found some aspects of the service were not consistently safe. Risks to people were not always identified and managed effectively. For example, the provider had purchased a countertop appliance to provide instant boiling water from a tap. This was used by staff and people living at the home to make hot drinks without the need for boiling a kettle. There were no signs to indicate that the tap supplied instant boiling water and no risk assessments were in place to identify how risks of scalds would be reduced or managed. This was brought to the attention of the deputy manager who agreed to take immediate action to address this.

Risk assessments had been completed for people where they required support with behaviour that could be challenging to others. Staff were provided with clear guidance as to how to support people safely when assisting them with moving and positioning or when they needed support to move safely for example with the assistance of a hoist. We observed staff followed guidance in people's care plans, for example when transferring from a chair to a wheelchair. However, some risks had not been assessed and care plans lacked guidance for staff in how to manage some risks. For example, one person had been identified as being at risk of choking due to dysphasia. There was no risk assessment or guidance for staff in how to manage this risk. An assessment had been completed by a Speech and Language Therapist (SALT) and the person's care plan indicated that they needed a mash-able diet however there was no clear information included in the person's care plan to guide staff in how best to manage their swallowing difficulties. This meant that staff did not always have the information they needed to provide care and support that people needed. Since the inspection this has been addressed and staff now have the guidance they require.

There were systems in place to test the fire alarm system on a weekly, monthly and quarterly basis. However there were gaps in the recording of these tests. This meant that the provider could not be assured that the system was working properly and that people and staff would be alerted in the event of a fire. The deputy manager took immediate action to rectify this omission.

People and staff told us that there was usually enough staff on duty during the week, but that staff numbers were reduced at weekends. The rota confirmed that this was the case. The deputy manager said that two staff were on duty during the day at weekends. The deputy manager said that they determined how many staff were needed by asking staff if they could manage. However, we noted that some people had been assessed as needing one to one attention at certain times of the day and other people needed two members of staff to assist them. Some people also had behaviour that could be challenging to others and this could pose a risk to other people if staff were not available to support them. Some people had health needs that may require urgent attention from staff to maintain their safety and meet their needs. We asked how staff managed these risks when only two staff were on duty. The deputy manager said that some people were able to alert staff if another person needed help, but agreed that these risks would potentially be challenging with only two staff on duty. They acknowledged that this level of staffing may no longer be adequate as one person had declining health and needed two staff members to support them. This is an area of practice that needs to improve. The deputy manager told us that they would take immediate action to ensure that there was an additional member of staff on duty at weekends to maintain people's safety and meet their needs.

The provider had safe recruitment procedures in place and this included criminal records checks undertaken with the Disclosure and Barring Service (DBS). Staff files included application forms, previous work history, records of interview and appropriate references. Safe recruitment procedures ensured that people were supported by staff with the appropriate experience and character to work in the care industry.

Staff had received training in safeguarding adults and were able to describe how they would recognise signs that someone maybe being abused. One staff member told us, "Our job is to keep people safe, I would always report any concerns to the manager." People told us they felt safe living at the home. One person said, "I feel safe here, it's a very nice place to live." Another person told us they felt "safe and happy" and a third person said, "They (staff) always make sure I'm alright, so I do feel safe."

Incidents and accidents were logged and recorded details of any actions that had been taken following the event. These were signed by the registered manager or the deputy manager. The deputy manager said that people's care plans were updated if an investigation following an incident or accident identified that a change was needed.

People's medicines were managed so that they received them safely. Some people needed to have their medicines administered by staff. Staff had received training in how to administer medicines safely. Medication Administration Record (MAR) charts were signed by staff and we saw that there were no gaps in recording. Where medicines needed to be given at specific times this was clearly recorded and included in the person's daily routine guidance for staff.

Some people were being supported to manage their medicines themselves. People had lockable storage boxes in their rooms where their medicines were kept. Risk assessments identified which medicines they were able to manage themselves and identified any help or assistance that people required. A monitoring system was in place to enable staff to support people to manage their medicines safely. One person was able to tell us what medicines they were taking and what they were for. This information was included in their MAR chart and they said they liked having the opportunity to manage their own medicines. They said, "I can take my own medicines, the staff make sure I do it right." A visitor told us that people received their medicines on time. They said, "(Person's name) has seizures but now that they get the medicine regularly they don't get them so much." A relative told us their relation was supported to manage their medicines, they said, "They do their own with supervision and they are so much more confident now."

Infection control procedures were in place and the home had an infection control champion. They explained that their role ensured that staff understood the importance of maintaining standards of cleanliness and staff had access to appropriate personal protective equipment (PPE) such as gloves and aprons when necessary. There were systems in place to ensure that the environment and equipment was cleaned regularly and that maintenance issues were addressed in a timely way. The deputy manager told us that one toilet was in need of refurbishment and that carpets throughout the building had been identified as needing to be replaced. They said that this work was due to be undertaken soon as the most urgent areas of the home had been completed first.

Good

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. Comments included "They know how to look after me," and "They have enough training, they do a good job." A visitor said, "All the staff a really good," another visitor told us, "Each new person is trained. They know how to support people."

Staff told us that they had benefited from having an induction when they started at the home. One staff member said, "It was very beneficial, particularly shadowing staff and being able to ask lots of questions. I felt quite confident when I started." Records confirmed that staff had received training in subjects relevant to the needs of the people they were caring for. For example, some staff had received dementia awareness training, manual handling and health and safety training. One staff member told us that they had received training in how to support people with diabetes and epilepsy. Staff told us they felt well supported in their role and received regular supervision. Supervision is a mechanism for supporting and managing workers. It can be formal or informal, but usually involves a meeting where training and support needs are identified. It can also be an opportunity to raise any concerns and discuss practice issues. One staff member told us, "I have supervision every two or three months and it is useful to have time to talk about any issues or training needs that I have."

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

Staff were aware of their responsibilities with regard to the MCA. One staff member said, "When people can't make decisions for themselves we have to step in and decide what's in their best interests." They went on to say, "We always offer them choices and encourage them but if they refuse something we can't force them." Staff had received training in MCA and we heard them checking that they had people's consent before providing care and support. For example, when it was time for one person to have their medicine the staff member said, "Shall we go to your room now and then I can help you with your tablets if you like?" Mental Capacity assessments were recorded for people in line with the legislation and guidance. For example, one person had been assessed as needing bed rails to keep them safe. A mental capacity assessment had been completed and this showed that they did not have capacity to consent to this restriction on their freedom. A best interest decision had been made with the involvement of an Independent Mental Capacity Assessor (IMCA) who acted as an advocate for the person. A DoLS application had been authorised to ensure that the provider was acting within the law. The deputy manager was aware that the DoLS authorisation was due to expire within the month and that a further application would be needed.

People told us they were happy with the food and drink at Acorn House and told us that they had enough to eat and drink. One person said, "I like the food here," another person said, "The food is very, very nice, you can choose from the menu and I can get drinks when I want." A visitor told us, "The food looks fine." We observed the lunch time meal. A pictorial menu was clearly displayed on the notice board. Staff told us that the menu was based upon people's preferences. We asked what would happen if a person didn't want the meal on offer, one person said, "They will make something else, we can choose what we want." Staff had a good knowledge of people's likes and dislikes, for example a staff member told us that one person described themselves as a vegetarian although they did also eat fish. This was reflected in their care plan. Where people were identified as being at risk of malnutrition or dehydration staff monitored their food and fluids.

Not everyone was eating their meal at the same time. People told us they could choose when to eat and staff confirmed that they accommodated people's wishes. We saw one person come into the dining room sometime after other people to ask for their lunch, staff responded quickly to bring their meal. Some people had a pureed diet and one person needed support to eat. Staff were engaged with the person throughout the meal, encouraging them to eat. The pace of eating was dictated by the person with the staff member telling them what food they were presenting and waiting until each mouthful was finished before offering the next spoonful. There was a relaxed atmosphere with joking and banter between people and the staff.

People were supported to access the health care services that they needed. One visitor told us about the health care needs of the person they were visiting saying, "Their needs have changed. They (staff) got the doctor involved and all the equipment they needed. They keep me informed completely." Care records included a learning disability health assessment and a health action plan. Individual health needs were identified with guidance for staff included in care plans. For example, there was clear guidance for staff in how to support someone with epilepsy including when they had a seizure. Another person had a diabetic care plan in place and they were monitored regularly by the diabetes nurse specialist. People's health care was regularly reviewed by relevant health care professionals such as the community learning disability team, psychiatrist, continence nurse and community physiotherapist. People were supported to keep regular appointments with their dentist, optician and GP. Care records included a 'hospital passport.' This provided relevant information about people that would be useful for nursing staff to know in the event of an admission to hospital. For example, one hospital passport described how to communicate with the person, detailed their medical needs and described things that were important to them and things that they didn't like such as changes in routine.

Good

Is the service caring?

Our findings

People and their relatives told us that the staff were caring and kind. One person told us, "They are all jolly nice people. They should get a gold medal, they work jolly hard." Another person said, "I'm happy living here because the staff are all nice." A visitor told us, "I am a worrier, but when I leave here I don't worry about (person's name). The staff here are just on the job and they keep me informed .The staff are really caring."

Staff spoke warmly about people and it was clear that staff knew the people they were caring for very well. They were able to tell us about them, including their personal history, likes and dislikes and particular character traits. For example, one staff member spoke about being a key worker for one person. A key worker is a named member of staff who takes a lead and special interest in the care and support of a person. They told us about the person's life including their family circumstances, and things that were important to them. They spoke with affection and warmth about the person and demonstrated a clear understanding of their needs. We noted that this information was included in the person's care record. Another person had some communication difficulties and we observed that staff were able to communicate effectively with them because they knew them well and could recognise and understand what they were saying.

People were happy and relaxed with the staff and we saw positive caring interactions throughout the inspection. Staff spoke to people in an appropriate way, asked questions and listened to people's responses to check that they were happy. People were encouraged to be vocal and express themselves using gestures to indicate their views. For example, when playing a game of skittles staff were skilled at ensuring that all the people who wanted to join in were included. They encouraged participation with cheering and clapping to engage people in the game and this was clearly enjoyed by those taking part.

People told us they were included in decisions about their care and support and their care records confirmed this. One person said, "I can choose what I wear and how to spend my time, I like to go out sometimes, it's up to me." We noted that the person went out for a walk during the morning of our visit. We noted that care plans reflected people's views and choices. For example, one care plan stated, 'I like my daily responsibilities, including updating the pictorial notice boards.' A member of staff told us that this person usually changed the photos on the notice board every day. Staff told us that they encouraged people to make choices about their lives whenever possible. One staff member said, "What people do on a daily basis is usually up to them, they decide what they want to do or where they want to go. We know what people like to do and we offer suggestions, but it is their choice that counts."

People's bedrooms were individually decorated and furnished with their belongings. For example, one person told us they supported the local football team and this was evident from the memorabilia displayed in their bedroom. We noted that art work created by people living at the home was on display throughout the house and people were keen to show us their designs. This indicated that staff recognised and respected their work. People told us they could go to their rooms for privacy whenever they wanted to and we saw that some people were spending time in their bedrooms. Staff were seen to be mindful of respecting people's privacy. For example, we observed that staff knocked on bedroom doors and waited for a response before entering. Staff offered support to people in a discreet way, for example suggesting quietly that people

might want to return to their bedroom where they could be supported privately. One staff member told us, "People usually see their visitors in the lounge and we suggest people got to their bedrooms if they need any help to preserve their privacy." People's personal records were kept in the main office in locked cabinets.

People had been supported to make their wishes known regarding arrangements for end of life care. Staff told us that people's religious beliefs were respected and we saw that this was recorded in care records. Pictures and symbols had been used to help people to communicate their wishes concerning end of life care and any arrangements that they wanted to make following their death. For example, people had chosen whether they wished to be buried or cremated. One person's advanced care plan had specified, 'I only want normal music played at the funeral, no hymns. I want the Beatles, Bing Crosby and Elvis.' One person was receiving end of life care and staff told us that they had support from palliative care nurses to ensure they could meet the person's needs and keep them comfortable. A visitor told us, "The staff are will look after them here, and stay with them all night until the very end."

Good

Is the service responsive?

Our findings

People and their relatives told us that staff were responsive to people's needs. One person said, "They (staff) are very nice and helpful." Another person said, "If I have any problems with something they will help me." A relative said, "The staff will act on things and sort things out." A visitor said, "Their quality of life is as good as it can be, I can't imagine anything that could give a better quality of life."

People's care records included assessments of their individual needs and care plans gave clear guidance for staff in how these needs could be met. Care plans were written in a personalised way and included details of personal history and specific information that was important to and about each person. This helped to give a clear picture of the person and guided staff in how to provide personalised care. For example, one person had communication needs and their care plan included guidance for staff such as 'Talk slowly and only use short sentences, you may have to repeat yourself.' Another care plan guided staff in how to support someone who had behaviour that could be challenging to other people, it stated, 'I love heart and ball shaped things, talking about these can help me to calm down if I am agitated.' Staff told us that they used the information in people's care plans to help them when they were first getting to know people and to be able to respond when care needs changed. We noted that care plans were reviewed and updated following changes in needs. For example, an occupational therapist had visited to assess someone who needed to receive their personal care in bed. The care plan had been updated following their visit with clear guidance for staff in how to provide appropriate bed care.

Routines were important for some people and this was evident in their care plans. For example, one person's care plan included a daily routine with clear guidance for staff about possible triggers that might result in the person displaying behaviour that could be challenging. This included having an allocated staff member at certain times of the day. The care plan provided a description of behaviour that could indicate that the person was becoming anxious or frustrated, as well as strategies for staff to support them. Staff told us that having a clear personalised care plan, had resulted in them having fewer incidents of behaviour that was challenging.

People were supported to maintain their relationships with relatives and friends who were important to them. One relative told us, that they visited their relation regularly and that they felt the staff were always welcoming to visitors. They told us, "The staff are always friendly, happy and cheerful, they will sit and have a chat." One person told us that they liked to visit their family in another town and that staff supported them to do this.

People told us they were able to follow their interests and to have choice about how they spent their time. We saw examples of this in people's records and observed people undertaking a range of activities during the inspection. One person was painting a picture and told us that their art work was displayed throughout the home. Another person was spending time in their bedroom sorting through some photographs. They told us that they liked photography and we noted several cameras in their room. Some people had gone out, either independently or with a staff member. One person told us they had been to the cemetery and then to the shops. Staff told us this was what the person had chosen to do. People were supported by staff

with structured activities. We saw people enjoying a game of skittles and a game of bingo. Staff were skilled in encouraging people to take part and we noted that people were engaged and clearly enjoying the activities.

People told us that they were involved in household tasks such as doing their laundry and keeping their bedroom clean and tidy. A relative told us their relation was supported to undertake a number of tasks including loading the dishwasher, cooking, making tea and coffee. They said that staff supported them with their interests such as going bowling and watching sports, especially football. Staff said they supported people to be as independent as possible. We noted that people had been supported to undertake the health and safety check of some areas of the home. Photographs were used to prompt checks of certain areas to ensure they were clean and tidy. There were photographs of the kitchen including the cooker hob, rubbish bin and light switch. This enabled people to have meaningful involvement in the running of the home.

People and staff told us that meetings were held regularly with people living at the home to ensure their views and opinions were sought. One person said, "Staff ask us about what we'd like to do and if we'd like to go out anywhere." Notes from these meetings confirmed that people were encouraged to express their views. People told us that their views were listened to, for example notes of one meeting included requests from some people to visit the Harry Potter studios and staff and people told us that this had been arranged.

The provider had a system in place to record any complaints. People and their relatives knew how to make a complaint if they needed to. One person told us they would speak to their key-worker, another named the deputy manager as the person they would talk to. A relative said, "I have no complaints, but they would act on it if I did have." A visitor said, "I know how to complain but I've no concerns." The deputy manager told us that they regularly checked with people to make sure they were happy and to ask if they had any complaints. There were no complaints recorded at the time of the inspection.

Good

Is the service well-led?

Our findings

The registered manager was on maternity leave at the time of the inspection and the day to day running of the home was managed by the deputy manager. People and their relatives told us that Acorn House was well managed. Their comments included, "It's marvellous, always clean and tidy," "Staff always seem to know what they are doing," and "Management is very good, very efficient and on the ball." The atmosphere was described as friendly, warm and welcoming and people told us they felt the place was homely. One person said, they were "settled and happy," another person said, "It's nice living here." Staff also spoke highly of the management at the home and said that they were happy working at Acorn House.

Staff told us that they and people living at the home were encouraged to be involved in its running. One staff member said, "Everyone gets on well, everyone is involved and we can all have discussions about changes. Our views are listened too." Notes of meetings with staff and people in attendance confirmed that people and staff were able to express their views. For example, ideas and opinions had been expressed about the recent refurbishment of two bathrooms. One person told us that they had been asked about the type of bath they would like, they told us, "We wanted one that made bubbles and we have got one now." Another person said that they wanted to have more flowers in the garden and staff told us of plans to improve the garden including a number of tulips being planted.

People were supported to maintain links with the local community. For example, staff were aware that some people had religious beliefs and they supported them to attend their preferred place of worship. One person was out at a local day centre on the day of the inspection and the deputy manager said that there was good communication between staff at the day centre and at Acorn House. The deputy manager told us that they had made positive links with the local GP surgery, and had regular contact with other health and social care professionals.

Staff spoke positively about the culture of the home and described a homely atmosphere. One staff member said, "It's a lovely place to work and people are happy living here and working here." This view was shared by a relative who said, "People here are always happy and cheerful, it's a warm and friendly place." People, relatives and staff told us that the managers were approachable and easy to talk to. One person said that the Deputy manager was, "Very nice, I can ask them anything." The deputy manager said that morale was very good and that staff were committed to ensuring people lived, "Happy lives and felt comfortable in their home." They described a co-operative staff team that "pulled together" to ensure that shifts were covered. They told us, "Staff don't want people to have strangers coming in, so we cover any vacant shifts between us." Staff told us that the provider was helpful and supportive, one staff member said, "They do listen and are happy to make changes if needed."

There were a number of quality assurance systems in place to monitor quality and drive improvements. A recent survey undertaken with people living at the service was positive in most aspects. Where people had expressed some dissatisfaction, actions had been taken to address their concerns. A number of audits had been undertaken and check lists were completed to ensure that areas identified for improvement were actioned. For example, a system was in place to ensure that daily cleaning tasks were undertaken to

maintain hygiene standards around the home. The deputy manager had oversight of audits and other quality assurance systems and used this information to develop action plans for improvements. This included monitoring incident and accident reports to look for trends or patterns.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The deputy manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The deputy manager was also aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.