Acorn Lodge (Bournemouth) Limited

Acorn Lodge - Bournemouth

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

This unannounced inspection took place on 18 October 2016 and was carried out by one inspector.

Acorn Lodge is registered to provide accommodation for up to nine people over 18 years old with learning disabilities. At the time of our inspection nine people were living there.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People had person centred care plans which identified their likes, dislikes and preferences. This included how people liked to spend their day and what foods they liked as well as what was important for them and their aspirations. Staffing was provided according to people's needs and their plans for the day. There was a well-established staff team who were knowledgeable about people. The registered manager told us they had enough staff and would not use agency staff to work in the home as they did not consider it appropriate.

The provider had a small holding which people could attend as an occupational or recreational activity. This gave people opportunity to spend time outdoors and we saw photographs of people enjoying the time they spent there. One person confirmed they enjoyed the small holding and during inspection two people attended it.

Staff told us they were supported through supervision and were provided with sufficient training to carry out their job roles. One member of staff told us about their most recent training in nutrition and how this was important in supporting and monitoring people to ensure they had enough to eat and drink.

Staff were recruited safely; the appropriate pre-employment checks were carried out prior to new staff starting. For example references were obtained and checks made with the Disclosure and Barring Service to ensure staff were safe to work with vulnerable adults. New staff went through a comprehensive induction and probation period in which they were observed in practice to ensure they were competent to work with people.

Medicines were stored and administered appropriately and there were checks in place to ensure people received the correct medicines at the correct time. There were protocols in place for medicines which were prescribed as required which provided staff with suitable guidance which they followed.

The registered manager was visible around the home and people were relaxed and comfortable approaching them. Staff told us the registered manager was approachable and one relative told us the home was well run they had confidence in management.

People had a comprehensive assessment which included if they were at risk in any way. For example risk of pressure sores or not having enough to eat as well as specific risks associated with social activities or people's medical condition. Where risks were identified plans were developed to minimise the risk of people coming to harm.

Staff had completed training in safeguarding adults and were aware of their responsibilities in recognising and reporting actual or potential abuse. There was a whistleblowing policy and staff were aware of how to escalate concerns about poor practice.

People were asked what food they would like and the menu was planned with people, one person told us they loved the food and we saw people planning what they were having for lunch on an individual basis.

During our inspection people spent time involved in a variety of activities. For example two people went to the small holding, two people were planning to go out shopping using public transport one person was being supported by staff to go to a local coffee shop and another person was going out to the shop alone. One person was sat quietly and staff spent time on a one to one talking with them. People were able to use the garden or be involved in crafts or games or other activities of their choice.

Staff were kind and caring and told us they loved their work. One member of staff told us there was a homely atmosphere and they enjoyed their work and spoke warmly about people. Staff were able to describe to us how they supported people to maintain their privacy and dignity.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. There were enough staff and staffing was flexible according to people's needs and the activities they chose to do.

People's medicines were stored and administered safely.

People were at reduced risk from harm and abuse because staff had the received training and were able to talk with us about how they would recognise and report actual or potential abuse.

People's risks were assessed and if a risk was identified a plan was developed to minimise the risk.

Is the service effective?

Good

The service was effective. People were cared for by appropriately trained staff.

People had choices about what they would like to eat and drink. Staff monitored people to ensure they had sufficient food and drink.

Staff had an understanding of the Mental Capacity Act 2005 (MCA). Mental capacity assessments were decision specific.

People received healthcare when they needed it.

Is the service caring?

Good

The service was caring. People were supported by kind and caring staff.

Staff were knowledgeable about people and were familiar with people's likes, dislikes and preferences.

People had their privacy and dignity maintained.

People and their relatives were involved in decisions about their care and people had access to advocacy when required.

Is the service responsive?

Good

The service was responsive. People had detailed personalised care plans which indicated what was important to them.

People had opportunity to engage in a range of social and leisure activities.

People were supported to maintain contact with the community.

People and their families knew how to raise concerns and complaints

Is the service well-led?

Good

The service was well led. The registered manager was visible and accessible. Staff told us they felt supported.

There was a positive culture within the home and an openness to receive feedback and make improvements.

There were systems in place to monitor the quality of the service.

Acorn Lodge - Bournemouth

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 unannounced inspection took place on 18 October 2016 and carried out by one inspector.

Prior to the inspection we requested and received a Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We considered information we held about the service which included notifications regarding safeguarding, accidents and changes in the service. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We also contacted a representative from the local authority quality improvement team.

We met seven people and spoke with three people; we also contacted two relatives for their views on the service. We spoke with three staff which included the registered manager, deputy manager and a care worker. We looked at three people's care plans and three staff files. We saw four weeks of the staffing rota, the staff training records and other information about the management of the service.

We used the Short Observational Framework for Inspection (SOFI).This is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People told us they felt safe living in the home. One person told us staff helped to keep them safe by supporting them to go out to the shops and on trips. They told us staff took good care of them at the home. One relative told us "It is certainly safe; I know (name) is somewhere safe and I don't have to worry." Staff were visible around the home and checked on people throughout the day. People were protected from harm and abuse. This was because staff had received training in safeguarding adults and they knew how to recognise potential abuse and their responsibilities in reporting concerns. The registered manager had consulted with the local safeguarding team appropriately as a precautionary measure however there were no safeguarding concerns. Staff were able to describe how they would escalate concerns about poor practice which included following the Whistleblowing policy and contacting the local safeguarding team as well as CQC.

Medicines were stored and administered correctly by staff who had received training and were assessed and deemed to be competent. There was guidance for staff when to administer medicines which were prescribed as required. For example medicines which were required for seizures or pain relief. There were regular checks of the Medicine Administration Record's (MAR) to ensure people had received the correct medicine at the correct time. These meant errors would be identified and corrected promptly.

There were sufficient numbers of staff to meet people's care and support needs. There was a well-established staff team who knew people well. Staffing was flexible according to people's activities and plans for the day. People told us they were able to go out whenever they chose to and there were enough staff to support them. Staff were unhurried and we saw they had time to sit and engage with people. The registered manager told us they were fully staffed and never used agency staff. They did not feel it was appropriate to have agency staff who they described as strangers working in the home and told us they were always well staffed. The rosters confirmed staffing was provided at the assessed levels which varied according to the needs of people.

Potential new staff met people living in the home and the registered manager told us feedback from them was very important when considering a new applicant for a post. They told us they observed how the applicant interacted with people and their attitude towards them. Appropriate recruitment checks were carried out which included references and checks with the Disclosure and Baring Service (DBS) to check staff were safe to work with vulnerable adults.

People had their risks assessed and if a risk was identified a plan was developed to minimise the risk of them coming to harm. Risk assessments included skin integrity, malnutrition screening, moving and handling and more specific risk assessments associated with social activities which people were involved in. For example one person enjoyed swimming and a risk assessment was completed to consider their safety during this activity. People also had individualised risk assessments which were specific to them. For example one person had risks associated with epilepsy. A plan was developed to provide guidance for staff on how to manage these risks correctly so the person was kept safe. People had care plans which highlighted what support they needed in an emergency situation such as the fire alarms activating.

Good

Is the service effective?

Our findings

People told us they enjoyed the food which was prepared by staff. Menus were planned with people and there was flexibility around choices each meal time. Leading up to lunch people were making individual choices about what they wanted to eat and staff supported them with decision making. People were offered drinks throughout the day and one person told us "Staff get me drinks whenever I want them." People had individualised care plans which indicated if there were risks associated with preparing hot drinks or food. People's likes and dislikes were also documented and one person told us that staff knew their favourite foods. People had nutritional assessments which highlighted if there were concerns. These were reviewed monthly. This meant staff monitored people's nutritional needs regularly and staff understood what actions they would need to take if concerns arose. For example one person had previously been referred to the Speech and Language Team (SALT).

People were supported by staff who had the appropriate training and skills. A record was kept which indicated which training staff were required to do and when it was next due. Essential training included annual diet and nutrition, hand hygiene and safeguarding adults and fire training four times a year. Staff had completed the required training. One member of staff told us they had completed recent training on diet and nutrition which they considered important to ensure they were knowledgeable about people's nutritional needs. Staff had received training specific to people's care and support needs. For example staff had received training in epilepsy and were able to describe to us what actions they would take if a person had a seizure. This was reflected in the person's care plan.

The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. The provider had cross referenced the standards identified in the Care Certificate with their existing induction framework to ensure all staff had the required competencies. The registered manager told us people living in the home were vulnerable adults and it was their duty to ensure that staff had the right skills to be able to provide people with high quality support and care.

New staff underwent an induction and probation period. During this time they were observed and assessed to ensure they provided people with the right care and support. The registered manager told us if staff did not meet the required standard they did not complete the probation period. They were able to give us examples of when this had happened. This showed us that staff received the sufficient training and induction and that they were required to meet the standard set by the provider to ensure they were able to support people appropriately. Staff told us they were supported and received regular supervision and an annual appraisal.

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 by 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. Staff understood the principles of the MCA and we saw that mental capacity assessments were decision specific. For example one person was assessed to establish if they had capacity to agree to staff

administering their medicines. Where a person lacked capacity to consent staff had followed the correct processes to ensure that decisions were made in a person's best interests. For example one person was supported to clean their teeth with staff support in their best interests. People had access to an advocacy service. We saw one person's care plan showed they were supported by an advocate.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had developed a decision checklist to support them to follow the correct processes when deciding if a person was being deprived of their liberty. The appropriate DoLs applications had been made to the local authority.

People had access to a wide range of health professionals which included district nurses, GP's, chiropodists and mental health team. Appointments with healthcare professionals were documented in peoples care records, each healthcare professional had a separate sheet. This meant there was a clear record of what had occurred during each appointment. The registered manager told us they had good relationships with health and social care professionals and we saw this was confirmed in feedback they had received. People were supported to attend annual physical health checks and were monitored by staff on an on-going basis so if there were any health concerns the appropriate referrals were made. For example staff had concerns about one person and referred them to a GP. Their prompt actions led to the person receiving hospital treatment for a serious medical condition. The person had returned to the home and was recovering well.

Good

Is the service caring?

Our findings

People were cared for by staff who were kind and considerate. One person told us "Staff are kind to me." Another person told us staff were helpful and knew how they liked things. One relative told us "Staff are wonderful, they care so much." One member of staff told us "I love working here, it is very homely." There was a relaxed atmosphere within the home and people moved around freely and at ease. Staff talked with people throughout the day which included what people wanted to do and also what they wanted to eat and drink. People chose their plans for the day, for example two people decided they wanted to go on the bus shopping and for lunch. Another person wanted to go to a local coffee shop. Staff were responsive to people and supported them with planning their day. Staff were patient and flexible. For example they listened and adjusted household routines so that people could be supported in the way they chose. People were also asked about their aspirations and were supported to achieve this.

People's preferred communication method was documented in their care plan and we saw that pictorial care plans were included as part of people's care plans. One member of staff told us that staff had received training in Makaton however people in the home did not use it. Staff were attentive to people's communication styles and we saw staff adapt how they interacted with people according to their communication needs.

There were positive relationships between people and staff .One member of staff described how the people living in the home were reliant on staff and that it was important to ensure "They come first." People were familiar with staff and knew them by name. Staff engaged with people on a one to one either by checking how people were or if they wanted anything as well as sitting with them and chatting informally. People's care plans reflected their personal communication style and their preferred routines and what was important for them. Staff told us they got to know people by spending time with them as well as reading their care plans.

The registered manager told us about one person who had been unwell. They described the support staff provided to the person during their hospital stay and afterwards. They told us "We know (name) and we will do a 100% for them." The registered manager was proactive in ensuring the person was seen by the hospital team. Staff demonstrated they knew the person well and were able to recognise the person was not well. This showed us that staff were caring and were took actions to ensure people received the right care and treatment to support their wellbeing.

People were supported to maintain contact with people who were important to them. One relative told us they always felt welcomed when visiting their relation. Another relative told us staff supported their relation to maintain weekly visits with them. They told us that their relation was always happy to return to the home.

Staff were able to explain to us how they ensured that people's privacy and dignity were maintained For example one member of staff described how it was important to knock on people's doors before entering and check with people before touching any of their personal items. Another member of staff told us it was

important for people to feel they had choices and were involved in making decisions about their care. People's care plans reflected that they were involved in the assessment of their care and support needs and that they influenced how decisions about their care were made. For example one person had expressed a preference for not making hot drinks. Another person had identified what was important for them and their care plan highlighted how this improved their sense of wellbeing. One relative told us their relation was unable to articulate their views however they were involved in the care planning process and they felt listened to when decisions were made which impacted on the persons care plan.

Good

Is the service responsive?

Our findings

People were supported to live in the home in a way which suited them as individuals. Staff were respectful and they consulted with people to ensure they were supported in the way they chose. People had person centred plans which were developed in collaboration with them, their relatives and health and social care professionals when appropriate.

Before moving into the home there was a pre assessment and people visited the home. This was a two way approach to ensure they liked the home and that they would fit in with other people living in the home as well as staff being sure they could meet peoples care and support needs. This meant that people's needs were carefully considered and personalised care plans were developed to ensure staff had the right guidance to support people in the way that met their needs.

People's care plans were reviewed regularly and this was documented. Reviews took place according to individual needs. There was an annual review which relatives and health or social care professionals were invited to. Care plans were updated or amended to reflect changes which were identified during the review process. For example one person had changes to their medicine which was updated in their care plan and another person was identified as needing referral to a specialist healthcare professional. The changes were captured in their care plan with specific guidance for staff how to support the person. One relative told us they attended reviews whenever they could and if they missed one they were asked for their views and were also sent the paperwork.

Relatives and people were able to provide feedback in a variety of ways This included informal discussions with people and relatives, meetings and questionnaires. The most recent one dated 2016 which consisted of positive feedback regarding the home.

The provider had a small holding which people could attend as part of an occupational or recreational activity. During our inspection two people had gone to the small holding to help out as identified within their care plans. The registered manager showed us pictures of people enjoying being at the small holding which included having picnics, helping with maintaining the small holding and blackberry picking. One person told us they liked being outside and enjoyed the animals which were kept at the small holding.

Staff were knowledgeable about people's likes, dislikes hobbies and interests. This was identified in peoples care plans however staff talked with people daily to check with people how they would like to spend their day. Staffing was planned around people's activities. Some people chose to spend time at home and staff gave people space to have time alone as well as ensured that people did not become isolated. Staff told us it was a small home which made it easy to be aware of peoples changing needs throughout the day. One member of staff explained that there was always at least one member of staff at the home to ensure that people who remained at home were not alone and that they were offered opportunity to participate in activities within the home, such as crafts or games.

People told us they had enough to do. One person told us they attended clubs within the community and

another person told us they enjoyed swimming and going out on trips.

There was a complaints procedure which had been communicated to families and healthcare professionals. One relative told us they did not have any cause for complaint and was confident if they had concerns that they could address these with the registered manager. The registered manager confirmed they had not received any complaints in the last 12 months.

Good

Is the service well-led?

Our findings

People, their relatives and staff were positive about the management of the home. One person told us "(name) is good." A relative told us the registered manager was accessible and available to talk to, they felt the home was well run and that communication was effective. The registered manager told us they had an open door policy. During our inspection the office door was kept open when staff were in it and people were able to walk in and out freely. We saw people approaching the registered manager in a relaxed manner to ask questions and the registered manager spent time responding to people as necessary.

The registered manager told us that it was important that people were happy as Acorn Lodge was their home. They told us they led by example and we saw this ethos was embedded in staff attitudes. All staff we spoke with emphasised that Acorn Lodge was people's home and that people came first.

Staff worked well as a team and there was clear communication between staff members throughout our inspections. Staff were professional with each other and told us they felt supported and valued by management. The registered manager told us they were proud of their staff and recognised the good work they did.

The registered manager told us they monitored quality in a variety of ways. This included regular audits such as a monthly medicines audit, and annual personal protective equipment audits. They also obtained feedback through contract monitoring visits, staff meetings, visitor books and surveys. When areas for improvement were noted actions were taken promptly. For example the registered manager had received feedback to include interview notes in staff records. We saw they had actioned this immediately.

There were staff meetings and we saw notes from meetings which had taken place. For example in July 2016 staff were reminded to record the date when opening food packages. In May 2016 staff were reminded of the correct disposal of cigarette butts. The registered manager told us that as they were a small staff team day to day communication took place at handovers and informally during shifts. Staff told us they were kept informed of any changes or updates to peoples care and support needs as well as within the home. This showed us the registered manager had effective communication with the staff team.

The registered manager explained they maintained good working relationships with other registered managers in the area as well as the local authority, commissioners and healthcare professionals. They considered this important in terms of partnership working as well as having support networks in place. They told us they made use of good quality resources such as professional journals to ensure they kept up to date with current practice.