Oldham Property Investments Limited

Acorn Lodge Nursing Home

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 inspection took place on 15 and 19 December 2016 and the first day was unannounced. At our previous inspection in August 2015, we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to deprivation of liberties, managing storing and administering medicines, assessing need, and providing training. At this inspection we found the home had made improvements in all these areas.

Acorn Lodge is a privately owned care home. It offers nursing and residential care and support for up to 85 older people, some of whom have a diagnosis of dementia. There are four units, but at the time of our inspection one unit was closed as the home was undergoing some refurbishment, and this unit was in the process of renovation. When we inspected Acorn Lodge there were 61 people living there. The home is located in located in Failsworth, close to Oldham and the city of Manchester and is a large purpose built care home with a secure garden. All rooms are single and some have en-suite facilities.

There was no registered manager in post at the time of inspection. The former registered manager had left in November 2015. A new manager had been in post for three months and had submitted an application to register 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.

When we spoke to people who used the service they told us they felt Acorn Lodge was a safe place and that they felt secure. We saw that there were systems were in place to protect the safety and welfare of the people who used the service. When we spoke to staff at Acorn Lodge, they demonstrated a good understanding of safeguarding adult procedures, and we saw that recruitment procedures were sufficiently robust to help ensure that people were protected from the risk of unsuitable staff being recruited.

We found there were sufficient numbers of staff to meet people's needs in a timely way. The provider had recently recruited some staff and worked hard to reduce sickness levels. Rotas showed that shifts were covered and there was less reliance on the use of agency staff. One care worker told us, "Sickness has gone down and morale has gone up. Staff are smiling and are happier". All staff had access to a computer based eLearning package to improve their skills and knowledge.

At our last inspection we found that the service was not managing medicines in a safe way. We found at this inspection that the service had reviewed medicine protocols, and there were systems to ensure that medicines were managed, stored and administered safely.

Where risk was identified plans were put into place to minimise harm. Care plans were detailed and subject to regular review. Attention was paid to people's dietary and nutritional needs, and the service supported people to make lifestyle choices around their food. People who used the service told us they had sufficient

to eat and drink.

We saw that arrangements were in place to assess whether people were able to consent to care and treatment, and people were offered choices about how their care was delivered.

Where health needs were identified, the staff at Acorn Lodge liaised with appropriate health professionals, such as doctors, district nurses and dieticians to ensure that health needs were not neglected.

We saw examples of kind and caring support, and one person who used the service told us, "The staff really make an effort to get to know us, and they are so kind. Nothing is too much trouble."

Systems were in place to ensure that people at the end of life received appropriate care in accordance with their wishes, and were supported with the relevant healthcare as needed.

Care plans documented people's interests and what they enjoyed doing. Staff were encouraged to help people to maintain their interests. The service had looked at innovative ways of supporting people to maintain an active life, including setting up a small shop which was run by and for the people who used the service

The service had a complaints policy, and complaints were taken seriously. People told us that they knew how to make a complaint and were satisfied that their issues were addressed.

All the people we spoke with were positive about the manager. One visitor told us, "There is a massive improvement in staff morale since the new manager started, a real positive difference".

The service had good systems to audit service provision and used information to improve performance.

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.

Systems were in place to protect the safety and welfare of the people who used the service

A safe system of medicine management was in place.

There were sufficient, suitably trained staff who had been safely recruited.

Is the service effective?

Good

The service was effective.

The management and staff demonstrated their understanding of the Mental Capacity Act 2005 (MCA) and deprivation of Liberty Safeguards (DoLS).

There were good relationship with local health care professionals, and staff closely monitored people's health care needs.

Care was delivered by well trained and knowledgeable staff who were encouraged to develop their skills.

Is the service caring?

Good

The service was caring.

Staff were friendly, welcoming and patient, and spent time sitting and talking with people who used the service.

Privacy and dignity were respected.

People were very well cared for at the end of life.

Is the service responsive?

Good

The service was responsive.

Care plans documented people's interests and what they

enjoyed doing. Staff were encouraged to help people to maintain their interests.

People knew how to make a complaint and were happy that their issues were addressed.

Is the service well-led?

Good

The service was not always well led.

There was no registered manager in place.

The new manager was respected buy staff and visiting relatives.

There were good systems of management oversight including regulatory visits and audits.

Acorn Lodge Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was carried out over two days on the 15 and 19 December 2016. Our visit on 15 December 2016 was unannounced. The inspection team consisted of two adult social care inspectors.

Before the inspection, we reviewed the previous Care Quality Commission (CQC) inspection report about the service and notifications of incidents that we had received from the service. We looked at the Provider Information Return (PIR) before our visit. A PIR is a document that asks the provider to give us some key information about the service, what the service does well and any improvements they plan to make.

We also contacted the local authority and health service commissioners, Oldham Metropolitan Borough Council (MBC) Health Protection Unit and Healthwatch, Oldham. Healthwatch Oldham is an independent organisation, working to help people have their say on local health & social care services to seek their views about the home. We did not receive any information of concern.

During our visits, we spoke with the home manager, the area manager, and two unit managers. We also spoke to two nurses, five care workers, a volunteer, an activity coordinator and two members of the domestic team. We spoke to five people who used the service and four visiting relatives.

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

We looked around the building including some of the bedrooms on each unit, all of the communal areas, toilets, bathrooms, the kitchen and the garden areas.

We examined the care records for six people living at Acorn Lodge, medicine administration records, the recruitment and supervision records for four staff, training records and records relating to the management

of the home such as the quality assurances systems.

Good

Is the service safe?

Our findings

We spoke with five people who used the service and they all told us that they thought the home was safe. One person said, "I feel very safe here. The [staff] all look out for me, and make sure I have what I need. Yes I am content. This is the right place for me". Another person told us, "I have never had any concerns. I have never seen anything aggressive or disrespectful".

Visiting relatives also told us that Acorn Lodge provided a safe environment. One person told us, "I always feel [my relative] is safe and secure when I leave," and another visiting relative us, "I have no problems with safety. The staff can't do enough, and have a good understanding of [my relative's] needs. They know the limits".

We looked at six care records which showed that risks to people's health and well-being had been identified and assessed. These involved risks such as mobility, eating and drinking, nutrition and hydration, communication, and hygiene. Where risks were identified, for example where a person's behaviour could cause a risk to themselves or other people who used the service, we saw that appropriate actions were recorded in care plans to minimise the risk of injury and followed up by staff. Risk assessments were detailed, for instance, mobility risk assessments considered risks when walking, transferring, sitting or lying down.

We saw the home was secure. When we arrived our identity was checked and we were asked to sign in to the visitors book. The entrance was kept locked; this ensured that unauthorised people would have difficulty entering the home, and that staff were aware of who was in the building at any time.

When we looked around the premises we saw that call bells in bedrooms were positioned close to hand so that people could summon help when required, and we saw that staff would respond promptly to calls. However, when we checked the main lounges we saw that there was no call bell in the lounge on the dementia unit. We spoke to a member of staff who was working in this unit who told us that there was always a staff presence in this lounge, but if they required assistance they would not be able to summon assistance without calling out to other staff for help. During our inspection we saw that a member of staff was always present in the dementia lounge.

Acorn Lodge is separated into four units, with two on each floor. Access to the stairs was protected by doors with key codes, but people who were able were free to walk along corridors and into communal areas.

We saw that staff took care when helping people to transfer, for example using lifting hoists and wheelchairs. For example before escorting a person from the lounge into the dining room the care workers carefully checked the wheelchair including brakes and footrests, and transferred the person safely. Once in the chair they checked that the person was comfortable and safe before setting off.

All the staff we spoke with were aware of their responsibilities to protect vulnerable adults from abuse. They told us that they were aware of the procedures in place and understood how to safeguard residents from

different types of potential abuse. Staff we spoke with said they had received training about protecting vulnerable and discussed with us the signs that would alert them to potential abuse and the actions they would take. One person told us, "I would definitely report it if I saw anything amiss. I have attended training and I know what the triggers might be. I'd be first in the queue to tell if I thought anyone was being neglected". Other staff were able to give examples of when they had recognised concerns.

The service kept a file detailing all incidents of alleged abuse. We saw that this showed concerns were taken seriously with evidence of an investigation, an outcome to the investigation and action taken to minimise the risk of repeat occurrences. Incidents were reported on a monthly basis to the local authority safeguarding team, and we checked our records which showed that we had also been made aware of safeguarding issues.

When we looked around the home we saw that steps had been taken to prevent injury or harm, for example, crash mats next to beds so if a person were to roll out of bed the risk of injury would be reduced. We spoke with a senior nurse who told us the service would not admit anyone into Acorn Lodge until the appropriate equipment to safely meet their individual needs were in place.

Environmental hazards had been assessed and we saw records to show that equipment within the home were serviced and maintained in accordance with the manufacturers' instructions. This included generic checks around the home in areas such as gas safety, portable appliance testing, fire detection and emergency lighting. In addition, all equipment including nurse call systems, hoists and slings, and baths had been serviced as required. This helped to ensure the safety and well-being of everybody living, working and visiting the home. The fire alarm and fire doors were checked on a weekly basis. People told us that routine maintenance jobs were completed quickly.

We found systems were in place in the event of an emergency. There was a fire risk assessment in place and we saw that personal emergency evacuation plans (PEEPs) had been developed for the people who used the service. These plans explain how a person is to be evacuated from a building in the event of an emergency evacuation and take into consideration a person's individual mobility and support needs. The service also had a business continuity plan in place. The plan contained details of what needed to be done in the event of an emergency or incident occurring such as a fire or utility failures.

We saw that corridors and walkways were kept clear of any obstacles which might cause an obstruction; larger items of equipment such as mobile hoists and wheelchairs were stored in recesses. The manager and area manager recognised that the building needed to be refurbished; and at the time of our inspection Acorn Lodge was undergoing a major refurbishment, with one of the four units closed. Once this unit had been redesigned and ready, there were plans to move on to complete a full refurbishment of the other units. The home was clean, but we noticed on the first day of our inspection that a mobile hoist and the sit-on scales on the nursing unit were grubby. We pointed this out to the Housekeeper, who agreed to incorporate cleaning this equipment into the cleaning schedule. On the second day of our inspection they had been cleaned. We noticed a slight odour on the corridor outside the dementia unit lounge, but in all other areas the service was odour-free. Toilets and communal bathrooms were clean and well stocked with paper towels, liquid soap, pedal bins and handwashing posters.

People told us that they felt there were enough staff to meet their needs. One person who used the service told us, "There is always a staff member knocking about", and a visiting relative told us, "It's very well staffed, and they are all approachable". The service used a risk matrix to determine the number of staff required, and we saw that there was a good ratio of staff to people who used the service.

There was an appropriate skill mix to support people. We saw the deployment of staff throughout the day was organised. People who required support with their personal care needs received this in a timely and sensitive way. Staff told us they felt they had time to spend with people on an individual basis. This included domestic staff; one housekeeper told us, "It's good that we can stop and chat with the [people] who use the service. They are who we are here for, and it's them who are important".

The manager told us that when they first came to Acorn Lodge earlier in the year there were high levels of absenteeism which meant that the service relied on agency staff to fill the weekly rota. However, following recruitment and sickness management the level had reduced, and any gaps covered by regular staff who were paid overtime rates. This meant that people were cared for by staff who were familiar with their needs

We looked at the recruitment procedures which gave clear guidance on how staff were to be properly and safely recruited. This helped to protect the safety of people living at Acorn Lodge. We looked at four staff files. These contained proof of identity, an application form that documented a full employment history and accounts for any gaps in employment, interview notes, a job description, and two references. Nurses were required to provide evidence that they has registered with the Nursing and Midwifery Council (NMC). Checks were carried out with the Disclosure and Barring Service (DBS) before any member of staff began work. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. This meant that checks had been completed to reduce the risk of unsuitable staffing being employed at Acorn Lodge.

Where issues of poor conduct had been raised we saw that these were investigated and if needed appropriate disciplinary procedures had been taken, including verbal and written warnings. Proportionate action had been taken as necessary, including dismissal, retraining and close monitoring and supervision. We looked at one investigation following medication errors, which culminated in the person leaving employment, and a referral was made to the NMC.

When we last inspected Acorn Lodge we found that the service did not have safe systems to ensure medicines were administered as prescribed, and there had been no protocols in place for "PRN" medicines. These are medicines prescribed by a doctor to be taken as and when needed. At this inspection we saw that the service had introduced protocols to ensure that all medicines were administered when they were required, with the reason for administering PRN medicines clearly documented.

We saw medicines had been checked on receipt into the home, given as prescribed and stored and any surplus medicines were disposed of correctly. We looked at three medicine administration records (MAR charts) for people which included photographs of people to help staff identify them and listed any allergies and recorded the prescribed medicines required. MAR charts are a formal record of administration of medicine in a care setting, and provides all information about the person's current prescription, including dose, formulation (i.e. whether in tablet or liquid form) and time of administration. We saw that these were completed correctly.

Most medicines were provided in pre-sealed blister packs. This minimised the risk of providing the person with the wrong medicine or the wrong dose. Where medicines were provided in boxes not within the blister pack, a 'countdown' sheet was used to readily check when supplies were running low, so that further medicines could be ordered.

Medicines were administered by nurses, or by trained senior staff on the residential units. Where topical creams had been prescribed, these were administered by care staff who had undergone a competency assessment. A body map was used to show where the cream should be applied, with a separate chart used

to record when the creams had been applied. We saw that these were completed correctly.

Medicines were stored in locked trolleys which when not in use were stored in treatment rooms. Fridge and room temperatures were checked to ensure that the medicines were kept at the right temperature: if stored incorrectly medicines can lose their potency and become ineffective. Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. We saw that controlled drug stocks were checked morning and night by two staff.

Good

Is the service effective?

Our findings

People and relatives we spoke with said they felt staff were meeting their needs. One person told us, "they seem to know what they're doing and they certainly know us and what we like". A visiting relative remarked, "The staff can't do enough, sometimes they have bent over backwards to get what [the person] wants". When we spoke to staff they were able to demonstrate a good understanding of the differing needs of people who used the service and spoke fondly of their individual mannerisms and wishes.

At our last inspection we found that some staff had not received an induction into the service. We saw that a full Induction program was now in place and was provided to all new and returning staff. New starters were given a full induction package and received supervision every fortnight for the first three months of their employment, and were appointed a mentor to assist them to get to know and understand their role.

We asked the staff that we spoke with what training they had received in order to carry out their role. They told us that they received on the job training, which covered the core standards in the Skills for Care Certificate. All staff had access to e-learning through a training package which taught a variety of topics, including emergency procedures, medicine management, food safety, health and safety, infection control, manual handling, safeguarding, dignity, and diversity training. The training matrix (record) showed that 79% of staff had competed this learning. Further face-to-face training was available, for example, one member of staff informed us they had recently completed training on the Six Steps end of life model of care. When we spoke to a carer who had recently moved on to the dementia unit from a different part of the service they informed us that they completed a three-day course on living with dementia. They told us, "I really enjoyed it and it gave me more of an understanding of dementia". Other staff told us the manager encouraged staff to undertake professional qualifications to develop their skills, one person was currently undertaking NVQ level 3, and a Housekeeper informed us that they had been enrolled on a Housekeeping course to begin in the new year. When we spoke with the manager they informed us that training remained a priority and the service was keen to improve the core knowledge of staff.

Discussion with staff and staff records looked at confirmed they received regular supervision. Formal supervision sessions provide an opportunity to monitor the performance of individual staff members and provide staff with an opportunity to speak in private about their training and support needs as well as being able to discuss any issues in relation to their work. We looked at four staff supervision records which showed that meetings were productive. One member of staff told us that they looked forward to their supervision as this provided them with a chance to reflect on how they worked with individuals and consider how best to manage their work. When we spoke to the manager he told us that staff received six supervision sessions each year, one of which would form a yearly appraisal, but extra support would be provided if required, for example following incidents to de-escalate and discuss learning from such incidents.

Throughout our inspection we saw that staff communicated well with each other and passed on information in a timely fashion. Staff attended a changeover meeting on each unit at the start and finish of each shift, where the current needs and status of each person who used the service was discussed. This helped to ensure that staff were fully updated on a person's condition and behaviour and ensure that any

change in their condition had been properly communicated and understood. Staff shared information about individual people who used the service and tasks were delegated appropriately and shared fairly. Nursing staff from the dementia unit and the nursing unit would meet together on a daily basis and share information. One member of staff told us this helped them if they needed to provide extra support on an emergency basis.

Staff meetings were held every three months, and we were told that these were well attended and representative of all sections of staff. We looked at the minutes of the previous meeting (8th December) and this reflected a good level of discussion and information sharing. Minutes were distributed to all members of staff.

In addition the manager convened regular meetings with the Service leaders, including unit managers, chef, Maintenance officer and head housekeeper. This ensured effective communication and allowed the opportunity for staff to bring forward ideas to improve the service.

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.

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 Deprivation of Liberty Safeguards (DoLS). By law, the Care Quality Commission must monitor the operation of any deprivations and report on what we find. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

When we last inspected Acorn Lodge in August 2015 we found that the service had not submitted requests for DoLS, which was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the manager told us and we saw information to show that applications to deprive people of their liberty had been applied for, and where they had been authorised by the supervisory body (local authority), CQC had been notified of these authorisations. Where a DoLS had been requested or authorised the information was stored within the person's care records, along with details of why the DoLS had been agreed, and any conditions relating to the restriction. We saw that the manager kept an updated matrix to show when a request had been made, authorised or due to expire. This reduced the risk that the authorisation could expire without the knowledge of the registered manager, and allowed a quick check to determine if the deprivation made was legally permissible.

When we looked in care records we saw that Capacity assessments had been completed to determine if people needed a DoLS authorisation, and where people had the capacity to make their own decisions this was noted.

When we spoke with people who used the service, they told us that staff supported them in the way they had agreed and that they asked for the person's consent before carrying out care and support tasks. We observed this in practice, for instance, we saw a care worker knock on someone's door before entering and asked if they required assistance.

We asked the manager how the service would ensure that people who did not have family or representatives and were unable to speak for themselves would be supported. They told us that the service would use advocacy services from Age Concern, but at the time of our inspection nobody had an advocate to represent

them. An advocate is a person who can give independent advice and act in the person's best interest.

People told us they enjoyed the food provided at Acorn Lodge. One person remarked, "Dinner was nice. The food id always nice and the carers do their best to make it look good". A choice of hot meals was available at lunchtime, and we saw that the service could also meet specific dietary and some cultural requirements, for example, one person who used the service was a vegan, and the chef was able to assist this person to maintain his preferred diet. A visitor told us that their relative had very specific likes and dislikes, but these preferences were always respected.

We observed lunch being served in two of the units. Staff wore protective aprons and offered aprons to people to protect their clothing. Tables were nicely laid, and on the nursing unit Christmas decorations were placed on each table. Cold drinks were provided during the meal and a cup of tea or coffee was offered with desert. On the nursing unit there were enough staff to help those people who required assistance, whilst on the residential unit staff assisted with serving meals and supervised the dining area, but encouraged people to be self-sufficient with their food. However, as mentioned previously more attention could have been paid to people who had difficulty with swallowing. We observed that staff discreetly monitored all the people eating in the dining room but on one occasion all staff left the room for a very short period, and on a second occasion staff were distracted when another person dropped their plate onto the floor. Meals were not rushed and people were left to eat at their leisure. We saw the individual preferences were respected, for example, one person left the dining room after their main course to go outside for a cigarette before returning for his dessert, which was kept warm until they returned. Another person preferred to eat their main course in the dining room, but would retire to their room for dessert.

Where risk with eating and drinking had been identified appropriate diets were provided. These included diabetic meals, and thickened or pureed meals. Build up drinks were also provided for people who had a low body weight. We saw that for people at risk of malnutrition diet sheets were kept and fluid and food intake was monitored on a daily basis. This showed the service made sure people were monitored so that any risks would be acted upon to keep people healthy.

People told us and we saw documentation in care files to confirm, that people were supported to see other health professionals when required. One nurse we spoke to told us that staff worked hard to avoid any unnecessary hospital admissions, and had developed very good working relationships with general practitioners (GPs). They told us, "We get to know the person really well, so we can pick up if we notice a change in demeanour or if they are out of sorts." We saw case records included records of regular GP visits.

Residents had good access to healthcare and their physical and mental health needs were monitored by staff. Weights were regularly checked, and the service had established good working relationships with speech and language therapists to monitor diet and swallowing and seek advice about food consistency. Evidence in the case notes we reviewed on the residential unit showed liaison with district nurses, for example, to monitor skin integrity. We saw that residents had regular access to other health care professionals such as dentist, optician and chiropody appointments. This meant that residents were receiving care and support to access additional health care services to meet their specific health needs.

Good

Is the service caring?

Our findings

People told us they found that care staff knew them well and were kind and caring. One person told us, "The staff really make an effort to get to know us, and they are so kind. Nothing is too much trouble." A visiting relative remarked, "The staff are kind and very respectful. I enjoy coming here, they are all lovely." This person told us that they were impressed by the way staff spoke to people who used the service, saying, "People are very much respected and not ignored. If they ask for something it is followed up, for example, if they want the toilet staff are patient; it doesn't matter how many times they've been. Since I've been coming here I've never known anyone to say you can't do it or can't have it. Staff are adaptable and always pleasant".

There were no set rising times, and people were assisted to get up in their own time. One visitor told us that their relative liked to have a lie in, and that that was respected. We saw that as staff were assisting people to get up they would knock on their door and introduce themselves by name before entering and ask if the person was ready to get up. They continued to treat people in a caring manner throughout the day, and respond appropriately to their needs.

Care was taken to support people with personal needs. People told us that the staff take time to ensure they were well groomed and that they thought the care staff made an effort to get to know them. Staff agreed that this was important and spoke affectionately about the people they supported.

When we looked at care records we saw that these included details about people's individual likes and dislikes, including how they liked to be addressed. We saw that people were addressed by their preferred names and spoken to in a friendly manner by staff, making eye contact and touch where appropriate. Interactions between care staff and people who used the service were respectful and caring.

Throughout our visit we observed positive and meaningful interactions between staff and people who used the service. Care staff were polite and respectful, and displayed a good understanding of the individual's personality. They would respond in an appropriate manner, for example, sharing a self-deprecatory joke with people, or discussing activities that the person was interested in. A senior carer remarked, "I am proud to work here. The staff are really caring and will go out of their way to help".

The care workers we spoke with demonstrated a good knowledge of the people who used the service, their lives likes and past histories. They were able to talk about, and give examples of how they helped to maintain people's dignity. We observed a person being transferred using a hoist and we saw that staff made every effort to ensure that this was done safely and with dignity; they explained to the person each step, providing reassurance, and placed a blanket over their legs to protect their modesty.

We saw care staff spending time with people who used the service, for example sitting and talking with them and encouraging a steady conversation. As they did so, they provided reassuring interventions, bending down to their level or sitting next to them in a position where they could maintain eye contact, talking in a calm and level voice, and discreetly adjusting clothing. We asked one member of staff about this and they

told us, "I love it here. I hope I am saying the same thing in fifteen years. I love being able to spend time talking, sitting and listening, or holding hands or cleaning their nails. To know that they are loved and have a lovely day. The smile on their face says it all!"

People were encouraged to form friendships, and we saw evidence that people had developed new friendship groups since they moved in to Acorn Lodge. Staff also supported people to maintain relationships with family and friends.

Feedback from visitors was positive about the care provided, and the relatives we spoke with had no issues about the quality of care. There were no restrictions on visiting and those visitors we spoke with told us that they were always welcomed and supported when they visit. One visitor said to us, "There is a positive atmosphere. Staff are happier and it makes the place seem brighter and cleaner".

We observed that people were asked discreetly about their personal care. When people needed assistance with personal care we observed that staff ensured they closed doors in bedrooms and bathrooms.

Staff were aware of the need for confidentiality and we saw they were discreet when talking to professionals on the telephone. Care records were stored securely and locked in staff rooms when not being used so information held about individuals was secure.

The home had an equality and diversity policy, and the staff we spoke with had a good understanding of what this meant and gave examples of how they would respect people's individual beliefs, culture and background.

Staff had a good understanding of the needs of people approaching the end of life. We saw evidence in the care files we looked at that personal wishes had been considered, and individual plans made for this aspect of care, including DNAR records. A DNAR (do not attempt resuscitation) form is a document issued and signed by a doctor, which advises medical teams not to attempt cardiopulmonary resuscitation (CPR). We asked staff how they supported people who were nearing the end of their life and they were able to explain how they would consider their needs, and liaise closely with families and relevant health staff to deliver high quality end of life care in a compassionate and understanding manner.

Good

Is the service responsive?

Our findings

Prior to being admitted into Acorn Lodge the service would carry out a full assessment of needs, visiting the person to develop an understanding of how they wanted care to be delivered, and speaking with family, relatives and professionals who might know the person. This helped to formulate an initial plan of care which could be reviewed and updated once the person was admitted into the service. The manager and senior nurse informed us that they would not admit a new person into Acorn Lodge until all required equipment, such as air mattresses, or oxygen was in place.

We looked at six care records. Information about each person was detailed and well presented, so that anyone who was unfamiliar with the person would be able to form a good understanding of how best to meet their individual needs. Information provided gave a good indication of the person's character and personality and contained detailed information to guide staff on the care and support to be provided. They also showed that risks to residents' health and well-being had been identified, such as the risk of poor nutrition and the risk of injury. Where a risk had been noted action to reduce or eliminate any identified risk was recorded in detail. We saw that specific specialist information and guidance from the relevant professionals involved in their care was contained within the care records. The records were reviewed and updated on a monthly basis to ensure the information was fully reflective of the person's current support needs.

Care plans indicated social needs, hobbies and interests, and some effort had been made to build up personal histories and life stories which was shared with staff. For example we were told that one person served during the war in the Royal Navy. Through conversation, a member of staff discovered the name of the ship they served on and researched this, finding a picture of the ship and crew which they were able to present to them. However, interests were not always followed up, for example, we saw one care plan which indicated that a person enjoyed listening to popular music, but there was no evidence that this was addressed: the person spent all their time in bed, but there was no radio in the room to allow them to listen to music.
One person required feeding via a percutaneous endoscopic gastrostomy (PEG). This allows people who are unable to swallow to be fed through a tube directly into the stomach. We saw that there were clear guidelines on how to manage the PEG, including how to care for the tube and the site. Their care plan identified that the person was not to be fed by mouth.

The service employed two part time volunteer co-ordinators. We spoke to one who told us, "People have a lot to live for….I want to ensure that they have something to get up for in the mornings." They told us they spent time on an individual basis with people to get to know them and help them to feel valued, They told us "I want to ensure that [people who use the service] are not neglected, and go away with a smile on their face". They helped to create memory boxes which would help provide an identity and stimulate reminiscence.

We saw the service had developed a number of innovative ways of providing stimulation and interest, for example, they had opened a shop, which was manned by people who used the service three mornings each

week, where people could buy small items. Activities had been designed to encourage and stimulate conversation. In addition to chair exercises and games, themed activities around seasons and events were utilised. The volunteer coordinator had enlisted the support of people who used the service to decorate the Christmas tree, and was helping them to produce and write Christmas cards as a group activity, generating conversation around Christmas past.

We asked people if they knew how to make a complaint. They told us they would speak to the manager. We saw that there was a complaints procedure, and complaint and compliments forms were available in the entrance Hall. We reviewed the complaints file and saw that there had been 23 complaints made over the previous twelve months. It was evident that all complaints had been taken seriously with detailed recordings of investigation, evidence of issues raised, findings and action taken clearly recorded. We spoke with one visiting relative, who told us that they felt able to make a complaint and that when they did, they were satisfied that there had been a full investigation and they were provided with an explanation. They told us "I was happy with the explanation, and there has been no repeat. [My relative] is better cared for".

Relatives told us that they were happy with the way the service provided them with information. They told us that they were invited to relatives meetings, and we saw minutes of the most recent relatives meeting, which provided information about upcoming issues affecting the running of the service.

Relatives also told us that where there were issues or concerns regarding the provision of care to their relatives, staff would contact them to provide information or seek advice, and if they needed information all the staff were approachable and willing to offer support.

Good

Is the service well-led?

Our findings

It is a requirement under The Health and Social Care Act that the manager of a service like Acorn Lodge is registered with the Care Quality Commission. When we visited the manager had only recently been appointed and was not yet registered with the CQC. An application had been made and the registration process was underway. This was acknowledged by the CQC Registration Team who confirmed that the application had been received, and his registration was completed shortly after our inspection.

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

Before our inspection we checked our records to see if any accidents or incidents that CQC needed to be informed about had been notified to us by the registered manager. This meant that we were able to see if appropriate action had been taken by management to ensure people were kept safe. We saw that incidents had been reported to us and gave us information about actions taken to respond to the issue.

We had also received a detailed provider information return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.

All the people we spoke with were positive about the manager. A volunteer at the service told us, "[The manager] is working very hard and is turning this place around". This view was echoed by visiting relatives and staff. One visitor told us, "There is a massive improvement in staff morale since the new manager started, a real positive difference", and a care worker said, "[The manager] is great, he's taken a lot off my shoulders. Nothing is too much trouble for him."

The manager was supported by an area manager , who was providing close support at Acorn Lodge, and visited two or three days each week. Prior to the appointment of the manager the area manager had been managing the service. Both were present throughout both days of our inspection. Each of the units had a unit manager.

We asked the manager about his priorities, and they told us the aim was to improve the quality of life for people and improve standards at Acorn Lodge. This was a work in progress. We observed a happy atmosphere in the home and staff commented positively about working there. One carer said, "The management structure is very good, I feel very well supported by my unit manager and the home manager. I think we are really well led. Sickness has gone down and morale has gone up. Staff are smiling and happier''. This view was not restricted to care staff; when we spoke to domestic staff they told us that they felt well supported in their role. One told us, "[The head housekeeper] keeps an eye on us, but I feel valued and part of a team. We have time to talk with people, and it's not discouraged. The atmosphere has gone sky high; I feel the managers are all supporting us".

There were effective systems in place to monitor the quality of the service. The area manager completed monthly regulatory visits, and review parts of the service, such as care records, supervision and appraisal, medication, etc. This fed into a rolling action plan to drive on the quality of the service. The area manager told us that the service provider was supportive, and would respond positively to any reasonable requests. For instance, all beds at Acorn Lodge had been replaced over a two-year programme with profiling beds to help ensure the safety and comfort of people who used the service, and a programme of refurbishment for the whole of the building was underway.

We saw records which showed that care files were audited on a monthly basis, and any requirements were acted on. Similarly the manager completed monthly and three monthly audits of key performance indicators (as a part of the action plan), pressure ulcers, hospital admissions and infections, weights, safeguarding, infection control, medicines, health and safety and maintenance. Where issues were identified we saw that there were action points to help improve the quality of service delivery.

We looked at the accident and Incident records and saw that where incidents had occurred these were duly recorded, with appropriate actions to minimise the risk of repeat events. Where they related to personal injury, body maps were in place, and we saw these cross- referenced case notes. Similarly the manager analysed safeguarding alerts and complaints to check for emerging trends.

Staff told us that they were involved in discussions about issues in service provision during team meetings. Minutes demonstrated that staff were encouraged to raise issues and take responsibility where mistakes had been made. Staff told us they found team meetings useful, and felt supported to raise issues and suggest changes they felt needed to be made.

The manager was aware of the importance of maintaining regular contact with people using the service and their families. The relatives of residents we spoke to told us that they were kept informed of any changes in their relative's condition and felt comfortable about contacting the service Relatives meetings were advertised and relatives were invited to attend in order to feedback and share information about the home. This also gave them an opportunity to air any collective concerns about Acorn Lodge. The manager told us that he had agreed to vary the time of these meetings to allow for more people to attend at a time convenient to them. The manager operated an open door policy and was available to privately discuss issues with relatives or people using the service. However, we did not see any surveys or questionnaires about the service or formal system to seek feedback or collate the opinions of people living at Acorn Lodge or their relatives. Such a system could be used to inform improvement plans for the development of the service.