Acacia Care (Nottingham) Ltd

Acorn House

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?	Outstanding
Is the service well-led?	Good

Summary of findings

Overall summary

This unannounced inspection took place on 14 and 20 November 2017. Acorn House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single packages under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Acorn House accommodates up to 64 people in one adapted building. During our inspection, 60 people were using the service, including some people who were living with dementia.

At our last inspection in October 2015, the service was rated 'Good' overall. At this inspection we found that the service remained 'Good' overall and had improved to 'Outstanding' in Responsive.

The service had a registered manager in place at the time of our inspection. 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 were supported by staff who understood and acted appropriately in relation to their responsibility to keep people safe. Risks to people's health and safety had been identified and mitigated to reduce the risk of harm as much as possible. People were supported by a sufficient amount of staff, received their medicines safely and lived in a clean and hygienic service.

People were supported by staff who had received appropriate training and support. People were supported to eat and drink enough and staff monitored and responded to changes in their health conditions. People lived in a building which had been specifically designed to meet their needs. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were treated with kindness and respect and we saw that staff took time to sit with people and let them know they mattered. The staff we spoke with were knowledgeable about the people they supported and ensured that people were involved in making decisions about their own care as much as possible. People could be assured that their privacy and dignity were respected by staff.

People received care which was focused on them as individuals and staff went the extra mile to enhance people's lives. Efforts had been made to overcome any barriers people may face to achieving their aspirations, partake in activities and maintain or develop relationships. People were provided with opportunities to make a complaint about the service and these were responded to efficiently. People's preferences as to how they wished to be cared for at the time of their death were recorded and followed and relatives were complimentary of how their loved one had been supported at the end of their life.

There was an open and transparent culture at the service and the management and staff team were

committed to a shared philosophy to deliver excellent care. People's views regarding their satisfaction with the service and any areas for improvement were regularly sought and acted upon. Robust systems were in place to monitor the quality of the service and the management continually sought to make improvements to the service people received.

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 remains safe.

People were supported by staff who understood and acted appropriately on their responsibility to keep people safe.

Risks to people's health and safety had been identified and mitigated to reduce the risk of harm as much as possible.

People were supported by a sufficient amount of staff, received their medicines safely and lived in a clean and hygienic service.

Is the service effective?

Good

The service has improved to be effective.

People were supported by staff who had received appropriate training and support.

People were supported to eat and drink enough and staff monitored and responded to changes in their health conditions.

People lived in a building which had been specifically designed to meet their needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Is the service caring?

Good

The service remains caring.

People were treated with kindness and respect and we saw that staff took time to sit with people and let them know they mattered.

The staff we spoke with were knowledgeable about the people they supported and ensured that people were involved in making decisions about their own care as much as possible.

People could be assured that their privacy and dignity were respected by staff.

Is the service responsive?

Outstanding ☆

The service was very responsive.

People received care which was focused on them as individuals and staff went the extra mile to enhance people's lives. Efforts had been made to overcome any barriers people may face to achieving their aspirations, partake in activities and maintain or develop relationships.

People were provided with opportunities to make a complaint about the service and these were responded to efficiently.

People's preferences as to how they wished to be cared for at the time of their death were recorded and followed and relatives were complimentary of how their loved one had been supported at the end of their life.

Is the service well-led?

Good ●

The service remains well led.

There was an open and transparent culture at the service and the management and staff team were committed to a shared philosophy to deliver excellent care.

People's views regarding their satisfaction with the service and any areas for improvement were regularly sought and acted upon.

Robust systems were in place to monitor the quality of the service and the management continually sought to make improvements to the service people received.

Acorn House

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 14 and 20 November 2017 and was unannounced. The inspection team consisted of one inspector, a specialist advisor with experience of falls management 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.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. The inspection was also informed by other information we had received from and about the service. This included previous inspection reports and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also sought feedback from the local authority, who commission services from the provider.

During the inspection, we spoke with 12 people who lived at the service and three visiting relatives. We spoke with three unit managers, two care workers, the activities co-ordinator, activity assistant, a housekeeper, the chef manager, maintenance person, the registered manager and owner. Following our visit we also sought feedback from healthcare professionals who routinely visited the service and received a response from one visiting professional.

We looked at all or part of the care records of 10 people who used the service, the medicines administration records of eight people, staff training records and the recruitment records of three members of staff. We also looked at a range of records relating to the running of the service, such as audits and maintenance records.

We observed care and support in communal areas of the service and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People were protected from abuse and avoidable harm. All of the people and relatives we spoke with told us they felt the service was safe. One person told us, "I can lock my room so I feel safe. It's a safe place to stay," whilst another person's relative commented, "[Relation] is very safe. It's down to the staff and the place is so secure."

We observed the atmosphere in the service to be calm and relaxed and saw that people appeared confident when interacting with staff. Staff held regular meetings with people and discussed what action people should take if they did not feel safe. In addition to this, information about safeguarding was available in various places and in different formats around the service. This ensured that people were provided with appropriate information about and opportunities to discuss their safety.

People could be assured that staff had received training in recognising and responding to potential abuse. The staff we spoke with were able to describe the different types of abuse and told us they would act to protect people if they suspected abuse had occurred. Staff were confident that the management team would take appropriate action in response to any suspicion of abuse. Records we viewed confirmed that relevant information had been shared with the local authority when incidents had occurred. The local authority is responsible for investigating any allegations of abuse. Where recommendations which had been made to help staff keep people safe and avoid harm, these had been implemented.

Risks to people's safety were managed appropriately and people were actively involved in decisions about risks they took wherever possible. People's care plans contained risk assessments in relation to risks associated with skin integrity, nutrition and falls. One person had been assessed as being at high risk of falls. As a result of this referrals had been made to relevant external professionals. The recommendations made by external professionals had been followed as long as the person had given their consent. Records showed that the person's independence and dignity were fully considered alongside how best to keep the person safe.

People were living in a safe environment. Records showed that regular safety checks had been carried out as required. For example in relation to fire safety, water temperature and equipment. Information was available to staff about the support people required to evacuate the building in the event of an emergency, such as a fire, and records showed that staff had received relevant health and safety training.

Some of the people who used the service were living with dementia and sometimes expressed their emotions through behaviour. We found that people were supported by staff who were knowledgeable about how to manage this in a positive way. People's care records contained information about the behaviour the person may display, what caused this and how to respond. The staff we spoke with told us they had received relevant training and talked confidently about how they responded to people's behaviour in a way which was as least restrictive of their rights and freedom as possible.

People were supported by a sufficient amount of staff to keep them safe and meet their needs. Although

people and their relatives expressed mixed views of whether they felt there were sufficient members of staff, all of the people we spoke with told us that call bells were answered quickly and staff regularly checked on them to ensure they were safe. One person said, "Mostly it's a good (staffing) level but sometimes they're a bit short if (staff) off sick." Another person's relative commented, "I think there's plenty. Every time I come in anyway."

During our inspection, we observed there were sufficient numbers of staff to keep people safe and meet their needs in a timely manner. Records showed that the number of staff required was determined by the dependency needs of people using the service. We checked the staffing rota for a period of three weeks and found that the staffing levels identified by the registered manager as being required were maintained. The staff we spoke with also told us there were enough staff to ensure the needs of people were met. One staff member commented that staffing levels were "fine" and explained that if staff rang in sick, the management were usually able to arrange sufficient cover.

People could be assured that safe recruitment processes were followed. Before staff had started working at the service, a check had been carried out through the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. We also saw that proof of identity and appropriate references had been sought prior to staff commencing work. This meant that the provider had taken appropriate steps to ensure people were protected from staff who may not be safe to support them.

People received the support they needed to take their medicines as prescribed by their doctor. We observed staff administering people's medicines and saw they followed good practice when doing so. For example, we observed a staff member asking a person if they were in any pain and required pain relief and ensured people took their medicines in a way they preferred. Staff told us they had received training in the administration of medicines and had their competency to do so checked on a yearly basis. Records we saw confirmed this to be the case.

Information was available to staff to help ensure the administration of medicines was safe. People had protocols in place to provide staff with information about medicines which had been prescribed as required (known as PRN) and bottles and external ointments had been dated upon opening to ensure medicines were being used at their most effective. People's medicines were stored securely and regular checks were carried out to ensure medicines were being managed appropriately. External audits carried out by commissioners and the pharmacy showed a high level of compliance. This meant that people could be assured that medicines were managed safely.

People were supported by staff who understood the need to report accidents or incidents to the management team. The registered manager told us that a thorough analysis of the specific incident was carried out when required. We saw examples of this which considered what factors may have contributed to the incident and made recommendations to prevent a reoccurrence. We checked some of the recommendations made following one incident and found these had been implemented. The staff we spoke with confirmed that 'lessons learnt' from specific incidents were discussed at staff meetings. This meant the service was thorough and questioning when investigating incidents which had occurred at the service and were committed to making changes when required.

People told us they felt the service was clean and our observations during our inspection confirmed this to be the case. All areas of the home appeared very clean. Equipment was available in the service to help prevent the spread of infection, including hand gel in communal areas and disposable hand towels in toilets. The staff we spoke with were aware of procedures to help prevent the spread of infection and we saw

that staff used protective clothing when required, such as gloves and aprons. All of the staffing had received training in infection control and the housekeeping staff had additional duties, such as the completion and monitoring of cleaning schedules and audits to ensure hygienic standards were being maintained. We looked at one of these audits and found it had been effective in identifying and implementing improvements.

Good

Is the service effective?

Our findings

Before people started using the service, an assessment of their needs was carried out to ensure that appropriate support could be provided. The registered manager described using 'person centred planning' as the basis for individual care plans to ensure people received support in line with their preference and wishes.

The registered manager told us they followed NHS England's guidance to ensure they had considered people's communication needs and that information was accessible to people. This meant that each person had a document detailing their communication needs. We saw evidence that staff adhered to the guidance provided in these documents. For example, by ensuring people had access to pictorial information if required, had information provided in their first language or the support of an advocate if required. The registered manager was committed to ensuring that people did not face discrimination and told us in their Provider Information Return (PIR) that, "All staff receive training in respecting people's diversity. Staff knowledge with regards to equality and diversity is reinforced through regular supervision." Supervision records confirmed this to be the case.

People were supported by staff who were capable and competent in meeting their needs. People's comments included, "They (staff) seem very capable when handling [relation]," and "Oh yes, they (staff) are well trained. They're perfect." One person's relative told us, "It's really reassuring that they're so good with [relative]." Our observations confirmed what people told us and we saw that staff were skilled in responding to people's needs. This included the needs of people who were living with dementia and we saw staff using visual aids and reassurance when providing support.

The staff we spoke with told us they received an induction when they commenced working at the service which included a period of working alongside experienced staff. The staff we spoke with told us their induction prepared them sufficiently to undertake their roles. Staff were also complimentary of the training they received and told us the management team ensured they received all the mandatory training they required. One member of staff talked about the support they received from the management team and told us "I can't fault it." Records showed that staff received regular supervisions and an annual appraisal during which discussions took place about their development and performance.

People were supported to eat and drink enough and their individual preferences were catered for. People told us they received a good choice and quantity of food and that staff were knowledgeable about their specific needs. For example, one person said, "It's all good and we always get some choices. I'm diabetic so I'm sensible with the puddings. They'd (staff) get you a snack between meals, no quibble." Another person commented, "I'm never thirsty as I've got a jug of water and they bring me cups of tea and a milkshake."

We spoke to the chef manager who showed us the information they collated in relation to people's likes, dislikes and dietary requirements. We saw this included cultural, religious and ethical considerations, for example one person did not eat particular foods due to their religion whilst another person did not eat some food types due to their ethical beliefs. We found these people's choices were respected and if required,

specific menus had been devised. The chef manager told us they encouraged choice and feedback on the food by using pictorial information and for one person translating the menu into their first language. Our observations confirmed what staff had told us and we saw that the food was a regular item of discussion at residents meetings.

The support that people required to eat and drink well was provided in their care plan. Records showed that nutritional risks had been considered, such as the risk of choking or malnutrition and guidance was provided for staff about how the risk could be reduced. If people had been identified as being at risk of weight loss we saw this was monitored, discussed with external professionals and measures implemented to reduce the risk. We observed a mealtime at the service and saw that people were provided with the support they required to eat their meal. For example, one person required support to eat their meal and this was provided in a patient and supportive manner with gentle interaction and encouragement from the staff member.

People were supported to maintain good health. People told us staff took appropriate action in relation to changes in their health and they were supported to attend routine appointments. One person told us that staff had responded appropriately to changes in their health condition by stating, "They've (Staff) saved my life a few times." Another person's relative told us, "[Relation] has seen the optician and chiropodist here and gets hair and nails done too. They've been good at getting the doctor in when (health condition) has been a problem."

People's care plans contained succinct and useful information about their particular health conditions. This included a summary of the health condition, signs and symptoms of deterioration and what action staff should take to prevent and respond to changes in the person's health. The staff we spoke with were knowledgeable about people's health conditions and how to monitor these and were confident medical support would be sought in a timely manner. The registered manager told us the service was currently using telemedicine. Telemedicine is the use of telecommunication and information technology to provide clinical health care from a distance. The registered manager told us they were in the process of analysing the benefits of telemedicine and were confident it had helped to develop staff knowledge and confidence and reduced the instances of people being admitted to hospital unnecessarily.

A healthcare professional who routinely visits the service told us that staff contacted them appropriately when people's health conditions had changed and followed any advice given. They added; "The manager has been supportive regarding introducing telemedicine and telehealth and also ensuring that appropriate feedback is provided to the staff".

The registered manager informed us that they endeavoured to ensure a smooth transition when people moved to or from the service. For example, they told us that for a recent admission they ensured that an external healthcare professional remained a point of contact for a falls review at the service as the person had developed a trusting relationship with the professional.

The premises that people lived in met their needs. The service was modern and purpose built and people benefited from a physical environment which was easy to navigate, spacious and well lit. One person told us, "It's the best home I've been in. It's easy to find your way around the corridor" whilst another person said, "So many places to sit. It's very easy to get around. I can smoke outside too."

The registered manager told us that occasionally if people's needs changed they moved to a different floor of the service. As each floor was a similar layout, staff would try to provide a bedroom in a similar position to their previous bedroom to aid the person's orientation. We saw that people had made their own decisions

about the information they chose to display on the door of their bedrooms and that some people had brought their own furniture when moving to the service.

People had access to a secure garden area which we saw being used on the day of our inspection. We also saw that people had adapted their bedroom to suit their needs, for example one person had chosen not to have pictures on display whilst two people who lived at the service had chosen to create a shared private living space.

People told us they were able to make their own decisions about how they spent their day and that staff asked their consent before providing support. One person told us, "It's quite up to me what I do all day long," whilst another person said, "We're never told to do things. We make up our own minds." Our observations confirmed what people told us. We saw that people were asked for their consent before support was provided and offered explanations to aid their understanding. For example, we saw that people were offered the choice to wear an apron during a meal by staff who explained it would protect their clothes.

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.

The staff we spoke with showed an understanding of the principles of the MCA. The staff were able to describe how they supported people to make their own decisions and acted in people's best interests in the event they lacked capacity. People's care plans contained details of people's capacity to make decisions and where people had been assessed as lacking the capacity to make certain specific decisions, an appropriate best interest decision had been made and recorded.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We 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.

Records showed that a number of applications had been made to the local authority if people were identified as potentially being deprived of their liberty and some of these had been authorised. The staff we spoke with were aware of which people had a DoL authorisation and described how the person should be supported in line with the authorisation.

Good

Is the service caring?

Our findings

People described feeling at ease with the staff who supported them and described their interaction with staff as very positive. One person told us, "They're all marvellous, very friendly," whilst another person said, "I find them very caring." People's relatives also spoke positively about the staff at Acorn House. One relative commented, "You can tell they care as soon as you come in."

People's comments during inspection were also supported by the results of the latest relatives and friends satisfaction survey. When relatives and friends were asked, 'Do staff treat your loved one with kindness, dignity and respect?' 100% of those who responded replied yes to this question.

The service had adopted a 'Butterfly project' approach with the aim of making people feel valued by increased staff engagement and interactions. The project was co-ordinated by a member of staff who recruited 'butterfly champions' who committed to providing group or one to one projects with people who lived at Acorn House. The staff who had volunteered to become butterfly champions reported on the impact of the projects they had undertaken. For example, a member of the domestic staff had set themselves the goal of encouraging certain people who lived at the service, and who often appeared restless and anxious as a result of their dementia, to assist them with light domestic duties. It was recorded that the people involved in this project had expressed how they enjoyed helping the member of staff and staff had noticed that these people appeared less anxious when engaged in this activity.

We observed numerous instances of staff taking the time to greet people and have a chat with them. This included care, domestic and management staff. The interactions we witnessed showed that staff knew people well and appeared to have a positive impact on the person. For example, one member of staff sat with a person in a communal area of the service and engaged them in conversation about where they used to live. This generated a conversation about local amenities and how the person used to spend their time. The person appeared to enjoy talking to the staff member about their past.

We observed that staff ensured people were comfortable and made an effort to relieve people's distress. For example, we observed that one person appeared distressed when they entered a communal area. A member of staff asked them what was wrong; however, the person found it difficult to explain what was wrong. The staff member sat with them and started singing. The person joined in the singing and we heard them laughing and enjoying the company of the staff member.

The staff we spoke with knew the people they were supporting well. This included their personal histories, cultural and religious needs and preferences about how they were supported. Staff told us they get to know people by spending time with them and reading their care plans. The staff we spoke with knew about people's likes, dislikes and preferences. One member of staff described a person's preferences as to how they liked to be supported with their personal care. Staff told us that people's care plans contained the information they needed to get to know people and how they liked to be supported. People told us they felt comfortable talking to staff and asking for support and that their requests for support were responded to.

People had care plans in place with provided staff with guidance about how the person communicated.We saw that staff took their time to ensure that people had the information and explanations they required. This included reading to people if their eyesight was poor or using visual aids to help their understanding. For example, people were shown a choice of meal during a mealtime to help them make a choice about what they would like to eat. This meant that staff ensured they communicated with people in a way they would understand. Staff told us that one person's first language was not English and they tried to ensure that staff were available on alternate shifts who could speak the person's first language. The registered manager informed us that people's level of communication was reviewed if staff needed to monitor for signs of pain and that staff used gestures and facial expressions to monitor or an appropriate non verbal pain assessment form to identify the severity of the pain.

People had access to independent advocacy. Two people who lived at the service were using an independent advocate at the time of our inspection. The service was proactive in identifying which people would benefit from the support of an advocate and referring to advocacy services on behalf of people. We saw that contact details about local advocacy services were available in the service and the registered manager told us an advocate had previously attended a residents meeting to inform people about their role. An advocate is an independent person who can provide a voice to people who otherwise may find it difficult to speak up.

People were supported to maintain their dignity and spend time in private if they wished. All of the people we spoke with told us that staff respected their privacy and treated them with respect. One person commented, "My privacy is respected very much as they (staff) know I like the peace of my room. They'll always knock even with my door open." Another person confirmed, "I've no qualms at all about being respected."

Members of staff had been identified as 'Dignity Champions' within the service. The registered manager informed us that these staff members were confident and competent to challenge any issue or individual they perceive to not be upholding the dignity of people. We saw that information was on display in the service in relation to the Acorn House 10 commitments to dignity. The staff we spoke with were able to discuss strategies they used to ensure that people's privacy and dignity were maintained. These included knocking on people's doors before entering, closing curtains and respecting people's preferences about how they were supported with personal care. People's comments and our observations confirmed that staff ensured people's privacy and dignity was maintained.

We observed that staff were respectful of people's preferences, for example by referring to people by their preferred name. Staff also described strategies they used to ensure people were supported appropriately with their personal hygiene in line with their preferences. For example by checking their preferences as to the gender of staff who supported them or the time they preferred. People told us they were supported to be as independent as possible and in line with their wishes. One person told us, "They keep me very independent so I can make my own decisions."

People were supported to maintain relationships with their family and friends. The registered manager confirmed they had an open door policy with regards to people's families and friends visiting although visits during mealtimes were discouraged. The registered manager told us this was because they found that people ate better if they minimised distractions during the mealtime. However, if a relative wished to support their relation during a meal time this was supported. They also told us that all of the rooms had Wi-Fi and that people had contacted relatives via skype from the privacy of their rooms when their relatives had been abroad.

Outstanding ☆

Is the service responsive?

Our findings

People were aware of opportunities to be involved in planning and reviewing their care but in most instances chose to entrust staff and relatives to do this on their behalf. The relatives we spoke with confirmed they had the opportunity to talk to staff about their relations care or look at their care plan. Several of the relatives we spoke with had seen and had reviewed their relations care plan. One relative told us, "I've seen [relations] care plan and can check it any time, the staff say." Another person's relative said, "Yes, I feel involved in [relations] care as I sit and talk to the staff."

The registered manager described different ways in which people were supported to be as actively involved in planning and reviewing their care as possible. This included care staff reading one person's monthly review to them due to their poor eyesight. In most cases this involved seeking input from the person's family. The records we looked at showed that people or their relatives were involved in planning and reviewing care and we saw a relative being asked if they wished to review their relations care plan whilst they were visiting. During our inspection a person was accessing the service for a period of respite. We saw that a senior member of staff was ensuring staff had all the information they needed to meet the needs and preferences of the person by asking questions of the person and their family. Consideration had also been given as to whether people required the support of an independent mental capacity advocate (IMCA) to attend care reviews and we saw that a referral had been made to an IMCA on behalf of a person.

The registered manager told us in their Provider Information Return (PIR) that they ensured that people received personalised care by carrying out thorough and appropriate risk assessments in the first instance. If a risk was identified a care plan would be developed which provided staff with guidance on how the risk should be managed. Records showed this to be the case and the care plans we viewed were comprehensive and structured, providing detailed and accurate information for staff. These had been regularly reviewed, updated or discontinued as people's needs or circumstances had changed. We were fully assured that people were receiving the support they required as supporting documentation showed that checks or care interventions had been carried out as outlined in care plans.

In their PIR the registered manager stated, 'Care Plans are formulated considering the things that define our residents, for example their cultural background, gender and religious preferences.' Records showed that information had been sought from people and their relatives as care plans contained a document entitled "What you should know about me." This contained information for staff which the person or their relatives felt was important. Throughout people's care plans we saw information which would help staff provide care for people in line with their preferences. For example, one person's care plan contained information about their favourite colour, when they liked to get up and go to bed and their hobbies and interests.

The level of information in people's care plans helped ensure that staff could provide support in line with the person's preferences and thereby reduce any anxiety the person might feel. For example, one person's care plan contained information about where they liked their handbag to be kept during the night. It had also been identified that two people who lived at the service had the same coat and this information was included in one person's care plan as it could cause them anxiety if they felt another person was wearing

their coat. The care plan contained guidance for staff about how they should support the person to their room to show them where their coat was. The level of detail in people's care plans ensured that staff had the information they required to support people in a person centred way.

Some of the people and relatives we spoke with gave us specific examples that staff understood their needs and treated them as individuals. One person told us staff were supporting them to prepare for a loved one's funeral by purchasing a shirt in a colour they had chosen and making arrangements to accompany them. The person told us, "I can tell them (the staff) if anything needs to be different. They're only too happy to oblige." Another person told us, "I find they (the staff) are very good with me and know my eyesight problems and what trouble I have doing some things."

We found the service went the extra mile to find out about people's backgrounds, what they missed about their past and to accommodate people's aspirations. One person's relative told us, "They've straightened (relation) out since they've been here. They let (relation) do little things to help as they used to be a caretaker so like to be handy." The relative told us how staff use tools and jobs to occupy the person when they notice them becoming distressed. We also saw that thought had gone into the pictures on display in the service which were from an era which many of the people living there would be likely to remember. Further resources were available which connected people with their past working lives and hobbies. For example, we observed staff sharing objects and photos with people which generated discussion about what people remembered. These included household items, pictures of celebrities and a member of staff told us that several of the people living at the service had worked in local factories and that pieces of old machinery had been brought in for people to look at and talk about.

We spoke to one person who lived at the service about their visitors. The person talked about how much they enjoyed these visits and laughed as they described the time they spent with them. The activity co-ordinator told us that the relationship the person had with their visitors had developed since the person had lived at the service. They told us that staff had identified the person was unhappy, isolated and unsettled when they moved in. They told us the relationship with the visitors was supported by staff and had a beneficial outcome for both the person and their visitors. The activity co-ordinator told us, "The impact on [person] is amazing. [Person] now doesn't stay in their room, will accept care and has put weight on."

The service recognised how important it was for the people who lived there to feel part of the local community. As a result of this they had formed and developed many community links. This included participating in a project with a local social enterprise which involved young adults talking to people about their working lives and comparing them to work ethics and experiences today. People living at the service were interviewed by young adults and both the service and the social enterprise worked together to evaluate the success of the project and impact on young adults and older people. The activity co-ordinator told us that for weeks after the project had finished people were talking about the young adults visiting and talking to them. They told us that one person had previously isolated themselves in their room until their interview with the young adult. Following the interview they had decided to eat their meal in the company of others and talk about their day. As a result of this the person began to develop relationships with other people who lived at the service.

The activity co-ordinator described links with other community organisations such as the local primary school, day nursery and local churches. This had led to regular visits which benefitted the people living at the service. People had also been involved in a community project and contributed their ideas on what improvements could be made to the local community in exchange for offering the community group a base for meetings. The service was also planning an afternoon community luncheon at the service and that people had contributed their ideas about the food and activities they wanted to provide. They told us that

the drive for the luncheon was feedback from the people living at the service that they wanted to socialise more with the local community.

People gave us positive feedback on the provision of activities at the service. The exception to this was that some people did not feel as many activities were provided on one floor of the service. We discussed this with the activity co-ordinator who told us of their efforts to include people in activities and explore what people wanted to do. Records showed that meetings were held every month to discuss the provision of activities. People's comments about activities at the service included, ""Yoga and things like that they have. I see them come in to do church services too. I like quizzes and watching TV. We can go in the garden in the summer or we go out to some places now and then." One person's relative told us, "they try and involve (person) in activities. (Person) has been taken to the coffee ship and to the Goose Fair. (Person) liked the Halloween party here too."

During the course of staff working with people to learn more about their past lives, it was found that people sometimes shared information about events or circumstances which had caused them distress. The activity co-ordinator told us in these instances a protected life story was developed which considered which staff needed to be aware of what the person had disclosed and any potential triggers to recalling distressing past events.

The staff we spoke with were aware of people's protected characteristics under the Equality Act and told us how they worked with people to overcome any barriers to social inclusion and participation in events and activities at the service. For example, one member of staff described carrying out risk assessments when people first started living at the service to determine what support they required during outings. We were told this involved staff assessing people's needs initially in the secure garden area as to whether the person became distressed, could follow instructions and become orientated. It was then determined what support the person would require to access the local community.

The activity co-ordinator also told us that regular meetings for people who lived at the service were used to talk about different cultures or health conditions. They told us this was because some of the people living at the service were wary of people who did not come from the same culture or who were living with dementia. They told us that they had talked about different cultures and also the impact that dementia could have on people. They told us that they had developed talking about different cultures into theme nights with pictures, activities and food tasting based around a particular culture. They told us they thought this had developed people's understanding.

People could be assured that any complaints they made about the service would be investigated and acted upon. The people and relatives we spoke with told us they had not needed to complain but were aware of what action they needed to take if they did wish to raise concerns. One person told us, "I'd get in touch with the floor manager if I had cause to complain." Another person's relative told us, "I've had no cause to complain. If I did, I'd see the senior on this floor."

All of the people we spoke with told us they would feel comfortable approaching the unit manager with any concerns they may have. Each floor had a unit manager who was visible and people told us they felt comfortable to approach senior members of staff. Throughout our visit we saw that people were comfortable speaking with members of the management team. Information was available within the service to inform people about how to make a complaint and what action they could take in the event they were not happy with the outcome of their complaint. The registered manager told us that all of the complaints received were discussed with the provider during regular governance meetings with the aim of determining whether any improvements were required to service.

We reviewed two complaints which had been received since our last inspection. One of these had only just been received and an initial response had been provided and an investigating officer appointed. The other one had been investigated and responded to, this included an apology to the complainant and confirmation of the action taken in response to the complaint.

People were supported well at the end of their life. The provider told us in their PIR that, 'Our care planning process views end of life as an integral aspect of the service we provide.' We viewed some comments the service had received from relatives whose loved one had been cared for at Acorn House at the end of their life. These included, "The staff treated my (relation) with dignity and respect as (relations) needs changed and most importantly at the end of their life, through their final days. They also supported us as family members at that difficult time." Also, "A comprehensive care plan was put into place by Acorn House in consultation with (relations) GP, and this was followed through very carefully. When (relation) died peacefully in their sleep, the staff treated (relation) with the utmost respect and dignity."

The staff we spoke with told us they were aware of people's wishes in relation to how they would want to be supported at the end of their life as this information was contained within care plans. One member of staff spoke about one person's expressed wishes for how they wished to be cared for at the end of their life. They added, "The staff who are Butterfly champions are aware of people who are coming towards the end of their life and ensure that spend time with them. Family can stay over if they wish to too, a spare bedroom is offered or they can stay in (relations) room. People are never on their own if they are at the end of their life." The staff member told us about one person who had passed away and had been an active member of the local church, they told us that approximately fifty members of the church had visited at different times to sit with the person and read the bible with them.

The care plans we viewed contained information provided by the person or their relatives about how people wished to be cared for at the end of their life. Some people had chosen not to discuss this aspect of care and if this was the case, it was recorded. We saw that some people had a Do Not Attempt Resuscitation (DNAR) in place and if appropriate, an advance care plan which had been provided by the person's GP. People's views regarding aspects of their care at the end of their life such as pain relief and religious and cultural considerations were recorded. We saw that one person had made specific arrangements in relation to how they wished their body to be cared for after they had died and this information was carefully recorded. This meant that people's decisions and preferences for how they wished to be cared for were respected.

Good

Is the service well-led?

Our findings

The service had a clear philosophy to provide excellent care to people. The majority of people we spoke with were extremely positive about the service and most people could not suggest any improvements they would make. We did receive comments from two people in relation to the differing needs of people living on one floor of the service and whether there were sufficient activities on the same floor. These concerns were already known by the registered manager who told us how they had responded to these. People's comments included, "It is perfect as it is," "There are no faults at all," and "It's so happy [here]."

Several people and relatives had provided reviews of the service on an external website. All of the reviews provided in the last 12 months were positive and everyone who left a review stated they would recommend the service. Comments included, "We have found the care and attention our [relation] has received during the three months they have been at Acorn House, nothing short of exceptional. On our first visit to see the home we were impressed by the warm, friendly staff and general caring attitude to all the residents. Delighted to see the improvement in our [relation] in the short space of time they have been here. Staff are always willing to sit down and talk to family members if we have any questions." Another person who had stayed at the service commented, "Every aspect of my care has been excellent."

The support provided by Acorn House to staff was evidenced by a nomination as a finalist for the Great British Care Awards in 2016 in the East of England for the category of Care Employer of the Year. Records showed that the provider regularly sought feedback from the staff team in order drive improvements at the service. The results of the last staff survey were very positive and showed an overall satisfaction score of 92%.

The staff we spoke with were happy working in the service. One member of staff told us, "The atmosphere is amazing, everyone gets on with everyone and people work well as a team." They qualified this statement further by saying they received regular feedback on their performance during supervisions and felt able to bring their own opinions as to whether any improvements could be made. Another staff member said, "It's a really nice atmosphere. Staff help each other. I know that if I am not happy, issues would be dealt with. I feel listened to." The staff member told us about a recommendation which staff had made which was implemented by the management team. This meant that staff were encouraged by the management team to contribute to the development and improvement of the service

Staff told us they had opportunities to progress and develop within their roles. Each of the floors at the service had a unit manager who had a thorough understanding of their roles and responsibilities and were supported to undertake care management qualifications if they wished. One of the unit managers told us they were provided with the resources and support they needed to undertake their roles. They said, "All unit managers are supernumerary (not counted in staffing levels) but available to support staff if needed. I get the support and guidance needed. (Provider) is amazing and if we need anything it is provided." The provider informed us that they made it a priority to ensure that all staff members took collective accountability for the delivery of the service.

The service had an open and transparent culture. The staff we spoke with told us they felt comfortable to report any incidents or accidents which occurred and that any learning or recommendations from incidents were shared with them. The service was committed to upholding a duty of candour which meant that staff were encouraged to be honest with people when things had gone wrong. Records showed that staff understanding of duty of candour and whistle blowing were discussed with them during supervision to ensure their understanding. Whistle blowing is a term used to describe the reporting of concerns about the care being provided by a person who works at the service. The staff we spoke with were familiar with this term and told us they felt confident to follow the homes procedure and report any concerns they had.

The registered manager sought to embed equality and diversity amongst staff at Acorn House by regular discussion and reflection. This was evidenced in staff supervision records and minutes from a staff meeting. The registered manager told us that staff had discussed the needs of people from the LGBT community who may come into care and had reflected on how they could best meet any specific needs people may have.

There was a registered manager in post and we found they were clear about their responsibilities. For example, providers are required to notify us of certain significant events which occur in a service, such as serious injuries or allegations of abuse. We checked our records and found that we had been notified of such events as required. The registered manager told us they received "phenomenal" support from the provider to deliver their role. Both the provider and registered manager endeavoured kept up to date with any changes and best practice. This was through the attendance of local, regional and national networks to share good practice ideas with other managers and through the use of an external quality auditors to ensure indepedent reviews of service provision were carried out.

The service worked in collabortation with external agencies and was participating in the care homes vanguard programme. The vanguard programme is set to improve the way that health and social care services are delivered in care homes. It has a particular focus on applying the use of technology in care homes and in working with pharmacy experts on medicines management. The registered manager told us of their own detailed analysis of the impact of the use of telemedicine in the service which showed a reduction in paramedic call outs and subsequent transfer to hospital for non urgent treatment. They also told us they were currently working closely with a health professional to improve outcomes for people from the use of medicines.

People and their relatives were not always familiar with the registered manager. In most cases this was because people were confident in the unit manager to address any concerns they had. One person told us, "I'd recognise (registered manager) but don't see her too much." Another person's relative said, "I only met her once. It's always the staff I see and any concerns, I'd talk to (unit manager)." The registered manager confirmed their details were on display within the service and that unit managers were held responsible and accountable and were an appropriate first point of contact for people and their relatives.

The staff we spoke with were very complementary of the support they received from the management team. One person told us, "(Registered manager) is really good. I have my own line manager but if I needed her to (registered manager) would sort issues. (Provider) is visible and visits regularly. I would approach if I needed to." Another staff member told us that a member of the management team was always available for support if needed. They said, "There is always a manager available, always, even at weekends."

People and their relatives were given opportunities to feedback and comment on the service provided. Records showed that questionnaires were provided to people and their relatives twice a year. We looked at the results of these questionnaires for the last three years and saw that people's satisfaction with the service had increased. For example, people's satisfaction with the staff and care provided had risen from 92% to

97% and satisfaction with the food had risen from 86% to 97% during the last year. Any negative comments received were considered by the registered manager and we saw that an action plan was produced to inform people about the action taken in respect of any areas of improvement. In addition, regular meetings were held with people who lived at the service which provided opportunities to provide people with information and gather their views on different aspects of the service. This meant that people's feedback was sought regarding the running of the service and acted upon to help drive improvements.

People could be assured that robust quality monitoring systems were in place. Records showed that each unit manager compiled information on a monthly basis in relation to areas of care such as falls management, dependence levels, weight monitoring and call time response logs. We saw that a high level of analysis was carried out by unit managers and the registered manager and that any falls and changes in weight were analysed for trends or action needed. In addition, call bell response times were analysed on a daily basis to ensure that people's needs were being met safely and in a timely way. If serious incidents had occurred at the service, a 'root cause analysis' was carried out. We saw that recommendations made as a result of the analysis had been acted upon which had led to changes in how information was disseminated to staff and ensuring that staff understood they had a duty of candour to the people who used the service.

The provider told us that governance meetings were held each month and records evidenced this to be the case. During these meetings each fall which occurred at the service was scrutinised to ensure that the service was taking all reasonable action to reduce the risk of harm. We reviewed a number of people's care plans during our visit who were at high risk of falls and found that best practice guidance in relation to the management of falls was being adhered to, this included the use of equipment and referrals to specialist professionals when required. This meant that the level of scrutiny of falls which occurred at the service ensured that the risk of harm was reduced as much as possible and records showed this had led to a reduction in falls for some people.