Acacia Number 1 Limited

Acacia House - Tenterden

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 1 and 2 August 2017 and was unannounced.

Acacia House provides accommodation for up to 47 people with nursing and personal care needs. There were 41 people living at the service at the time of our inspection, although one person was in hospital. Some people had complex needs and required continual nursing care and support, including end of life care. Others were living with dementia and because of physical frailty or medical conditions, needed assistance with person care and moving around the home safely.

The service is an old house with a new extension on the ground floor. There are 44 rooms of which three can accommodate two people. The lower floor provides a dining room and three lounges as well as level access to the secure and well maintained gardens. Access to the upper floor is by a passenger lift and two staircases. There is onsite parking available.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Acacia House was last inspected in May 2016 when the service was rated overall as 'Requires Improvement.' This was because people did not always receive their medicines in accordance with their prescriptions or medical guidance and some people's wishes about their end of life care were not always recorded. People were not always involved in the decisions about their care and treatment and, if people or their representatives were involved in care decisions, the process was not always recorded. Quality monitoring was not always effective; shortfalls in people's care and treatment had not been identified by the provider or senior managers and people and staff were not always consulted or involved in the running of the service. This inspection found improvement had been made.

Staff followed correct and appropriate procedures in the storage and dispensing of medicines. People were supported in a safe environment and risks identified for people were managed in a way that enabled people to live as independent a life as possible. People were supported to maintain good health and attended appointments and check-ups. Health needs were kept under review and appropriate referrals were made

when required.

An adequate system to recruit new staff was in place and made sure staff employed to support people were fit and suitable to be working at the service. There were sufficient numbers of staff on duty to make sure people were safe and received the care and support that they needed.

Staff had completed induction training when they first started work at the service. Staff were supported during their induction, monitored and assessed to check that they had gained the right skills and knowledge to support people in a way that met their needs. Staff continued to receive training and support. There were staff meetings, staff could discuss any issues and share new ideas with their colleagues, to improve people's care and lives.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and DoLS and the least restrictive measures were in place to keep people safe and ensure they were not deprived of their liberty unnecessarily. Staff continued to seek consent of people for their everyday care and support needs.

People were protected from the risk of abuse because staff had received safeguarding training and were aware of how to recognise and report safeguarding concerns. Staff knew about whistle blowing and were confident they could raise any concerns with the provider or outside agencies if needed.

The care and support needs of each person were different and their care plan was individual to them. Personalised care plans, risk assessments and guidance were in place to help staff to support people. People's legal rights were protected as staff provided care in line with the Mental Capacity Act (2005). Staff followed the guidance of healthcare professionals where appropriate and we saw evidence of staff working alongside healthcare professionals to achieve best outcomes for people.

Staff encouraged people to be involved and feel included in their environment. People were offered varied activities and participated in social activities of their choice. Staff knew people and their support needs well, they treated people with kindness, compassion and respect. Staff took time to speak with the people they were supporting. People were offered a choice of nutritious meals, snacks and drinks were always available.

There were positive and caring interactions between the staff and people and people were comfortable and at ease with the staff. People's privacy and dignity was respected.

People and relatives said they knew how to complain if necessary and that the registered manager was approachable. There was a clear complaints process in place

Staff felt there was good communication and were clear about their roles. They felt well supported by the registered and deputy managers. Feedback was sought from people, relatives and professionals about how the service was run.

A number of audits and checks were carried out each month by the registered and deputy manager, which were effective in identifying and addressing concerns and driving forward improvements.

We have however identified a number of areas where improvement is required. You can see these in the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were enough staff on duty to support people and keep them safe. Appropriate checks were completed when employing new staff.

People were kept safe from abuse or improper treatment. Actions to reduce known risks to people had been taken.

Medicines were managed safely and people received their medicines when they needed them.□□

Is the service effective?

Good

The service was effective.

People's rights had been protected by proper use of the Mental Capacity Act (MCA) 2005.

Staff training and supervision was effective in equipping staff with the skills needed for their roles.

People's health was monitored and staff ensured people had access to external healthcare professionals when they needed it.

People received enough to eat and drink and were complimentary about the choice and quality of food provided. □□

Is the service caring?

Good

The service was caring.

Staff acted sensitively to protect people's privacy and dignity.

Staff engaged well with people. Staff spoke with people in a caring, dignified and compassionate way, people felt listened to.

People were supported to be independent where possible.□□

Is the service responsive?

Good

The service was responsive.

Care planning was person-centred and people's individual choices and preferences supported.

People participated in activities that they enjoyed. Staff had a good understanding of people's needs and preferences.

There was a complaints system and people knew how to complain. Views from people and their relatives were taken into account and acted on.□□

Is the service well-led?

Good

The service was well-led.

Audits and checks were in place and effective.

Feedback had been sought from people, relatives and staff and suggestions for improvement were acted on.

Events which affected people using the service had been appropriately reported to the Care Quality Commission.

Staff were clear about their roles and responsibilities and felt supported.□□

Acacia House - Tenterden

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 1 and 2 August 2017 and was unannounced. The inspection was carried out by two inspectors, a specialist nurse advisor with nursing experience of older people and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection we reviewed the information we held about the service including previous inspection reports and the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what it does well and improvements they plan to make. We considered information which had been shared with us by the local authority and other people, looked at safeguarding alerts and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met most of people who lived at Acacia House and spoke with 14 of them. We observed most people's care, including interaction with staff, the lunchtime meal, some medicine administration and some activities. We spoke with nine people's relatives. We inspected the environment, including the laundry, bathrooms and some people's bedrooms. We spoke with two nurses, three health care assistants, the activities coordinator, kitchen and housekeeping staff as well as the deputy and registered managers, the regional manager and service provider.

We 'pathway tracked' five of the people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the service where possible and made observations of the support they were given. It is an important part of our inspection, as it allowed us

to capture information about a sample of people receiving care. We also looked at some aspects of care records for eight other people. To help us collect evidence about the experience of people who were not able to fully describe their experiences of the service for themselves because of cognitive or other problems we used a Short Observational Framework for Inspection (SOFI) to observe people's responses to daily events, their interaction with each other and with staff.

We displayed a poster in the communal area of the service inviting feedback from people and relatives. Following this inspection visit, we did not receive any additional feedback.

Good

Our findings

People told us they felt safe living at Acacia House, one person said, "I am happy to live here, it's friendly and I feel safe." Another person told us, "I feel safe; I'm worried I might not be able to stay here, the care manager wants me to move to a residential home" and "I feel safe because there is always someone around and I've got a bell I can always press." A visitor, speaking of their relative, told us, "I feel he is totally safe," another visitor told us, "She was very lonely at home so she decided she should move into a home where she would be safer." However another visitor told us of an incident when their relative was thought to be missing from the service and after searches of the service, its grounds and surrounding area, they were eventually found having locked themselves in an empty bedroom in the service. We discussed this incident with the registered manager; they had correctly notified the local authority safeguarding team and police and carried out an investigation following the incident. We saw that learning had occurred and their policy updated when dealing with missing people.

At our last inspection medicines were not always administered safely or when people needed them. At this inspection we found that required improvement had been made. People received their medicines when they needed them. There were policies and procedures in place to make sure that people received their medicines safely and on time. All medicines were stored securely in locked cabinets in line with current guidance. Appropriate arrangements were in place for ordering, recording, administering and disposing of prescribed medicines. Clear records were kept of all medicine that had been administered. The records were up to date and had no gaps, showing all medicines administered had been signed for. Guidance was in place for people who took medicines prescribed 'as and when required' (PRN). Regular medicine audits were carried out by the registered manager or nursing staff. This helped to ensure people received all of their medicines safely.

Adequate recruitment practices were in place and checks were carried out to make sure staff were suitable to work with people who needed care and support. We saw that checks had been completed before staff worked unsupervised at the service, for most staff, these included obtaining suitable references, identity checks and completing a Disclose and Baring Service (DBS) background check and checking employment histories. These records were held in staff files along with application forms and interview notes. However, we noted where different nationality staff had come to work at the service as their first job, some of the references obtained were of little value as they had been provided by friends. More useful and verifiable references may have been available from previous places of education or landlords. Additionally although overseas criminal records checks were completed, the DBS check for one member of staff was not completed before they started work at the service as a National Insurance number, bank account and

address were not previously available. This is an area identified as requires improvement.

There was enough trained staff on duty to meet people's needs. The registered manager used a dependency tool to make sure there was sufficient staff on duty to meet people's assessed needs and kept staffing levels under review. The staff rota showed there were consistent numbers of staff available to make sure people received the care and support that they needed. During the inspection staff were busy but not rushed. Staff we spoke with felt they had enough time to talk with people and that there were enough staff to support people. At times agency staff were used; the registered manager told us they had an RGN vacancy. Although they had advertised to fill the post, they were having difficulty recruiting nursing staff.

The provider had policy and procedures in place for safeguarding adults from harm and abuse, this gave staff information about preventing abuse, recognising signs of abuse and how to report it. Staff had received training on safeguarding people and were able to confidently identify the correct procedures to follow should they suspect abuse. Staff understood the importance of keeping people safe. Staff told us they were confident that any concerns they raised would be taken seriously and investigated by the management team, to ensure people were protected. Staff were aware of the whistle blowing policy and knew they could take concerns to agencies outside of the service if they felt they were not being dealt with properly.

Risks to people had been identified and assessed and guidelines were in place to reduce risks. There were individual guidelines in place to tell staff what action they had to take to minimise the risks to people. There was guidance in place for staff to follow, about the action they needed to take to make sure that people were protected from harm in these situations. This reduced the potential risk to the person and others. Potential risks were assessed so that people could be supported to stay safe by avoiding unnecessary hazards. Risk assessments were reviewed and updated as changes occurred so that staff were kept up to date. For example, one person fell from a garden seat during our inspection, staff reacted well and calmly to support them. An accident form was completed and supervision of the person increased. Referrals to occupational therapists and falls clinics were routinely made; staff were aware and proactive to consider and address other possible contributors to falls such as dehydration and infections.

Checks took place to help ensure the safety of people, staff and visitors. Fire drills had taken place and a summary of each drill had been recorded, this meant that the provider could monitor staff attendance and participation in drills. Records showed that portable electrical appliances and fire fighting equipment were properly maintained and tested. Regular checks were carried out on the fire alarm and emergency lighting to make sure it was in good working order. Checks to ensure air mattresses were at the right setting were completed. Records showed Health and Safety audits were completed monthly and that these were reviewed to see if any action was required. Procedures were in place for reporting repairs and records were kept of maintenance jobs, which were completed promptly after they had been reported. These checks enabled people to live in a safe and suitably maintained environment.

People had personal emergency evacuation plans (PEEP). A PEEP sets out the physical and communication requirements that each person has to ensure they can be safely evacuated from the service in the event of a fire. Accidents and incidents were recorded and management reviewed these reports to ensure that appropriate action had been taken following any accident or incident to reduce the risk of further occurrences. A monthly analysis of accidents, incidents and action taken was completed.

The service was clean, tidy and free from odours. One person told us, "While I am out of my room they clean and tidy for me and when I say clean, I mean clean, they are very zealous". People's bedrooms were personalised with their own possessions, photographs and pictures. They were decorated as the person wished and were well maintained. Toilets and bathrooms were clean and had hand towels and liquid soap

for people and staff to use. The building was well maintained. Lounge areas were suitable for people to take part in social, therapeutic, cultural and daily living activities. There was a relaxed and friendly atmosphere at the service.

Good

Our findings

People told us staff looked after them well, one person told us, "If they think you need looking at then you can see a doctor the same day, the doctor is treating me for a chest complaint and my legs at the moment." Another person told us, "When the carer gave me a wash she noticed a sore place under my arm so she is calling the doctor." Most people thought the food was good, with comments including, "I have breakfast in my room, I could do with a bit more food but the food is good," "The food is generally quite good but can be a bit haphazard," "The food is alright, if I don't like it I don't eat it" and "The food excellent," and "I like the food." Relatives spoken with told us "My relative says the food is good, always plenty of drinks, they are very particular about drinks, they keep a chart especially in the hot weather," and "She's eating better than she was at home." People and their relatives had confidence in the staff who supported them.

Staff worked effectively together because they communicated well and shared information. Staff handovers made sure that they were kept up to date with any changes in people's needs. The registered manager attended each handover, including the handover between night and day staff. This ensured all staff were up to date with any developments during the day and night. Staff told us the Tuesday and Friday meetings were especially important to update them on outcomes from the GP visits on those days. One member of staff told us, "Handovers are very much two-way, our observations and opinions are heard and help in updating care plans. If I don't know something I can go to a nurse, senior or deputy – they all work on the floor. I'm very impressed by the management and can compare with my previous experience. There are enough staff and we cover for each other if we are short." Meetings were led by the deputy manager and all staff were clearly welcomed and encouraged to contribute. However, the activity coordinator was not present at the meetings and it was felt they would have offered a balance to the emphasis on physical wellbeing as well as benefitting from content of the meeting. This is an area identified as requires improvement.

People's health was monitored and health care professionals were regularly involved to make sure people were supported to remain as healthy as possible and meet any changing needs. Staff acted quickly if people became unwell and worked closely with healthcare professionals to support people's health needs. However, we found although staff were working to current guidance from visiting health care professionals, instructions they had provided were not always incorporated into care planning. For example, a letter received from the Speech and Language Therapist team (SALT) specified that one person needed thickened drinks and a pureed diet to help them eat and drink with a reduced risk of choking. Discussion with staff found they knew about these requirements and we saw that the person received their food and drinks as the SALT team directed. However, when the care plan had been reviewed, these requirements were not incorporated into the associated nutrition and hydration care plans. Care plan evaluation was in this case

superficial and did not take account of significant changes in the preceding month. This is an area identified as requires improvement.

People had health action plans; these detailed how to support each person to remain healthy and recorded details about appointments they attended and any test results. People who had specific medical conditions, such as diabetes, had guidance for staff to follow. This described symptoms they may display and how to support them. Some people had very specific requirements around how their nutritional and hydration needs were met, including percutaneous endoscopic gastrostomy (PEG) feeding (this is a tube that feeds directly into a person's stomach) and advice from specialists about the consistency of food and drink for other people to help reduce the risk of choking. Staff were vigilant about how much people ate and drank; records of people's food and fluid intake were monitored twice daily. We did however discuss with the registered manager that hydration charts may be more meaningful for staff if they stated the target amount of hydration people needed. This would enable staff to gauge how far advanced people were in reaching their desired amount. This is an area we have identified as requires improvement.

New staff had an induction into Acacia House during their probation period, this involved time spent reading people's care records, completing a workbook , training, policies and procedures and getting to know the service. They also spent time shadowing experienced colleagues to get to know people and their individual routines. Staff were supported through their induction, monitored and assessed to check that they had attained the right skills and knowledge to be able to care for support and meet people's needs effectively.

Staff were trained and supported to have the right skills, knowledge and qualifications necessary to give people the right support. There was an on-going programme of training which included face to face training and e learning. Staff commented, "It's good they get detailed training for us, we've had recent training about incontinence pads and use of pro-shield" and "Doing training in groups, we learn from each other and get different opinions." A training schedule was maintained by the registered manager and staff were supported to gain recognised qualifications in health and social care. Staff felt the training provided was to a good standard and happened regularly; they found the training effective in supporting them to fulfil their roles. One member of staff commented, "Training is always available, it's nice to be able to refresh on some topics and make sure I stay up to date."

Staff received regular supervision meetings with the registered manager or key staff and annual appraisals. Staff told us they felt very well supported by the registered manager and found these meetings useful. One member of staff told us, "It's good because you get praise for what you do well as well as guidance where you need it. There are also 'staff conversations' which is like supervision when someone has done something not quite right."

We observed staff providing care and support to people throughout our inspection. Staff adapted the way they approached and communicated with people in accordance with their individual personalities and needs. The staff team knew people well and understood how they liked to receive their care and support, and what activities they enjoyed. Staff were able to tell us about how they cared for each person on a daily basis to ensure they received effective individual care and support. They were able to explain what they would do if people became restless or agitated.

Management and staff were aware of the need to involve relevant people if someone was unable to make a decision for themselves. If a person was unable to make a decision about medical treatment or any other big decisions then relatives, health professionals and social services representatives were involved to make sure decisions were made in the person's best interest.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty they are the least restrictive. Applications had been made for deprivation of liberty safeguards (DoLS) authorisations for people who needed them, and were being processed. These authorisations were applied for when it was necessary to restrict people for their own safety. These were as least restrictive as possible.

The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. Records showed that people's mental capacity to make day to day decisions had been considered and there was information about this in their care plans. The registered manager had knowledge of the Mental Capacity Act 2005 (MCA). Staff had knowledge of and had completed training in the MCA and Deprivation of Liberty Safeguards (DoLS).

People's dietary needs and preferences were discussed with them or with people who knew them well before admission, and were regularly reviewed. Information about people's specific nutritional support and any food allergies, likes and dislikes was recorded and provided to the chef when preparing meals. Menus were flexible; two choices were available each day with a choice of alternatives also available. People and relatives told us that the food was good and that the chef knew their likes and dislikes very well. Some people required their food to be pureed; they told us the chef made sure to present it in an appetising manner. Plenty of drinks were available to people throughout the inspection and we observed people being supported to drink at regular intervals.

Meal times were well organised and people who needed support to eat received it. However, on the first day of our inspection the television was on at high volume throughout the lunch period, no one was watching it and the noise of grass cutting taking place directly outside the dining area was intrusive. People commented this was unusual. Discussion with the registered manager gained their acknowledgement of the importance of a conducive dining experience; on the second day of our inspection lunch was served with the television off and soft background music.

Good

Our findings

People told us they were happy living at Acacia House, many had lived there for several years and relatives we spoke with told us they were happy with the high standards. One person commented, "They are all nice people and they care not just routinely but in loving way," another person told us, "Everybody is friendly, the staff are very friendly" and "I'm quite happy with the care here, they are all very nice." Visiting relatives told us, "Carers are extremely good with my husband, they are very patient, when I come in he always looks clean and his clothes are clean" and "Some of the foreign carers are really kind especially the male carer, he's lovely with residents. My husband has dementia and doesn't react much but when he is in a good mood he smiles at them".

Our last inspection found people's end of life wishes had not always been discussed and were not always recorded in care plans. This did not promote good practice to ensure people were supported in accordance with their wishes. At this inspection we found improvement had been made; of the care plans sampled, end of life wishes were recorded. Although no longer accredited to The Gold Standards Framework for End of Life Care, the service continued to adopt these principles.

Staff were friendly and accommodating of people's requests and support needs. However, some staff habitually called people by pet names such as, "Darling, love, chick and girl." Although people did not object it did not project the ethos of a service that recognised individuals. In addition, calling people by pet names can mean some people did not know who staff were speaking to; whereas calling a person by their name helped to orientate a person to know that they were being spoken to. This is particularly important for people in a new environment and people who may be living with dementia. This is an area we have identified as requires improvement.

Staff spent time with people to get to know them. There were descriptions of what was important to people and how to care for them, in their preferred way, in individual care plans. Staff told us when they were new they had read the care plans to get to know how to support people and had worked with more experienced staff in the team to see how people were supported with their lifestyles. Staff talked about people's individual needs in a knowledgeable way and explained how people were given the information they needed in a way they understood so that they could make choices. There was laughter, people and staff were seen to have fun together, they shared a laugh and a joke and people looked happy or smiled when interacting with staff. Maintenance staff were careful to forewarn people about a fire alarm test to make sure they did not become distressed or try to leave the building. After the test people were reassured that everything was alright and the alarm test had finished and was working properly.

There was a clear person centred culture at the service and a commitment to supporting people to express their views, feelings and maintain their independence. Staff knew about people's background, their preferences, likes and dislikes and supported people in a way that they preferred. One person told us, "I used to take myself to the toilet but I got ticked off, now I ring the bell for help." They were happy with this and understood this was to help keep them safe. People and relatives we spoke with thought the staff team worked well together to provide good care for people. Staff told us about some people who enjoyed helping around the service and we saw people doing little jobs such as setting tables and shaking out table cloths after meals. One person found pleasure and contentment in carrying a dementia doll, staff ensured the person had it and helped them look for it if it was misplaced.

People received consistent care from motivated staff. Staff were supportive in encouraging people to be independent. One person told us, "I keep my independence by washing and showering myself." A number of other people commented how they enjoyed their independence, they could come and go as they pleased and staff were always on hand to help them if they needed it.

Staff were attentive. They observed and listened to what people were saying and communicating. Staff picked up on communication cues such as use of arms and hands to communicate yes or no and facial expressions and body posture which may indicate discomfort. Staff knew people well and were easily able to hold a conversation with them. People responded well to staff and we saw staff interacting with people in a way that demonstrated they understood their individual needs and had a good rapport with them. Staff talked about and treated people in a respectful manner. Staff ensured to involve people in conversations. Each bedroom door was personalised for each person, for example; some had names, pictures or signs to help people recognise their bedrooms rooms.

People's privacy was respected. When people were at the service they could choose whether they wanted to spend time in communal areas or time in the privacy of their bedrooms. People could have visitors when they wanted. People were supported to have as much contact with family and friends as they wanted to. People were supported to go and visit their families, relatives and friends. Families told us that they felt the service was 'very welcoming.'

Staff described how they supported people with their personal care, whilst respecting their privacy and dignity. This included explaining to people what they were doing before they carried out each personal care task. When people had to attend health care appointments, they were supported by staff that knew them well, and would be able to help health care professionals understand their needs. People were moving freely around the home, moving between their own private space and communal areas at ease. Staff knocked on people's doors before entering. Doors were closed when people were in bathrooms and toilets. People were given discrete support with their personal care.

People's care plans told us how their religious needs would be met if they indicated they wished to practice. One person told us, "I sing in the choir at church. I am collected by a parishioner. I have joined since I have l lived here." Another person said, "We have a vicar come in, you can have communion if you want." People's information was kept securely and well organised. Staff were aware of the need for confidentiality and meetings were held in private.

Good

Our findings

Our observations during the inspection showed staff knew people's needs well and they were able to respond to people's needs in a quick and consistent manner. People were complimentary about the staff and the care they received. People's comments included, "Each day they shower and shave me, the carer is very thoughtful," "The staff are very caring and discreet" and "One of the reasons I came here, there is no restriction on what time I get up and go to bed it helps keep my independence."

Staff had developed positive relationships with people and their friends and families. Staff kept relatives up to date with any changes in people's health. People and relatives felt the care and support people received at Acacia House was responsive and suited to their individual needs.

Our last inspection found people and other relevant parties were not always involved in care planning, or this was not recorded. In addition we raised concerns about the lack of opportunity for activities or social stimulation for people who chose to stay in their rooms, or were unable to leave their rooms because of their frail condition. At this inspection, these concerns had been addressed.

Discussion with the registered manager found people, their families and relevant visitors were provided with aspects of care plans and invited to comment on them. These additions and comments were discussed with the person receiving care and incorporated into their care plans if wanted. This provided an opportunity for people to be involved in reviewing and planning the care and support provided.

The service employed a full time activities coordinator. People told us about the introduction of scrapbooks in bedrooms 'Acacia House Memories'. These were used as a photo record of things people did, including everyday activity, to promote short-term memory, reminiscence and show to families. People told us they were supported to take part in a variety of activities including music therapy, physiotherapy, quizzes, bingo, singers and entertainers. Planned social events took place such as garden parties; the service had recently held a summer beach party with deckchairs, sand, a Punch and Judy show and an ice cream van. One relative told us, "He reacts well to music so is always given a front seat if there is an entertainer," however, another person commented, "We had a Punch and Judy show the other day, you've never seen so much rubbish in your life." Other people commented more positively about the activities which were generally well received. Everybody we spoke with was very positive about the activity coordinator, describing them as 'engaging, enthusiastic and committed.'

The activity coordinator told us, they delivered the 'Daily Sparkle' an in house reminiscence newspaper. It is

published 365 days a year and offers a range of nostalgia topics and activities, targeted at the elderly and those with dementia. They told us, "I go to every room; all the residents want is a chat and a touch of the hand". "Each resident is totally different, I use other residents to start conversations and help me. We are a family at the end of the day, That's what we are". During the inspection we made several observations of the activity coordinator in one to one conversations with people in communal rooms, garden and bedrooms. They demonstrated close relationships and good knowledge of people's backgrounds and families as well as the ability to steer conversation into active reminiscence work. They told us, "Finding ways into individuals; it takes months sometimes of sitting and talking with someone before making a change. With one person, it was through engaging about funeral plans. I helped her get information and then got her to the church to see how it fitted with her plans. It was her first time out, other than for medical appointments, for nine years." The person told us "(Activity coordinator) has changed my life, church is really important to me but I just couldn't go for years." Other staff told us, "We go into people in their rooms so they are not alone. I watched the news with a resident today. At weekends we do ball games, bingo, singing, listen to music, and watch films. We get great guidance from (activity coordinator), she knows everyone, and so well, " and "We want to make it a home for both residents and their families. We are always adapting to the people we have. There is no point doing things people don't want."

Each person had a pre-admission assessment to ensure that the service would be able to meet their individual needs. The assessment included consideration of the current resident group and how the potential new person would adapt to living in the service, with the people already there. Admission assessments and resulting care plans captured an inclusive approach to care and included the support people required for their physical, emotional and social well-being. These included all aspects of care, and formed the basis for care planning after they moved to the service.

Staff demonstrated a clear understanding of the people they supported. Staff told us that they followed the care plans and guidance, and asked colleagues if they needed help. Within people's plans were life histories, guidance on communication and personal risk assessments. In addition there was guidance describing how the staff should support the person with various needs, including what they could and couldn't do for themselves, what they needed help with and how to support them. Care plans contained information about people's wishes and preferences and guidance on people's likes and dislikes around food, drinks and activities. Health plans detailed people's health care needs and involvement of any health care professionals. Each person had a healthcare passport, which would give healthcare professionals details on how to best support the person in healthcare settings if needed, such as if the person needed a stay in hospital. Care plans were regularly reviewed and reflected the care and support given to people during the inspection.

People had review meetings to discuss their care and support. They invited care managers, family and staff. Where able, people were encouraged to be involved in the content of their care plan and where possible family or friends were asked to assist. Where people had been involved, and were able to, they had signed their care plan.

Residents meetings and feedback questionnaires gave people the opportunity to raise any issues or concerns. Any concerns raised were taken seriously and acted on to make sure people were happy with the quality of service they received. Relatives were also invited to these meetings. They provided people and their relatives with an opportunity to discuss and comment on the day to day running of the service. People talked about what they would like on menus and what activities they would like to happen and upcoming events that they were looking forward to.

A system to receive, record and investigate complaints was in place so it was easy to track complaints and

resolutions. The complaints procedure was available to people and written in a format that people could understand. Eight formal complaints had been recorded since our last inspection, six were resolved and the remainder received on going attention. Complaints had been recorded, investigated and responded to within policy guidelines. One visitor told us they had not complained to the registered manager, but had discussed elements that required change in the care of their relative. They felt the response received was appropriate, reflected learning and the service getting to know how best to support their relative. They told us they were satisfied with the response received and had seen change in the support provided to the person.

Good

Our findings

The service had an established registered manager who was supported by a team of registered nurses, healthcare workers, a chef, domestic and maintenance staff. Staff felt they were well supported. Staff commented, "The manager is knowledgeable and approachable all of the management are helpful and supportive." Relatives also told us that they found the registered manager and staff team to be approachable. Their comments included, "Staff are available and approachable, I can speak to any of them whenever I need to" and "I can always talk to them and tell them any concerns I may have." However, one visitor told us "If I had any complaint it would be the slowness of answering the front door" and "My only complaint is it's difficult to get in sometimes, I have phoned once from the front door to be let in".

At the last inspection we found the systems in place to audit and monitor quality were not consistently effective. At this inspection we found the registered manager and provider were aware of their responsibilities and had a greater management oversight as a result of improved auditing. Audits such as medicines, accidents and incidents, health and safety, infection control, fire safety and equipment were completed both weekly and monthly. The audits identified any shortfalls and action was taken to address them. However, we found reviews of care plans undertaken by other staff did not always identify changes or events that had happened since the last review. This indicated that management checks focussed on the activity of review rather than ensuring the review was correct and represented people's current needs. It was particularly important that needs were correctly reflected, not only to ensure people received the correct level of support, but also because needs assessments helped to inform staffing numbers. This is an area we have identified as requires improvement. We spoke with the registered manager about these concerns and although they acknowledged corrections were required, they advised us that the service was soon to transfer to an electronic form of care plans. They were confident this would help to alleviate this problem as input information was more interactive and would highlight other areas to consider where care plan changes may be required.

Established systems sought the views of people, relatives, staff and health and social care professionals and had been undertaken since the last inspection. People had completed questionnaires about their opinions of the service. Questions covered staffing, choices, feeling safe, being listened to and menu choices. The responses were positive overall. Resident and relative meetings took place three monthly, the last one having taken place in July 2017. Discussion had taken place about the redecoration and use of one of the lounges as well as outings, activities and Christmas party planning. It was, however, not clear from one meeting to the next how items of discussion had been actioned or acted upon. Meetings could be improved by summarising the previous meeting and updating people on what had happened to the previous

comments and suggestions made. This would help people recognise their contribution to the day to day running of the service. This is an area we have identified as requires improvement.

Staff meetings were held six weekly and took place in evenings to accommodate night staff, although some staff work both nights and days. Staff felt they were listened to and suggestions were acted upon and gave an example of the provider approving new lifting hoists and slings as result of staff raising the need through staff a meeting. The registered manager told us they felt well supported by the provider in their role.

There were a range of policies and procedures in place giving guidance to staff about how to carry out their role safely and to the required standard. Staff knew where to access the information they needed. There was a positive and open culture between people, staff and management. Through our observations at this inspection it was clear that there was a good team work ethic and that staff felt committed to providing a good quality of life to people. Staff told us they were clear about their roles and who they were accountable to. They felt they worked well as a team, the care people received was good and they enjoyed working at Acacia House. The registered manager demonstrated a detailed knowledge and understanding of people's needs. During the inspection we observed that people engaged well with the registered manager who was open and approachable.

When we asked for any information it was easily accessible and records were stored securely to protect people's confidentiality.

Links with the local community through churches of different denominations had been developed. The registered manager and staff attended meetings with the local clinical commission group and had liaison meetings with local GP services.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This enables us to check that appropriate action had been taken. The registered manager was aware that they had to inform CQC of significant events in a timely way and had done so.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating in the reception and on their website.