Oakview Estates Limited

The Orchards

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 was carried out on 19 and 28 October 2016. It was unannounced. During our last inspection, in August 2015, we found that the service was meeting the legal requirements in the areas we looked at.

The Orchards provides a 24 hour care environment for people with mental health needs and learning disabilities. The service enables people to develop essential daily and community living skills. For some people this forms part of a pathway towards accessing supported living services. At the time of our inspection there were five people living at the home.

The home did not have a registered manager in post at the time of our inspection, although a new manager had been appointed and their application to become registered was being processed. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A team leader had been appointed to the home to support the manager with the day to day running of it. They were also supported by the provider's regional manager.

Staff were aware of the safeguarding process. Personalised risk assessments were in place to reduce the risk of harm to people, as were risk assessments connected to the running of the home, and these were reviewed regularly. Accidents and incidents were recorded and the causes of these analysed so that preventative action could be taken to reduce the number of occurrences. Where people had been involved in incidents because of behaviour that could have a negative effect on others, the triggers for such behaviour had been identified and action taken to reduce the occurrence of such behaviour. People received their medicines as they had been prescribed and there were robust procedure for the safe management of medicines.

There were enough skilled and qualified staff to provide for people's needs. Robust recruitment and selection processes were in place and the provider had taken steps to ensure that staff were suitable to work with people who lived at the home. Staff received training to ensure that they had the necessary skills to care for and support the people who lived at the home, and were supported by way of supervisions and appraisals. Staff were encouraged to undertake training to gain professional qualifications.

People's needs had been assessed before they moved into the home and they, their relatives and other healthcare professionals had been involved in determining their support needs and the way in which their support was to be delivered. Their consent was gained before any care was provided and the requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

People decided what food and drink they had and a variety of nutritious food and drinks were available to them. People were encouraged to assist in buying and cooking the food. Snacks and fruit were available to people throughout the day.

Staff were kind, caring and protected people's dignity. They treated people with respect and supported them in a way that allowed them to be as independent as possible.

Information was available to people about how they could make a complaint should they need to, although none had been made recently. Information was also available in formats that people understood about the services provided at the home. People were assisted to access healthcare services to maintain their health and well-being. Staff worked with healthcare professionals and people's relatives to ensure that the support provided to people best met their needs.

Staff were encouraged to attend meetings with the registered manager at which they could discuss aspects of the service and care delivery. People were asked for feedback about the service to enable improvements to be made. There was an effective quality assurance system in place and senior managers within the provider's organisation were made aware of any required improvements identified during the monthly review of performance completed by the regional manager.

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.

People's medicines were administered safely and as prescribed. Arrangements for the ordering, storage and disposal of medicines were robust.

Staff were aware of the safeguarding process and how to make appropriate referrals to the local authority.

Personalised risk assessments were in place to reduce the risk of harm to people.

There were enough skilled and qualified staff to provide for people's needs

Is the service effective?

Good

The service was effective.

People had a good choice of nutritious food and drink.

Staff were trained and supported by way of supervisions and appraisals.

The requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

Is the service caring?

Good

The service was caring.

Staff were kind and caring.

Staff promoted people's dignity and treated them with respect.

Staff encouraged people to develop skills to increase their independence.

Is the service responsive?

Good

The service was responsive.

People had robust care and support plans in place to meet their individual needs and were involved in the regular review of these.

People were supported to follow their interests and hobbies.

Is the service well-led?

Good

The service was well-led.

There was a manager in place who had made an application to become the registered manager. There was also a team leader who supported the manager with the day to day management of the service.

There was an effective quality assurance system in place.

Senior management within the provider's organization had oversight of the quality of service at the home.

The Orchards

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 visit took place on 19 October 2016 and a telephone call to the people's independent advocate was made on 28 October 2016. The visit was unannounced. The inspection was carried out by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed other information available to us, such as notifications and information provided by the public or staff. A notification is information about important events which the provider is required to send us by law. We also contacted four social care professionals and three healthcare professionals to ask for their feedback about the service.

During our inspection we spoke with two people who lived at the home, one senior care worker, one care worker and the provider's Director of Operations. Following the inspection visit we spoke with an independent advocate for the people who lived at the home.

We observed the interactions between members of staff and the people who lived at the home. We looked at care records and risk assessments for two people and at how people's medicines were managed.

We looked at two staff recruitment records. We also looked at training records and the supervision and appraisal meeting schedules for all staff members. We reviewed information on how the quality of the service, including the handling of complaints, was monitored and managed.

Good

Is the service safe?

Our findings

People told us that they were safe living at the home. One person said, "The staff make me feel safe." Another person said, "Yes I'm safe." The independent advocate for people told us, "[People] are safe. The staff want to look after them well."

The home was secure and visitors were required to sign in and out of the building. This protected people who lived at the home from harm because staff knew who had come into the home. The information would also be used to ensure that everyone in the building was accounted for in the event of an emergency evacuation.

The provider had up to date policies on safeguarding and whistleblowing. Whistleblowing is a way in which staff can report misconduct or concerns within their workplace without fear of the consequences of doing so. Information about safeguarding people was displayed on a notice board in the corridor on the ground floor. Staff told us that they had been trained in safeguarding and were able to explain the procedures on keeping people safe. One member of staff said, "I did my safeguarding training within the last three months. I would report any concerns to my senior in the first instance, unless it was them when I would report it to their senior. I would see if it had been followed up and reported to the council and CQC. The staff all know this but if we used agency staff they would need to have it spelled out so that they would know what to do." Another member of staff told us, "I would go to the manager but we have the details of the safeguarding team on the wall. It has the number we can call. It is in the corridor." Staff we spoke with were able to explain the types of harm that people may be exposed to.

The service used a risk screening tool that looked at the possible risks that people could encounter in all areas of daily life, such as socially inappropriate behaviour, eating habits, exploitation by others and attitude to authority. There were personalised risk assessments for each area appropriate to people who lived at the home. Each assessment identified the people at risk, the steps in place to minimise the risk and the action staff should take should an incident occur. We saw that risk assessments had included risks associated with people using the household appliances, such as the washing machine or microwave oven. They also included risks associated with people accessing the community, taking their medicines and as a result of behaviour that had a negative effect on other people.

The behavioural risk assessments provided staff with information about early warning signs that could indicate that a person was going to experience an episode of such behaviour, such as avoiding eye contact. The assessments also identified actions that staff should take to try to prevent such behaviour occurring and informed them of what they should do if a situation escalated. This included the various steps staff should take to de-escalate situations if they arose, such as distracting the person with another activity, and were supported by an 'Additional Support Protocol'. The risk assessment also provided information for staff as to what they should do following an incident. One member of staff said, "Our training teaches the physical restraint aspects but concentrates on techniques to manage and de-escalate situations. It is in-house and we are able to share ideas with other units [of the organisation]." We saw that specific activities were risk assessed, such as when people went on holiday to Center Parcs in October 2015. All activities that were to

be undertaken by people had been risk assessed and management plans put in place to reduce the risk of harm to people.

Risk assessments were reviewed regularly to ensure that the level of risk to people was still appropriate for them. Actions to reduce the risks posed to people were amended when this was appropriate. Staff told us that they were made aware of the identified risks for each person and how these should be managed by a variety of means. These included looking at the communication book and talking about people at shift handovers.

Senior staff had carried out assessments to identify and address any risks posed to people by the environment. These had included fire risk assessments and the handling of potential hazardous substances. Checks were also carried out to ensure that equipment had been serviced and portable appliances had been tested. Each person had a personal emergency evacuation plan that was reviewed regularly to ensure that the information contained within it remained current. Copies of these were in people's care records and in a folder by the emergency 'grab bag' that was readily accessible by staff. The 'grab bag' also contained emergency contact numbers, a copy of the service's business continuity plan, bottles of water, nutrient bars and blankets.

Accidents and incidents were reported to the senior staff and where appropriate reported to external bodies, such as the local authority safeguarding team and Care Quality Commission. We saw that a record was kept of all incidents which had occurred. This had been analysed to identify any possible trends and enable appropriate action to be taken to reduce the risk of an accident or incident re-occurring.

Staff we spoke with told us that there were enough staff on duty to keep people safe but that the provider had recently agreed to increase staffing levels during the day by an additional support worker. One member of staff said, "There are usually three staff on shift in the day and two on shift overnight. In addition the team leader is here from nine until five on Thursday and Friday. All service users are one to one or two to one when out in the community. It will be a lot easier to manage outings for people when we have the extra staff member."

We looked at the recruitment documentation for two members of staff who had recently started work at the home. The provider had robust recruitment and selection processes and gaps in an applicant's employment history had been explored during the interview process. We saw that appropriate checks had been carried out which included Disclosure and Barring Service Checks (DBS), written references, and evidence of their identity. This enabled the provider to confirm that staff were suitable to support people who used the service. .

People were supported by staff with their medicines. Medicines were stored in a locked cabinet within a designated medicines room. This room was locked when unoccupied and an air conditioning unit had been installed to ensure that the temperature did not exceed that recommended by the manufacturers of the medicines. This ensured that people received medicines that had not lost their effectiveness because of damage caused by excessive heat. Only competent care workers administered medicines and staff confirmed they had received regular training updates provided by their pharmacist.

We looked at the medicines records for people who lived at the home. We saw that these records contained a photograph of the individual and an alert to highlight issues associated with administering medicines for the individual, including known allergies and high risk issues, such as verbal abuse, physical abuse and property damage that could occur. We looked at people's MAR charts and saw that these had been completed with no gaps. There were protocols in place for medicines that had been prescribed on an 'as

needed' basis. However, where people required creams to be applied there were no body maps in place that informed staff where the application was to be made. Staff told us that they knew where this should be applied for each person but understood that any new member of staff may not. A senior staff member agreed to introduce them without delay. We checked stocks of medicines held for one person which were in accordance with those recorded. There were very robust processes for auditing medicines administration.

Good

Is the service effective?

Our findings

People told us that staff had the skills that were required to care for them. One person said, "They support me [well]." The independent advocate told us that staff skills had increased following the appointment of the team leader. They said, "[Staff] have all been made to realise what is required of them."

Staff received a full induction when they started working at the home and there was a continuing training programme in place to enable them to maintain the skills they needed for their roles. We saw the induction booklet completed by new staff to show that they had been assessed as competent in all essential areas during their induction period. One member of staff told us, "We do on-line training for most things but there is other training available too. The team leader lets us know when it is due and books us onto the courses. We all have access to any planned training." They went on to say, "Training develops skills and refreshes our memory [of how things should be done]." The Director of Operations told us, "We discuss training issues at the senior manager's meetings. We talk about specific training and where any shortfalls are. We have a consultant nurse who provides positive behaviour training to staff. They have a training schedule for this from September 2016 to December 2016. All staff will have this training." A member of staff told us, "There is definitely more focus on training now. I have got NVQ3 and NVQ4. We have an in-house NVQ assessor and I have asked if I can do NVQ5 now." The focus on training enabled the provider to be confident that people were supported by staff who had the required skills to do this effectively.

Staff told us that they did not need any specialist training in communication as all the people at the home understood when staff spoke with them and were able to respond. However, one person could not vocalise so used an 'app' on their mobile phone to communicate to staff.

Staff told us that they had regular supervision meetings. One member of staff said "I have supervision about once a month. We talk about how I am feeling, how I feel the service users are doing and how I am getting on with the other members of staff. We talk about how the team is working and any training that I think would be beneficial to me. I can talk about any problems I have." We saw that supervision and appraisals had been scheduled for staff throughout the year.

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

Staff told us that they had received training on the requirements of MCA during their induction and had regular training to refresh their knowledge of it. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to

do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). One member of staff said, "I did my training about February 2016. There are five main concepts, the first of which is the assumption that everyone is capable of making their own decisions." They went on to say, "Any decision made in a person's best interest must be as least restrictive as possible." They added, "DoLS is put in place for people's own safety not to exclude them from doing normal things."

We looked at the home's records around the requirements of the Mental Capacity Act 2005, and the associated Deprivation of Liberty Safeguards and saw that these had been followed in the delivery of care. One record showed that mental capacity assessments had been completed to determine a person's capacity to understand why the staff were at the home to support them and also to give consent to have medicines prescribed on an as needed basis to be administered. Both assessments determined that the person did have capacity to make and understand these decisions. There was a DoLS in place for one person as they were under constant supervision. Applications had been made in respect of two other people, who were very vulnerable because of their mental health, but these had not yet been assessed.

Staff told us that people made their own decisions as much as possible. One member of staff said, "We ask them and they have choices about day to day decisions, such as clothes, food and activities. If they don't want to do something then we speak with them. If they want to do something that could put them at risk I would carry out a risk assessment to see what the dangers were and explain these."

People liked the food they had and there was a good variety of quality and nutritious food and drink. One person told us, "The food is good. I like all the food, especially spaghetti carbonara. We can choose. There is always enough." A member of staff told us, "Before we do the shopping we ask them what they want to eat. We will always try to put salad or vegetables with meals but a lot of the time they want pizza and chips. It is quite difficult to make sure they get a healthy diet. There is always fresh fruit out in the kitchen as well as a biscuit tin. Crisps are also brought out at mealtimes. We try to budget the food money to get a take-away occasionally." People were able to make drinks whenever they wanted to. One person asked everyone else in the home, including staff and visitors, if they wanted one when they made their own throughout the day. People's weight was monitored

Records showed and people told us that they were supported to attend appointments with other healthcare professionals, such as GP's, mental health professionals, dentists and opticians to maintain their health and well-being. One person said, "I have had to go back to the chiropodist as I had dry skin on the bottom of my feet. I have to go back [soon]." We saw that people's forthcoming appointments were displayed on a whiteboard within the office. Appointments scheduled included ones with an epilepsy nurse and for a fasting blood test. Records showed that there were regular reviews of people's medicines. One person had a review completed on a quarterly basis.

Good

Is the service caring?

Our findings

People told us that the staff were caring toward them. One person said, "The staff are nice. They are friendly and they go out with me." Another person described the staff as, "Nice." The independent advocate told us, "All the [people] who live at The Orchards get on with the staff. They went on to say, "The staff all seem to know how to talk to people." A member of staff told us, "I love my job and the service users."

We observed that staff knew the people well and people knew the staff who supported them. There was friendly 'banter' between people and the staff who supported them. Staff were aware of people's life histories and were knowledgeable about their likes, dislikes, hobbies and interests. They had been able to gain information on these through talking with people and their relatives. This had helped them to support people to set goals for more independent living in the future.

We observed the interaction between staff and people who lived at the home and found this to be friendly and caring. We saw that staff spoke appropriately with people and people enjoyed interacting with the staff.

People looked clean and well groomed. One person told us, "I have learned how to shower." Staff told us of ways in which they promoted people's dignity. A member of staff told us, "They can all attend to their personal care but sometimes we have to prompt or encourage them." We saw that one person had care plans in place to support them to refrain from inappropriate sexual behaviour which could have a negative impact on their dignity.

People told us that they were respected and had choice in the way their support was given. They were also encouraged to be as independent as possible. One person told us, "I go to [supermarket] and help with the food shopping. I clean my bedroom. It has my own things in it and I chose the colour. I am also involved in the cooking." A member of staff said, "We encourage them to make their own lunch, for all the steps from getting the bread. After eating we get them to put the dishes in the dishwasher. We ask for a volunteer to empty the dishwasher when it's done."

People's relatives were encouraged to visit whenever they wanted and people were supported to maintain contact with them. Some people had short 'home visits' to their family. We saw that the information board in the office included details of the dates such visits had been arranged to take place and whether the person was to be accompanied by staff on their journey.

Good

Is the service responsive?

Our findings

People told us that they were involved in deciding what support they needed and how this was to be provided. One person told us, "My key workers are [name] and [name].They talk to me about what support I want them to give me. We have one to one chats." Another person, when asked, confirmed that they had been involved in determining their support plans.

The support plans followed a standard template which included information on people's personal history, their health, individual preferences and interests. They were individualised and included clear instructions for staff on how best to support people with their specific needs and the tasks associated with these. The support plans covered all areas of people's lives, including maintaining their dignity and autonomy, communication and lifestyle. One plan detailed the support a person required to assist with smoking cessation. This included an agreement that the person would have only seven cigarettes a day and only at set times during the day. The staff told us that the person was aware of when they were next due to have a cigarette. We saw that the person was focussed on the time that their next cigarette was due throughout the day but accepted that it was in their interests to wait. There were support plan for people to access the community and for travel in the mini-bus. One plan stated that the person was to be accompanied by one member of staff in the rear of the bus who was to offer support to the person during the journey.

People told us that they had been involved in the review of their support plans. One person told us, "They ask what is important to me." Each person who used the service had been allocated a key worker who completed a regular review with the individual. One member of staff told us, "We have a chance to sit down with people to make sure they are alright and what activities they would like to do. We get to spend a lot of time with them." During these reviews the key worker looked at the support plans and identified whether any changes were required. A formal needs assessment was completed every six months. The reviews were documented within the support records and where people were unable to sign staff had documented how the person had been involved in the review. One support record showed that the person had been involved in their needs assessment 'by sitting and discussing with the key worker'.

We did note that there was much duplication within the support records, with the general support plans as well as a 'person centred' file which contained similar material. Because the documentation had been prepared for both a hospital setting and the residential setting some of the terminology used needed to be amended, such as forms referring to 'patient'.

People were supported to maintain their interests and hobbies. Each person had a weekly schedule of activities with their time mapped out throughout each day. The activities included music sessions, swimming, clay modelling, going to clubs and developing cooking skills. One member of staff told us, "We are in the process of updating the activities people do. They tell us what they want to do at their one to one with their key worker. They are all able to tell us, although some people take a bit longer. It is about them trying things to see if they like them. If not we will try something else." One person had a keen interest in gardening. They told us that they had been involved in growing fruit and vegetables during the summer. They were proud to tell us that they had grown the tomatoes that had been used in the salad at lunchtime.

They had also recently bought some winter flowering plants that they had planted in the garden. Staff told us that people had a weekly budget for activities and would normally be expected to pay for additional costs incurred by their activities. We saw staff interacting with people, playing games on a one to one basis with them and accompanying them on walks in the surrounding countryside.

There was an up to date complaints policy in place and this was available to people in an easy read format. However people told us that they did not need to use it. One person said, "I can talk to any staff member." Staff showed us where any complaint received would be recorded, but none had been received.

Good

Is the service well-led?

Our findings

The registered manager had left the provider's organisation in December 2015. A new manager had been appointed who was also responsible for a private hospital also owned by the provider. They had made an application to become the registered manager for The Orchards, as well as the private hospital. In April 2016 the provider's regional manager had appointed a team leader, on a part time basis, who had been managing the home in the absence of the registered manager. The team leader also covered some shifts within the rota. Although not all staff had initially been pleased with the appointment, comments about the team leader were complimentary. The independent advocate, who visited the home on a fortnightly basis, told us, "[They] know the ins and outs of the service. [They] know the clients 'tick' and what they like and don't like." A member of staff said, "[Team leader] has been a breath of fresh air. [They] are very good and have really made it a better place. [They] have enthused the whole service and [their] enthusiasm for making changes has been so positive."

The team leader had been supported by regular visits by the provider's regional manager. It was clear that the people who lived at the home knew the regional manager well. People interacted with the regional manager as another member of their support team.

There was a very 'homely' atmosphere at the service. One person said, "I enjoy living here." A member of staff told us, "We work as a team. It is only small but we work together." Another member of staff told us, "We each know what we bring to the team."

People had been asked for their opinion of the service that they received at the home and any improvements that they would like by way of an easy read survey. All of the responses were positive about areas of their life in the home, such as the environment, care and treatment and people. Some people had commented that they would like to have a pool table and the staff were looking to see if this could be accommodated, perhaps in the outbuilding that was already used for the music and clay modelling sessions. This showed that the service enabled people to identify ways in which it could be improved and was committed to providing people with support that met their needs.

Staff were able to contribute to the development of the service during supervisions and staff meetings. One member of staff told us, "We have staff meetings but not that regularly. At the last one there were five of us there. Really they are a bit similar to supervisions. We talk about if there is anything that can be improved, how we can help people develop or if there is anything we think we need that is not available. We talk about anything we feel the unit needs which would make it better for the clients."

There was an effective quality assurance system in place. Quality audits completed by senior staff on a monthly basis included medicines management, infection control and support records. In addition, monthly performance reviews were completed by the provider's regional manager which covered a range of areas, including feedback from people and staff, complaints and compliments received and the quality of support plan documentation. Improvement plans had been developed where shortfalls had been identified and the actions were signed off when they had been completed. The manager produced a monthly service provision

report for the provider.

The provider had also appointed a Quality Compliance Manager who undertook risk based inspections of the provider's services. They had not yet completed any check of The Orchards.
The regional manager told us that the reports produced following the performance review were seen by the provider's Governance and Nursing Director and discussed at senior management team meetings. This enabled senior people within the provider's organisation to have oversight of the service and be confident that the policies and procedures that supported the organisations values were followed.

We saw that there were robust arrangements for the management and storage of data and documents. People's written records were stored securely and data was password protected and could be accessed only by authorised staff.