Autism Care Wiltshire Limited

Orchid House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Orchid House is a residential care home that was providing personal care and support for six adults with learning disabilities and autism at the time of the inspection. The service is registered to support up to six people and accommodates five people in one building and one person in a self-contained annexe attached to the building.

The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. However, we found the provider was not following these best practice guidelines in line with Registering the Right Support (RRS) to achieve effective outcomes.

People's experience of using this service and what we found
People's relatives told us that they felt their family members were no longer receiving the consistent care they had prior to Choice Care Group (the 'provider') taking over the service in May 2019. This was, in part, due to the turnover of care staff, resulting in new members of staff who did not always have the experience to work with people's complex needs. In addition, agency staff were being used to supplement the permanent staff.

The provider had not ensured that all staff had received the relevant learning and time to support people effectively and safely. The safe management of medicines was not always assured or delivered in line with the provider's policy and procedures.

Improvements were needed to improve staff training in areas such as safeguarding, infection control, food safety and fire awareness. Not all staff felt they were receiving enough support from managers to ensure their roles and responsibilities were safely delivered. This was because there had been limited opportunities for one to one support meetings to discuss support they needed, in order for them to develop and improve.

People's needs had not been regularly reviewed to ensure best practice guidance was used to achieve effective outcomes. Staff did not have the support in place to ensure they felt confident to deliver care to people with complex needs. People's health need requirements, such as specialist health appointments, were not always known. This meant that the provider and registered manager did not have a good overview to manage people's health conditions. People's nutritional needs were not always being met to ensure their diet was healthy and adequate to maintain good health.

People were supported by staff that cared for them. However, the provider had not ensured that people were supported with consistent staffing in relation to their autism and other complex care needs. This meant that people were not always supported by staff that had the time to get to know them well and

understand their care and support needs, wishes, choices and any associated risks.

People did not always have opportunities to pursue their interests and hobbies. People's care needs had been recently reviewed and new care plans had been drawn up and were with families to review and comment where necessary.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons. This was because people using the service did not receive consistent, planned and co-ordinated person-centred support that was appropriate and inclusive for them.

The provider's quality assurance systems had not always effectively identified shortfalls in the quality of care when they acquired the service. Following a compliance visit, the local authority had identified a number of concerns. We noted some initial improvements to the quality and safety of the service were being actioned. These improvements at the service were not embedded at the time of this inspection.

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

Relatives told us that improvements had been recently been made. This followed a number of reviews and meetings where they could discuss their concerns on areas discussed in this inspection report.

The provider was actively addressing the issues that had been raised during the inspection and demonstrated a willingness to work transparently and openly with all relevant external stakeholders and agencies.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection:
The last rating for this service was Outstanding (published 15 December 2017). Since this rating was awarded the registered provider of the service has changed. We have used the previous rating to inform our planning and decisions about the rating at this inspection.

Why we inspected
The inspection was brought forward because of concerns raised with the Care Quality Commission about the experience and training of staff. There was also concern about management of medicines. Concerns were also raised about leadership and quality monitoring at the service. A decision was made for us to inspect and examine those risks. We have found evidence that the provider needs to make improvements.

We have identified four breaches in relation to person centred care, safe care and treatment, staffing and good governance at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Orchid House on our website at www.cqc.org.uk.

Follow up
Full information about CQC's regulatory response to this inspection is added to the report after any representations and appeals have been concluded. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our well led findings below.

Orchid House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team:
The inspection was undertaken by two inspectors.

Service and service type:
Orchid House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided

Notice of inspection: This comprehensive inspection was unannounced.

What we did before our inspection
We reviewed information we held about the service. This included the last inspection report, information received from local health and social care organisations, and statutory notifications. A notification is information about important events, which the provider is required to send us by law, such as, allegations of abuse and serious injuries. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke the assistant regional director, the registered manager, deputy, a manager who had just started

working in the service and a positive behaviour support specialist. We also spoke with two members of staff. To help us assess how people's care needs were being met we reviewed four people's complete records and referred to the other two records for information about risks. We also looked at the medicines records for all people, and a range of records relating to the running of the service. We carried out general observations of care and support and looked at the interactions between staff and people who used the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We emailed and heard back from a number of staff who work at the service. We contacted six people's relatives and heard back from four with feedback about the service. After the inspection, we also spoke with the provider's nominated individual who is responsible for supervising the management of the service on behalf of the provider.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement: This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- Not all staff had received safeguarding training that the provider's policy and procedures had stated was mandatory. We reviewed the training and only 22 out of 44 staff had completed safeguarding training at the time of the inspection.
- Although staff said they would refer any concerns to the registered manager it was not certain that all staff would recognise all types of abuse due to the lack of training. One member of staff said, "I haven't really been spoken to regarding any safeguarding policies or procedures."
- We saw in staff meeting notes incidents had been discussed. This stated, "Times when management being made aware (of incidents) from parents not staff and incident forms not being completed."

We found no evidence that people had been harmed. However, people were not protected by effective systems and processes to keep them free from the risk of abuse. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Staff were aware of whistleblowing policies and procedures and reported they would use this if they were concerned. A member of staff commented, "I understand that whistle blowing is there to raise any issues that may occur about clients, staffing, colleagues of any other issues that I feel need to be dealt with."

Assessing risk, safety monitoring and management

- The service had not effectively audited areas of the service such as staff safety training. The provider took over the service in May 2019. At this inspection, six months later, we found essential training for all staff had still not taken place. This included, first aid, fire awareness and health and safety.
- People in the service had behaviours that could challenge and needed a specific approach from staff to reduce the risks to themselves and others. At the time of the inspection only 17 of 44 staff had received training on using a proactive approach to respond to episodes of behaviour that challenged. This training enables staff to intervene to prevent behaviours escalating which may then require a more reactive response. This meant people were not always supported by staff with the required skills to keep people safe.

We found no evidence that people had been harmed. However, people's care and support was not provided in a safe way as not everything was being done to reduce identified risks. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff were still using the previous provider's risk assessments. These had not been reviewed since the acquisition of the service in May 2019. The manager said the risk assessments had been recently reviewed and incorporated into new care plans which were with relatives to review and agree.

Staffing and recruitment

● There were not always enough staff with the right mix of skills, competence and experience to support people to stay safe. A number of existing staff who had worked with the previous provider had left the service. Therefore, there were new staff in post and the provider was also using agency staff whilst they recruited.

● A relative commented about their family member having autism and how the staffing was impacting upon them. They commented, "Prior to 'Choice' taking over there was a relatively stable staff who had a good knowledge of the residents and their routines; agency were never used. I visit at least twice a week and since 'Choice' took over there has been an array of new people including many agency and staff from other houses. I know that recruitment is difficult and turnover is high in this sector but it is very difficult for somebody there for the day to know and understand the needs of the residents in their care."

We found no evidence that people had been harmed. However, people were not being cared for by staff that had the competence, skills and experience to support them safely. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Recruitment systems were in place and appropriate recruitment checks were carried out to ensure the suitability of staff.

Using medicines safely

● Medicines were not always administered in line with the provider's policy and procedures. For example, we observed one staff member administering medicine on food to a person. Consent was sought from the person. However, the provider had not sought advice from a pharmacist to ensure the medicine would not be affected by mixing it with the food item. We reviewed the provider's medicines management policy which stated, 'Professional advice of a pharmacist would be needed.' The policy also stated that, 'Two members of staff be present to administer medication, one to administer medication and one to witness.' Therefore, the policy had not been followed in the medicine administration we observed.

● Times of administration were not always clear. For example, we saw one medicine stated to be taken at 'tea'. There was no reference to an administration time other than tea. This meant the time of administration could be open to interpretation from different members of staff.

● Topical medicines had not always been applied as required. For example, one person's records showed they had not had prescribed skin lotion applied for four days. Body maps to show where topical applications were to be applied were not in place.

We found no evidence that people had been harmed. However, people were not always protected by the safe management of medicines. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The service had introduced pre-packaged medicines prepared by a pharmacist which contained both liquid and solid medication in one pre-measured, personalised monitored dosage system. Where non pre-packaged medicines were used, we saw balances had been checked and were correct.

Preventing and controlling infection

● Not all staff had received infection control training or food hygiene. Only 10 out of 44 staff had undergone this training. Prevention of infections is the responsibility of all care staff to assess risks, prevent, detect and control the spread of any infections.
● Only 13 out of 44 staff had completed food safety training. The cook did not have food safety training. This training ensures staff have the appropriate training when handling or preparing food to avoid potential risks such as food poisoning. Both of these training requirements were stated as mandatory on the provider's policy on staff training. Staff not receiving training in this area meant people were not always kept safe from these risks.

We found no evidence that people had been harmed. However, the provider was not ensuring that infection control systems and process were being followed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We found no concerns on the day of inspection in respect of the cleanliness of the service.

Learning lessons when things go wrong
● The provider acquired the service in May 2019. The registered manager and area regional manager stated the provider had learnt lessons in the transition of acquiring the service and the importance of prompt auditing to gain an initial oversight of any risks and actions required.
● The service was working in collaboration with the local authority and other professionals to ensure the issues that had emerged, such as effective quality assurance were being rectified in a short timescale.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement: This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- The delivery of care and support was not consistently in line with best practice guidance. For example, the provider was not following best practice guidelines in line with Registering the Right Support (RRS) and National Institute of Clinical Evidence (NICE) to achieve effective outcomes.
- Prior to people moving to Orchid House, the previous providers had undertaken a full assessment of people's needs to ensure these could be met. However, these assessments had not been reviewed when the service was acquired by the new provider. Therefore, the provider did not have the oversight to ensure they were continuing to meet people's current needs. For example, ensuring care plans were up to date and still relevant and ensuring people's health needs were known of. Also reviewing if any social or healthcare referrals were necessary to ensure people's needs continued to be met.

We found no evidence that people had been harmed. However, people's needs had not been regularly reviewed to ensure their care and support was still appropriate and delivered to meet their needs and preferences. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience

- Staff did not always feel fully supported to ensure they could safely and effectively carry out their roles and responsibilities. A member of staff commented, "Sometimes I feel like the management are not very supportive at all, especially if you have had a situation with challenging behaviour. I don't feel like I could speak to any of the management in the home if I had a problem or a concern. I believe management need to have more of a duty of care towards the staff members."
- There had been no initial assessment of existing staff training when acquiring the service. In addition, new staff that had been recruited since the provider took over in May 2019, had not received training stated as mandatory by the provider's policy.

We found no evidence that people had been harmed however, staff induction, training and support was not sufficient to enable staff to carry out their duties they are employed to perform. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- We asked the registered manager why supervisions had not taken place. They advised that not having a home manager in post had impacted upon this. They had put plans in place to ensure these took place on

an ongoing basis and we were assured that staff had now all been met with on a one to one basis at least once.

Supporting people to eat and drink enough to maintain a balanced diet
● Not all relatives were confident that people's nutritional needs were met. Comments included, "[Person] has been given too many snacks between meals as new staff have misunderstood [person's] communications. As a result of this, combined with the lack of regular exercise, [person] has put on at least 7 kg in the last few months and is now in an overweight category."
● We saw that people were able to choose the foods they enjoyed and fluid records were kept for people who were at risk of dehydration.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Management did not have clear oversight about actions required to maintain people's health conditions. For example, we enquired about health appointments for people in the house and were told by the registered manager that they were 'Starting from scratch.' They said this was because they had received no handover information from the previous provider about health updates. However, we later came across a document from the previous provider giving full details of each person's health updates and appointments they had undergone and would require in the future. The management had no awareness of this information.
● Some health appointments had taken place including flu vaccinations.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

● Not all staff had received training to help them understand the principles of the MCA. A member of staff commented, "I haven't really looked into any of this yet so I don't have much understanding of these but I do know that as our service users are non-verbal, they lack capacity so we need to make their decisions for them."
● Despite not all staff having MCA and DoLS training, some staff we spoke with indicated they understood the principles of the Act. We observed staff during the day offering choices. For example, a person chose to continue their walk rather than returning to the house. The staff member supporting the person respected this.

Adapting service, design, decoration to meet people's needs
● People's environment continued to be personalised. For example, people's bedrooms had been

decorated in a personalised way to reflect their preferences. However, one relative raised concerns that their family member was not able to access the garden as freely as they used to. They had raised this with the management and this had improved.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Outstanding. At this inspection this key question has now deteriorated to Requires improvement: This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- People were unable to provide verbal views about the caring attitude of the staff. However, on the day of the inspection, we observed people in the service being treated with kindness by staff.
- The provider had not done everything they could to facilitate a caring and compassionate service. For example, they had not ensured that staff had the knowledge and skills they needed to support people. Only seven out of 44 staff had completed person centred care and equality and diversity training. This training provides information and understanding to staff about person-centred approaches and care and how to reflect on their own practice and its impact on the people they support. Staff have a key role in improving quality of care by understanding equality and human rights for people using services.
- Following the inspection, we asked people's relatives for their opinions about whether they felt their loved ones were treated with kindness and compassion and respect. One relative commented, "Previously I felt that my [relative] was in a home where I trusted the staff, where there was open and honest communication between close family members and all the staff. I felt that it was a place that was my [relative's] home, where [person's] health and well-being and those of the other residents took priority. I felt that the family and staff were working in partnership to maximise my [relative's] well-being and opportunities. The house [now] feels less like a home and more like an institution."
- Some staff felt they did not always have the time to get to know people well and understand their care and support needs. This was important, for example, one person's records made numerous references to the importance of staff consistency to help them manage their anxieties.
- A member of staff said, "I feel like I still don't know everyone as well as I should. Some of the service users I never shadowed; just got told to work with. Others I got to spend a few days with which caused problems because they got attached. I shadowed staff that knew the service user well but some staff didn't really do much for me to shadow."
- People were not supported to have their meals at times that suited them and be involved as they used to be. For example, a cook had been employed to prepare the main meal at lunchtime so not all people could be involved in preparing food during the day. Relatives told us previously people were supported to have as much involvement and independence as possible.
- A relative commented, "I often find when I visit that the kitchen is taken over by staff or management and the other residents are far less visible in shared areas. One carer informed me that meals have become 'like they have in hospital'; with a hot meal at lunch time and something like a sandwich at tea time."

We found no evidence that people had been harmed. However, people had not been enabled or supported

to make, or participate in making decisions about their nutrition and participation. This meant people's preferences in respect of choice and independence was not always sought or respected. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Other relatives felt that staff were doing their best and that they felt confident that they had people's best interests at heart.

Respecting and promoting people's privacy, dignity and independence
● People were encouraged to practise skills with support. Promoting independence involved individual goals. For example, taking their laundry to put in the washing machine.
● Privacy was supported by knocking people's door before entering. Staff we spoke told us that staff would carry a towel in order to protect a person's dignity in the house or in a public place, should their clothing be out of place.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Outstanding. At this inspection this key question has now deteriorated to Requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's care needs had not been reviewed on acquisition of the service. The previous provider's care plans were still in use but had not been reviewed since the provider took over seven months previous. Care plans developed by the previous provider were being used at the time of the inspection.
- Orchid House supported six people with complex learning disabilities and autism. People with autism often need planned and specific arrangements to assist them to manage any changes to their routines. A relative said, "My [person] has autism and constant changes have been difficult for them to deal with. We have noticed that [person] is often reluctant to return and there have been incidents of other residents being unsettled, and this has had a negative impact on [person]."
- People were dependent upon staff supporting them to follow and take part in their interests or hobbies and maintain contact with the community and its resources. Most people needed one to one support or sometimes two staff for one person when outside the service. At the time of the inspection there was limited information about what people were doing.
- We asked staff if they felt there were enough activities arranged that people enjoyed. Staff responses included, "There a quite a few activities that can be available, but it is down to staffing. The lack of not having the correct staff as it's the client's choice who they want to support them but it's not always the case. There are so many agency and different people constantly coming and going the clients don't know them and don't or won't allow them to support them, so they miss out on some activities" and "There are so many agency coming and going, different staff all the time, the clients need structure and continuity and familiar staff. Being told we have no vacancies when there are so many agency clearly isn't the case and cannot be fully staffed. The clients are missing out on some activities because they don't accept agency it's not fair on them and having one staff member between two clients is sometimes a struggle and one gets left out on support and missed out on activities due to being one staff for two clients."

We found no evidence that people had been harmed. However, people's needs had not been fully re-assessed to ensure their care and support was always designed and delivered to meet their needs and preferences. This placed people at risk of harm. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- We were informed that new care plans had been written up and were with relatives for checking. As these were not in use at the time of the inspection, we did not review these.
- People were supported to maintain relationships. Staff commented, "Visits are sorted regularly for service users to see their families. They either come to the house or the service users go home. We also update

parents every night about how the service users have been and what they have been up to during that day."

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● We observed people communicating non-verbally (e.g. by smiling) or with limited verbal expression that they were happy with their support.
● A member of staff told us it was important to know the person's preferred method of communication. They referred to communication books, picture exchange communication system (PECS), 'now and next' books and 'social stories'. We saw a visual 'social story' for a person on the benefits of using glasses. 'Now and next' was used to help people understand a time frame, when referring to activities further in the future might cause confusion or anxiety.

Improving care quality in response to complaints or concerns
● People in the service were not able to verbally complain or raise concerns. We asked families how complaints and concerns were responded to. A number of relatives had raised concerns about their relative's care with the provider. We saw that complaints had been dealt with in line with the provider's policy and procedures and all had been responded to in writing.

End of life care and support
● The registered manager told us nobody using the service was receiving end of their life care. People were relatively young and had families in constant contact with them. Therefore, the service would contact the families, as they would in any emergency, in the case of a sudden death.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

At the last inspection this key question was rated as Outstanding. At this inspection this key question has now deteriorated to Requires improvement: This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Relatives expressed concern about the changes in the service since the current provider had taken over. One relative commented, "There has been, what can only be considered as weak or complacent management. There has always been a lot of people around from 'Choice' when I have visited but it is difficult to know who is taking responsibility. There seems to be a bit of a blame culture going on which we experienced first-hand in a recent review. Blaming the previous owners and staff for the difficulties they are having currently and this even extends to some of the current staff who worked at the home prior to Choice taking over."

● Staff comments included, "I don't feel like I would be confident enough to raise any concerns due to feeling as though I wouldn't be listened to and my concerns would not be investigated and sorted out. So, I feel as though I would rather use the whistleblowing to ensure that my concerns were listened to and sorted."

● The provider's values were 'To provide positive and quality outcomes for people with learning disabilities and people with mental health disorders by providing person centred services that listen to the people we support and enable them to have power, choice and achievement.' However, the practice of these values were not evident at the time of this inspection.

● The provider told us they wanted to provide a person centred and high-quality care service and were responsive to feedback during our inspection. However, the time taken to identify and instigate the necessary actions to make improvements had been prolonged. This meant the service had not worked within the principles of Registering the Right Support and understanding of good practice when working with people living with a learning disability and/or autism; and in particular, when supporting people with behaviour that challenges. RRS principles underpin choice, promotion of independence and inclusion for individuals. It also means the service is complying with nationally recognised evidence-based guidance when developing and delivering care. This includes having effective service systems and staff training, plans to prevent and respond to crisis situations (including the use of positive behaviour support), and safe use of restrictive interventions.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● Governance was not always reliable and effective. The provider had not ensured they had good oversight of the quality of the service upon acquiring the service. They stated they had relied on the previous

provider's CQC rating of Outstanding which had been awarded in December 2017 and assumed the service was well managed without ensuring the necessary quality oversight.

● Quality assurance auditing had not taken place until five months after the provider acquired the service. This meant that the necessary improvements had been delayed which placed people at risk. For example, care plans

● There was a new manager in the service who was applying to be the registered manager for Orchid House. The current registered manager did not have a clear overview of what was happening in the service and deferred to the new manager to provide information. Therefore, it was not clear who held overall accountability for the management of the service at the time of the inspection. A relative commented, "At times I have been under the impression that staff whom I knew well were feeling demoralised because they felt unsupported by management in, what they understood to be, 'doing a good job' which included making sure residents were able to partake their usual routines and activities. [Staff] were overloaded with trying to support agency and staff new to the premises, who had little experience with the client group and their needs. After six months 'Choice' has put a fully trained manager in place."

● The service was not following its policies and procedures. For example, safe management of medicines and ensuring staff had the relevant training as stated in the provider's policy.

● We received feedback from commissioners after the inspection and they found the service needed to more proactive in making the required improvements identified during the local authority monitoring visits. For example, the timescales for making the improvements were not appropriate and that management needed to be more visibly supporting the staff.

● During the inspection, we identified three breaches of regulations related to safe care and treatment, good governance and staffing. This showed the provider's quality monitoring systems were not effective; they had not identified the issues we had identified at this inspection. .

We found no evidence that people had been harmed however, the quality and safety of the service had not been assessed, monitored or improved. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider explained there had been a difficult transition following the acquisition of the service. This included a period of appointed managers leaving after short periods and therefore placing pressure on the staff working in the service. Since late November 2019, a new manager had been sourced and they were in the process of working to make the necessary improvements necessary as identified in this inspection.

● Following the inspection, the provider sent an action plan they had developed to make the necessary improvements. This had been completed prior to the inspection taking place.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Surveys had been sent out to relatives and staff to assess their views of the service. However, there was no analysis in respect of the feedback or actions taken as a result of this feedback.

● There had been limited support to staff from management, and resources such as supervisions and team meetings, to enable the staff team to develop and be heard. There was no evidence to demonstrate how staff were consulted and involved in decision making, learning lessons and continuous improvement.

We found no evidence that people had been harmed however, the provider had not sought and acted upon feedback from all necessary to inform evaluating and improving the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open

and honest with people when something goes wrong

● The law requires providers to follow a duty of candour. This means that following an unexpected or unintended incident that occurred in respect of a person, the registered person must provide an explanation and an apology to the person or their representative, both verbally and in writing. The provider understood their responsibilities in respect of this. They had informed relatives of any incidents or accidents and worked closely with other healthcare professionals.

Working in partnership with others; Continuous learning and improving care

● The provider had acknowledged the issues that had been raised during this inspection and stated, "We were aware of the issues evolving. Admit we were not quick enough, and we are learning from that. We are committed to improving."

● There were some links with the local community resources which provided engagement outside of the home.

● The provider worked in partnership with local care managers, GP's and other health professionals to make sure they were providing a service which was responsive to local need.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People had not always been involved, or supported to participate, in making decisions in relation to their care needs and preferences. Care and support was not always delivered to meet people's assessed needs and preferences.