The Orchard Trust

The Orchard Trust - Sevenoaks

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 17, 18 and 20 October and 9 November 2017. It was unannounced and carried out by one inspector.

At the last inspection on 25 and 26 August 2016 we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured staff received appropriate support or supervision to enable them to carry out their duties effectively. Systems to maintain accurate and contemporaneous records in respect of each person who used the service were not in place. The provider sent us an action plan telling us how they would meet these regulations by 18 November 2016. During this inspection, we found the provider's improvement action plan had been completed and these requirements were met.

'Sevenoaks' is a care home which accommodates a maximum of 11 people in two connected units, with separate adapted facilities. People in care homes receive accommodation and nursing or personal care as single packages, under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of this inspection, 11 people with diverse and complex needs including learning disability, autism, sensory impairment and physical disability were living there.

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. 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. However, the registered manager resigned their post before our inspection was completed. The provider's head of support and operations told us they would register with CQC as manager of the service until a new manager could be appointed for the service.

During this inspection we identified breaches against two of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014. Regulation 12 Safe Care and Treatment was not met. Improvements were needed to ensure people's medicines were managed safely within the service. Temperatures in medicines storage areas were not monitored consistently, to ensure medicines were stored safely and staff did not always follow procedures in maintaining medicines records. The service was therefore again rated 'Requires Improvement'.

The provider's governance systems had not always been operated effectively and were not always sufficiently robust, to monitor and improve the safety of the service provided. Some managerial audits had not been carried out to monitor whether required standards were being met. Governance processes were not always robust enough to identify whether the systems in place were effective and to ensure external agencies had been informed of relevant incidents at the service.

You can see what action we told the provider to take at the back of the full version of the report. Following

our visit, the provider sent us an initial action plan, on action already taken and actions they planned to undertake, to address the shortfalls we identified during our visit.

People benefitted from a service that worked closely with health and social care professionals to understand and meet people's complex support needs. Staff understood how to protect people from harm and abuse. Risks to people's safety were identified and clear support plans were followed by staff. There were sufficient staff on duty and recruitment procedures were followed to protect people from the employment of unsuitable staff.

People were supported by staff who received on-going training and support to maintain or improve their skills and competency. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People were supported to eat and drink sufficient amounts and their weight and intake was monitored as needed.

People received support from caring staff who valued and understood them. People's privacy was respected and they were treated with dignity and kindness. People were supported to maintain relationships with others who were important to them. They received personalised and responsive care which enabled them to live as full a life as possible.

People could raise concerns about the service and have their complaints listened to. People benefitted from a culture that was open and transparent where staff and the management team worked together to improve the service.

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. People's medicines were not always managed safely to reduce potential risks to people.

People were not always protected against known environmental risks and incidents were not consistently reported to CQC in a timely way.

People were safeguarded from the risk of being supported by unsuitable staff because staff recruitment checks met the required standards and staff performance was monitored effectively.

People were protected against health related risks and there were enough staff to meet their support needs.

Plans were in place to keep people safe in the event of an emergency.

Is the service effective?

Good

The service was effective. Staff had the skills and knowledge to meet people's needs. They were well supported to carry out their roles.

People's consent to their care was routinely sought. Capacity assessments were completed when people were unable to consent to the care provided.

People received a balanced healthy diet and were supported to have enough to eat and drink. They had good access to health care.

Is the service caring?

Good

The service was caring. Staff developed positive friendly relationships with people who used the service. People were treated with respect, kindness and compassion.

People and their close relatives were listened to and were involved in decisions about their care.

People's dignity and privacy was maintained and their independence in daily activities was promoted.

Is the service responsive?

Good

The service was responsive. People received personalised care and were routinely consulted about the support they received.

Staff knew people well and worked flexibly to help them follow their interests.

People were enabled to maintain relationships with those who mattered to them.

People were able to raise complaints and these were responded to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. People were not always protected from environmental risks as effective governance systems were not operated.

People benefitted from an inclusive service where they were valued as individuals.

The management team and provider worked openly and transparently to improve the service.

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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 checked 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 unannounced inspection took place on 17, 18 and 20 October and 9 November 2017. It was carried out by one inspector.

Before the inspection, we reviewed information we hold about the service including notifications. A notification is a report about important events which the service is required to send us by law. A Provider Information Return (PIR) was not requested prior to the inspection. 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. This information was gathered at the inspection. We reviewed quality monitoring reports from commissioners' visits to Sevenoaks since our last inspection.

As part of this inspection we spoke with four people using the service. Most people were unable to tell us about their experience at Sevenoaks due to their complex needs. However, we observed staff interacting with all 11 people. For example, during meals and other day to day activities. We spoke with four people's close relatives, five health and social care professionals and sought feedback from an advocate for two people using the service.

We reviewed three people's care and activity records. We checked medicines records for three people and observed a staff member administering medicines. We reviewed the processes in place for managing medicines and the use of 'as required' medicines. We spoke with the registered manager and their deputy, the head of support and operations, chief executive, three domestic staff and five care staff. We looked at recruitment and supervision records for four staff, staff training records and rotas, complaints, accident and

incident records, maintenance records and provider policies and quality assurance systems. We also reviewed records relating to Deprivation of Liberty Safeguards (DoLS) for all 11 people living at the service.

Requires Improvement

Is the service safe?

Our findings

An audit of medicines management at Sevenoaks was completed in May 2017, by a community pharmacy service. Improvements were recommended and the service had responded in part to address these, but some of the shortfalls identified remained. For example, after medicines had been given, a second staff member checked medicines administration records (MAR) were signed, indicating all medicines had been given as prescribed. This check was carried out within two hours of when medicines were due, in the morning, lunchtime and evening. The aim being, any missed medicines could be given, within this time frame, as agreed with the GP, and any gaps in recording could be rectified.

Despite this check being in place, we found gaps in recording, particularly with creams: It was not clear whether these were always being applied as prescribed. We found that where gaps occurred, the second staff member had also not signed to say the check had been completed. We also found not all written entries on MARs, for new prescriptions, or alterations to prescriptions, had been signed and / or dated by staff. The staff we observed administering medicines did this safely, including completing records and secondary checks as expected. There was no evidence that poor recording practices had an impact on people as staff worked closely with the GP and the local Community Leaning Disability Team (CLDT) and routinely sought advice if they were unsure.

A weekly stock check was completed by a designated staff member and a monthly medicines audit was carried out, which included medicines with additional storage and recording requirements. We found two discrepancies in recorded stock balances for these medicines, which had not been picked up in monthly audits. These deficits were accounted for during the inspection, through reference to people's medicines administration records. Records were updated to reflect these recording errors during the inspection.

Medicines storage temperature checks had not been not recorded consistently. During June and July, temperatures had gone above safe levels on four occasions. On these occasions, staff took action to rectify this. However, storage temperature had not been recorded on 18 days during the summer months from June to August. This included days when action had been needed in the preceding or following days to reduce the storage cupboard temperature. This was a potential risk to people's health and wellbeing as when medicines are not stored properly, they may not work in the way they were intended.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Everyone we spoke with during our inspection had no concerns about people's safety at the service. Staff were clear about reporting concerns or potential abuse to their line manager and knew which external agencies should be involved. A staff member told us they would also report potential dignity issues, for example, if they felt someone was not appropriately dressed to go out. Staff recorded incidents, noting any injuries or potential injuries to people on body maps. For example, when one person had fallen, they were checked for bruises at the time. No injuries were found but the staff member documented how they had landed and marked areas where bruises may develop in the following days. Incident and accident records

were reviewed by a member of the management team and were sent monthly to the provider's head of support and operations.

Despite this good practice, we found that not all incidents and injuries were reported to external agencies as expected. For example, one person required hospital treatment to cuts sustained, on three occasions from April to July 2017, which we were not notified of. One of these injuries was sustained through an incident with another person who lived at the service. This was also not notified to the Gloucestershire adult safeguarding team. Injuries and altercations between people were, however, discussed with people's families, the local Community Leaning Disability Team (CLDT) and behaviour specialists. Inconsistent reporting to the Care Quality Commission (CQC) meant there was limited regulatory oversight of significant incidents occurring at the service. Which meant we were unable to check appropriate action was being taken to reduce risks to people when these incidents occurred.

People's support records and our conversations with health professionals assured us appropriate action had been taken to minimise risks to people. A health professional said, "I don't know how [person who had frequent falls] could have been managed any differently"." People's care had been reassessed after incidents and action was taken to reduce the risks of a similar incident occurring in future, whenever possible. For example, following a choking incident, where staff provided first aid, a risk assessment was carried out for sweets and other treats. Revised guidelines for eating and drinking were issued to staff and relatives and further training to improve staff awareness of swallowing difficulties was arranged.

Risk assessments were reviewed regularly and people's support plans included advice from healthcare professionals. People's close relatives or advocates were invited to participate in care reviews, where decisions were made about the support people received. Support plans were personalised and detailed. Expectations for reporting to external agencies were clarified with the management team during and after the inspection. Following this discussion, CQC and the safeguarding team have been notified appropriately and consistently.

People were protected from risks associated with fire, legionella, gas and electrical equipment through regular checks and management of identified risks. Personal fire evacuation plans were in place for each person. A monthly health and safety audit was completed and a risk assessment had been completed for the new sensory garden. Despite this audit and bi-monthly provider-wide health and safety meetings, we found action had not been taken to mitigate some environmental risks to people. For example, maintaining safe water temperatures in hand basins. The shortfalls we identified were addressed during the inspection. There had been no impact on people from these risks not being addressed prior to our inspection.

People were protected from staff who may not be suitable to care for them. All required checks had been carried out before new staff were employed to support people at the service. One of the four staff, whose recruitment we checked, had worked in care before: Evidence of their conduct in this role had been obtained and their reason for leaving was verified. In this case, evidence of conduct had been obtained from the applicant's supervisor. We discussed making conduct checks more robust by routinely involving registered managers in the process, to increase credibility of these checks. This was actioned immediately across the provider's services, by their head of support and operations.

Adequate staffing levels were maintained. The provider had addressed the difficulties of recruiting and retaining "good" staff in a rural location. For example, introducing salary bands to recognise staff experience and progression. Staff who were successfully recruited completed a probationary period, where their on-going suitability and progress was monitored. When staff did not meet required standards, their probation was extended and additional support provided to help them meet expectations. Staff could also be moved

to work in another of the provider's services, if that service was considered a better match for them.

The registered manager held staff to account for poor performance and attendance, through application of the provider's disciplinary processes. While this resulted in the loss of some staff, it had a positive impact on staffing numbers over time, as sickness absence reduced. Recruitment to the 'staff bank' and to one full time vacancy were in progress. Staff rotas demonstrated safe staffing numbers were maintained. Minimal support was required from agency staff in the ten weeks we sampled, up to and including the inspection.

People's relatives told us there had been a "high turnover [of staff] in the not too distant past", one relative said this had improved recently. A relative and a domestic staff member expressed concern about the impact high staff turnover, or use of agency staff, had on people. For example, resulting in increased unsettled behaviours, which unfamiliar staff may not be confident in responding to.

Managers were aware staff changes were unsettling for people in the short term. Conversations with staff demonstrated recent organisational changes had resulted in improvements to the way staff were supported during their induction, which minimised the impact on people. For example, a staff member told us they had felt apprehensive about supporting one person but they were introduced to them over a period of weeks. Gradually they did more to support this person, which allowed them to get to know each other, until the staff member felt "a lot more confident". They added; "As time went on I asked them [other staff] to step back"."

The registered manager told us that when staffing numbers fell below expected levels, due to unforeseen last minute staff sickness, planned activities were reviewed. If necessary community based activities were postponed or cancelled, to ensure people remained safe. Wherever possible, all shifts were filled by regular, or bank, staff employed by the provider.

Good

Is the service effective?

Our findings

At the last inspection on 25 and 26 August 2016 the provider had not ensured staff received appropriate support or supervision to enable them to carry out their duties effectively. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found the improvement actions, the provider told us they would take, had been completed. Improvements had been made to staff supervision and support and the service met the requirements of this regulation.

Staff supervision records demonstrated staff routinely met individually with a senior staff member four times a year, at three monthly intervals. These meetings were used to check staff knowledge, introduce new policies, discuss wellbeing and performance and identify learning needs. Clear actions for the individual or their supervisor were identified and these were followed-up at the next meeting. The fourth meeting of the year was an annual appraisal, due to be completed before December 2017. Additional meetings were arranged as necessary to meet support needs or in response to poor performance. New staff were complementary about the support they received. Comments included, "I've just got to call or ask [for support]" and "There has been a massive improvement in training. The team leaders are really supportive, they really have a big impact."

The latter comment referred to recent changes in how the staff team worked at Sevenoaks, with team leaders now working 'on the floor' alongside junior staff members. Senior staff job roles and areas of responsibility had been revised enabling team leaders to be more 'hands on' and available. Staff told us this had already had a positive effect as there was "more structure and consistency" to the care provided. Two new staff members told us of the positive effect this had on their morale and happiness in their role. Two of the three team leaders were newly recruited to their role and care was taken to ensure they had the right skills and experience to support others.

Managers, relatives and health professionals told us there had been a number of staff changes or 'high turnover' in the recent past. This had created an increased demand on the training places available. New staff completed an induction programme, incorporating the care certificate, during their probationary period. On completion they joined a waiting list to undertake the care diploma and were booked onto specialist training as places became available. The medicines training provided was under review, as the existing process took staff around six months to complete, which impacted on the support they could provide in the interim. For example, there were not always enough staff on duty trained to administer rescue medicine for epilepsy and to support people to attend community based activities. Records and staff confirmed this had meant activities outside the home had to be rearranged, or cancelled on occasion. Five staff were booked to undertake this specialist training in November 2017. Similarly, some staff needed to complete driving assessments for transporting people in the minibus. The head of support and operations assured us outstanding driving assessments would be prioritised.

Staff had good links with the local Community Leaning Disability Team (CLDT), who held four to six weekly "clinics" at the service. Staff regularly sought advice and feedback from the specialist team to guide their practice in meeting people's needs. A representative from CLDT described staff as "skilled and

knowledgeable". They were "impressed with the understanding of staff and their interest and engagement" when supporting people to receive care from the team.

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. When people were able to consent to care and treatment staff supported them to do so. For example, when a person with visual impairment was being given their medicines, the staff member told them what they planned to do at each step. The person responded positively, repeating "eye drops" and positioning themselves ready for these to be given.

People were routinely offered choices in their day to day lives and these were respected. For example, one person took themselves to bed after lunch for a nap as they were tired for a health related reason. After a little while, a staff member looked in on them, offering a hot drink and suggesting activities they could participate in. The person declined both and confirmed they wanted to sleep for a bit longer, this was respected. During handover, staff were informed another person had refused personal care one morning. The afternoon shift were asked to offer this again during their shift. Assessments detailed aspects of people's lives they were able to make decisions about, such as personal care and food choices and how staff should approach each person. A relative said, "[Person] likes certain foods. They try and cater to all of them [people living at Sevenoaks]. They try and give a favourite meal to each of them in the week."

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Applications for authorisation to deprive 10 people of their liberty had been approved. Another authorisation had been applied for, but was awaiting assessment by the Local Authority responsible for the person's care placement. Conditions, attached to the DoLS authorisation, were specified in three of the 10 authorisations granted. We found these conditions were being met.

Professional advocacy services were provided, in conjunction with the Local Authority, for those people who did not have a close relative to speak for them. They declined to give feedback about an individual service but told us they would raise any concerns if they had them.

People were consulted about their meal preferences and healthy options were offered. People's food and fluid intake was monitored when indicated or requested. One person's relative told us they believed their relative was not getting enough to eat as when they visited them at home they were "hungry" and "eating solidly". The quantities of food they said their relative needed were remarkable and unusual. They told us this had been discussed with managers who planned to write a diet sheet for staff to follow. A staff member told us this person was a "big eater" and confirmed they were offered snacks between meals. People's weights were checked regularly to make sure they were getting the right amount to eat. The records we sampled showed people's weights tended to fluctuate month to month, but overall were stable.

Intake monitoring records showed people were offered a balanced variety of foods, including all food groups and fresh vegetables. Fresh fruit and snacks were available in the home. We observed a plate guard being used to enable one person to eat independently. Other people were supported to eat safely. For example, staff used a "hand over hand" technique to control the amount one person put into their mouth before swallowing, to reduce their risk of choking. Recommendations by Speech and Language Therapists (SLT) were clearly recorded in people's support plans and the care we observed was consistent with these.

One person required a special diet. Staff were aware of this and told us a member of staff, with a cooking qualification, "made things" especially for this person. They told us they also planned to use a special recipe to make snacks for this person which could be frozen for use as needed.

Each person had a detailed Health Action Plan (HAP) which described their agreed support needs in relation to maintaining their health. This included a protocol for staff to follow when supporting people to attend GP appointments. The protocol was written by the GP and agreed with the service, to ensure reasonable adjustments were made to enable people to access their GP successfully. Records demonstrated referrals to support services were timely and appropriate and people's more complex needs had been assessed by specialist healthcare professionals. People had regular access to GP health checks, dental, optical and chiropody services. People's relatives were involved in planning care, informed of outcomes and invited to attend health reviews. For example, one person's support plan detailed that their relative attended all appointments when an injection was needed. One person's relative told us how effectively staff had supported the person during a planned hospital admission, describing it as "a brilliant experience".

During our inspection we learned that the high noise levels in Larch unit had previously been discussed with the service. The chief executive told us they were looking into soundproofing materials available, which they planned to use to absorb sound in the unit. Adaptations to the environment were in progress to assist people with visual impairment. These included use of darker colours on doorframes and a guide rail along the walls.

Good

Is the service caring?

Our findings

Each person had a 'keyworker' who supported them regularly and was involved in reviewing their care. People's relatives knew who the keyworker was and spoke well of them. Comments included, "They are so good. [Person's] keyworker always ensures [person] has choice over clothes and takes [person] shopping to Gloucester and Cheltenham" and "[Name] is excellent." Staff regularly worked either in Rowan or Larch unit, which meant people were supported by the same staff group whenever possible. Some staff had worked at Sevenoaks for many years and knew people exceptionally well. Our discussions with staff working in the service for only a few months, demonstrated they already had a good understanding of people's needs and what was important to them. A social care professional said, "They [staff] know the service users inside out and are able to speak about positive changes or regression". A relative said, "99 percent of the staff seem to be very caring and responsible."

Staff spoke fondly of people and interacted with them in a positive and inclusive way. For example, eating lunch together and staff giving praise and complements when people did something well. Staff also responded appropriately and kindly to undesirable behaviours. For example, when a person took a new staff member's packet of crisps at lunch, the regular staff member prompted them to return the crisps. When the person did not respond to these prompts and began eating them, they let this go and explained this was in line with the person's agreed care plan, for food related behaviours. Staff advocated for people and wanted the best for them. When we asked staff what could be improved, their answers included, ensuring there was a driver at the weekend, to take a person to an activity that meant a lot to them, and weekend treats, such as takeaway meals. Staff felt people at Sevenoaks should be able to enjoy things they liked at the weekend. A staff member said, "They [staff] are all good in their own individual way, they do something with each client that put's a smile on their face." They told us they had recently made trifle and planned to use a special recipe to make fairy cakes for a person who had particular dietary needs.

Staff told us how different people indicated their choices and wishes. For example, one person pulled the staff member's hand towards them if they wanted more to eat but pushed it away if they had had enough or didn't like it. Relatives told us about their involvement in decision making regarding changes to people's treatment and meetings they previously attended with staff and healthcare professionals. Records demonstrated on-going communication between staff and people's relatives, involving them and working with them on people's behalf. Two people who did not have close relatives to represent their interests were supported through use of an advocacy service.

Staff respected people's privacy and promoted their dignity and independence. Personal care was provided behind closed doors and people were supported to dress appropriately to maintain their dignity. For example, one person liked to remove their clothes but staff prompted them to put them back on and made sure another person was suitably covered when going out in hot weather. We observed staff prompting another person to stand up and walk rather than shuffle on their bottom and people being involved in daily housekeeping activities within the service.

One person had been identified as being at the end of their life during their last hospital admission. Staff

told us how their colleague supported this person and was "there for them throughout." Comments included, "[Person's name] carer was brilliant with [person]. They went out of their way for [person]. They had a bond as they arrived on the same day" and "When [person] passed away his favourite person [keyworker] was sitting next to [person] holding [person's] hand." A senior staff member said, "I've lost someone I care about" and told us what the person's close relative had said in relation to the upcoming funeral, "We include you [staff] as the family", so all had been invited to attend. Manager's recognised the impact this person's death had on the staff team and were supporting them in a variety of ways. Our communications with a senior manager demonstrated a caring, sensitive and dignified approach, both during and after the person's death.

Good

Is the service responsive?

Our findings

At the last inspection on 25 and 26 August 2016 the provider had not ensured accurate, complete and contemporaneous records had been kept in respect of each person who used the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found the improvement actions, the provider told us they would take, had been completed. Improvements had been made to people's care records to reflect their individual needs and records were reviewed monthly to include any changes.

People received care that was personalised and responsive to their needs. People's support plans were detailed and personalised, providing staff with step by step guidance in how to support people in their daily lives and during the specific activities they participated in. They specified what people were able to do for themselves and what they needed support with. Their background, family relationships, preferences and any adaptations needed were noted. For example, one person did not like to wear socks and liked to wear one shoe only, leaving the other off. At home they used their bare foot to help them find their way around independently, as they were unable to see well enough to navigate without using touch. Staff told us this person felt "confident" in their environment and was "aware of space". We saw them moving around Sevenoaks independently, including arriving at the dining table when they were ready for lunch.

When people had particular interests they were supported to follow these in a way that was acceptable to them. We observed a music therapy session for a person with sensory needs. The therapist was new to Sevenoaks and was introduced to the person by a staff member. The staff member told the person what they planned to do before carrying out each action; giving them time to process the information and to decline. During this introduction they removed a blanket the person had covered themselves with and told the therapist how the person would communicate if they became unhappy during the session. The person soon pulled the blanket back over themselves but waited, ready to start. During the session the person's breathing slowed and they became quite peaceful and still, listening intently to the sound. In a relatively short time, they were enabled to connect meaningfully with another person, whose sole interest and focus was them.

The therapist told us their session with another person also went well. A staff member joined the conversation, demonstrating excellent knowledge of the person. Sharing information about their musical tastes, what they responded well to and what made them laugh, so this could be used by the therapist to tailor their session to this person's preferences in future.

Visiting professionals recognised more work was needed with identified people to improve their experiences and opportunities and managers explained how they were addressing this. For example, chasing up a service providing specialist footwear for one person and identifying a new staff member, they got on well with, to work with them regularly. A relative said, "One could always want more daytime activities. [Person] goes swimming twice a week. I think they are going to try carriage driving next. [Person] does alright!" Records and our observations demonstrated people had regular opportunities to access their community, to socialise and follow their interests. Professionals said, "They support a diverse, vulnerable client group.

On the whole they do a very good job. There's some good person centred practice", "There are some good outcomes for people happening" and "Activities are not as good as they should be, but that's not the biggest concern [for any service]. They are responsive and act in a timely way".

People's close relatives were invited to participate in review meetings, to represent their relative when they were unable to do this for themselves. Our conversations with relatives demonstrated their involvement in decision-making and inclusion in people's day to day lives. One said, "We have found them [staff] very receptive to anything we say, it all goes in [person's] communication book". Two other relatives told us about suggestions or requests they had made that had been acted upon. One person's relative remained very involved in their day to day care, visiting several times a week and sometimes providing personal care. This enabled them to identify subtle changes in their relative's well-being, which they brought to the attention of staff who hadn't known them long. Another relative had privately arranged a weekly session to help their relative learn to use an 'app' on a mobile device to enable them to communicate more effectively.

People were supported to maintain their relationships, with some people staying with their families on a regular basis. A relative told us staff brought their relative to visit them, as their circumstances changed and they were now unable to collect them. They were in regular contact with their relative's keyworker and were confident in their care. They said, "[Person's] keyworker is excellent. They really relate to each other well. [Staff member] knows [person] better than I do now"."

A feedback and suggestions book was situated in the hallway, where visitors signed in and out of the home. No feedback had been given. Everyone we spoke with about the service felt able to approach the management team with any concerns or complaints. Comments from relatives included, ""I can speak to the managers if there's anything serious" and "If things go wrong they stand by it. They own up to it and do their best to put it right as quickly as possible." Information about complaints and advocacy services were in each person's room.

Two written complaints had been received since out last inspection and both had been addressed to the complainant's satisfaction. Records and our conversations with relatives demonstrated complaints were taken seriously and had resulted in improvements to the care provided. For example, following a complaint about oral hygiene, staff worked with the person's close relatives and healthcare professionals to address difficulties in providing this oral care to the person. Further to this, recommendations were made to improve practice, based on National Institute for Health and Care Excellence (NICE) 2016 guidelines for oral health for adults in care homes. These improvements were applied to the whole service and included baseline assessment and daily checks conducted by team leaders. These checks were documented on staff handover sheets.

At the time of the inspection only written complaints were logged, minor comments were not recorded. We discussed this with the management team who agreed they would log all complaints going forward, to demonstrate they were listening and responding to all feedback given. This would allow them to identify minor reoccurring complaints and areas for improvement.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was registered by the Care Quality Commission (CQC) to manage Sevenoaks on 23 August 2017. They had been in post since April 2017 and were new to managing residential care at that time. They told us there was "not much in place [audits]" when they arrived and showed us the manager's audit schedule they were developing. They were linking these audits to regulations, provider policies, commissioner requirements and national guidance. Audits they had completed included monthly medicines audits, service user financial audits and staff sickness absence audits.

The provider's head of support and operations later provided copies of five provider audits that registered managers were expected to carry out and send to them annually. These had last been completed at Sevenoaks in May and June 2016, by the previous manager. The provider's governance systems also included a three monthly visit to each service by a senior manager. These visits had recently been restarted by the head of support and operations, who had taken responsibility for Sevenoaks from November 2016 to April 2017, while there was no manager in post at the service. One senior manager's audit had been completed at Sevenoaks from October 2016 to September 2017. We saw a record of a Trustee's visit to the service in July 2017, where no recommendations were made.

During our inspection we found shortfalls in relation to reducing some known environmental risks to people. For example, water temperatures in identified wash hand basins in Larch unit consistently exceeded the provider's identified safe level. Known shortfalls in medicines management had not been monitored or addressed effectively. Analysis for trends in incidents and accidents occurring at the service had not been carried out and there was no system in place for managers to do this. This analysis would have enabled managers to identify common themes which may not otherwise be apparent, such as broader environmental factors, training needs, or staff allocation issues. The system in place for managing incidents and accidents did not ensure the registered manager was informed of all incidents in the service CQC should be notified of. As a result notifications to CQC and safeguarding were not always made as required.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The head of support and operations told us about immediate improvements made to governance processes following our initial feedback. Following the inspection, they provided an action plan demonstrating how the shortfalls we identified were being, or had already been, addressed.

The service had been going through a culture change following changes to the provider's senior management team and appointment of the new registered manager at Sevenoaks. Changes were in progress, to get the right staff into leadership roles, make effective use of their time and ensure the service "was about the service users" rather than organised around staff. For example, two new team leaders and an administrative staff member were in post and areas of responsibility had been reassigned to ensure more effective working at all levels. This included team leaders spending more time coaching and mentoring junior staff and raising the profile of the keyworker: Holding them to account and getting increased

commitment through a revised job role. A designated staff room had been created upstairs in the office areas, to provide space for staff to store their things, make drinks, check polices, do online training, meetings and handovers. This separation also reinforced that the remainder of the building was home to the people living there.

The registered manager said, "We've now got some very positive people [staff] in the right place". Senior managers spoke of a "slow, steady" change, "drawing the best out of people [staff]" and working towards a vision. A representative of the provider told us they planned to "revisit values" with staff across their services and consider "how to embed these in everything we do". Senior managers talked of openness and transparency in their approach. Comments from external professionals included, "They are accommodating… open to the idea of change. They recognise they need improvement and want to work with others to improve." and "They are open" and "Families are on board, they are all extremely positive". Our conversations with relatives demonstrated they were informed about changes in the service and any incidents involving their relatives. One said, "If things go wrong they stand by it. They own up to it and do their best to put it right as quickly as possible".

The registered manager was confident progress had been made but they were "looking at two years to put all improvements in place". External professionals confirmed an improving picture. One said, "Organisationally things feel better" and "It's very well managed". A member of the management team said, "The framework is being put together, to ensure everything's consistent." "[Registered manager] listens and gives me feedback". "They may not be able to see the changes downstairs [in the service] yet but I can see them".

Expectations of staff, including accountability and revised job roles, were being addressed by the registered manager in staff meetings. Records demonstrated good staff attendance, where clear direction was given about the responsibilities of different staff groups, to ensure a consistent and positive approach. Handover forms had been introduced to improve individual staff accountability. These were 'signed off' by the shift leader completing checks on the care provided. A senior staff member said, "We've got a good crew here, we're all working towards the same goal".

Staff were being introduced to the National Skills Academy, 'leadership qualities framework', at the appropriate level for their job role. This framework focuses on values and behaviours for effective leadership in social care. Staff across all the provider's services, including the chief executive officer (CEO) and head of support and operations, were due to complete this training. The provider's senior management team recently attended a care conference, where they were updated and introduced to new ideas for developing the services.

Registered managers reported to the provider's head of support and operations, who was responsible for day to day operations across The Orchard Trust. The CEO was responsible for strategy and direction for the charity: The CEO worked closely with the head of support and operations and reported jointly, to the board of trustees, eight times yearly. When newly appointed, the CEO had worked alongside staff to gain understanding of each of the services. The head of support and operations had formerly managed and overseen Sevenoaks. The registered manager described them as supportive. The registered manager resigned their position before the inspection was completed. The head of support and operations agreed to register with us as manager of the service, until a new registered manager could be appointed. Senior managers had reflected on the loss of the registered manager and were reviewing the induction process for new managers as a result.

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 12 HSCA RA Regulations 2014 Safe care and treatment Temperature checks were not carried out consistently to ensure people's medicines were stored safely. Staff had not always followed policies when completing records in relation to people's medicines. Regulation 12(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Information about incidents was not consistently shared with relevant bodies. The provider's governance systems had not always been operated effectively and were not always sufficiently robust, to monitor and improve the safety of the services provided. Regulation 17(1)(2)(a)(b)