Barchester Healthcare Homes Limited

The Orchard

Inspection report

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Date of inspection visit:
17 January 2017
23 January 2017

Date of publication:
27 March 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The Orchard is a privately run nursing home, part of the Barchester Healthcare Homes Limited group. It is registered to provide accommodation for up to 60 older people, including people living with dementia or other cognitive impairments. At the time of our inspection there were 54 people living in the home.

The inspection was unannounced and was carried on 17 and 23 January 2017.

There was a registered manager in place at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

People and their families told us they felt the home was safe. Staff and the registered manager had received safeguarding training and were able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns.

There were suitable systems in place to ensure the safe storage and administration of medicines. Medicines were administered by staff who had received appropriate training and assessment. Healthcare professionals, such as chiropodists, opticians, GPs and dentists were involved in people's care when necessary.

Staff knew the people they supported and were able to explain the risks relating to them and the action they would take to help reduce the risks from occurring. Staff sought people's consent before providing care and understood the need to follow legislation designed to protect people's rights.

People were supported by staff who had received an induction into the home and appropriate training, professional development and supervision to enable them to meet people's individual needs. There were enough staff to meet people's needs and to enable them to engage with people in a relaxed and unhurried manner.

Staff developed caring and positive relationships with people, were sensitive to their individual choices and treated them with dignity and respect. People were encouraged to remain as independent as possible and maintain relationships that were important to them.

People were supported to have enough to eat and drink. Mealtimes were a social event and staff supported people, when necessary, in a patient and friendly manner.

People and when appropriate their families were involved in discussions about their care planning, which reflected their assessed needs.

There was an opportunity for people and their families to become involved in developing the service. They were encouraged to provide feedback on the service provided through 'resident meetings' and an annual survey. They were also supported to raise complaints should they wish to.

People's families told us they felt the home was well-led and were positive about the registered manager who understood the responsibilities of their role. The provider was fully engaged in running the home, through the regional director and provided regular support to the registered manager. Staff were aware of the provider's vision and values, how they related to their work and spoke positively about the culture and management of the home.

There were systems in place to monitor quality and safety of the home. Accidents and incidents were monitored, analysed and remedial actions identified to reduce the risk of reoccurrence.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People and their families felt the home was safe and staff were aware of their responsibilities to safeguard people.

The registered manager had assessed individual risks to people and taken action to minimise the likelihood of harm in the least restrictive way.

People received their medicines safely, at the right time and in the right way to meet their needs.

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate checks had been completed.

Is the service effective?

Good

The service was effective.

Staff sought verbal consent from people before providing care and followed legislation designed to protect people's rights.

Staff received an appropriate induction and on-going training and support to enable them to meet the needs of people using the service.

People were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's choices and their privacy. People were encouraged to be as independent as possible within their abilities.

People were encouraged to maintain friendships and important relationships.

Is the service responsive?

Good

The service was responsive.

Staff were responsive to people's needs.

Care plans and activities were personalised and focused on individual needs and preferences.

The registered manager sought feedback from people using the service and had a process in place to deal with any complaints or concerns.

Is the service well-led?

Good

The service was well-led.

The provider's vision and values were clear and understood by staff. The registered manager adopted an open and inclusive style of leadership.

People, their families and staff had the opportunity to become involved in developing the service.

There were systems in place to monitor the quality and safety of the service provided.

The Orchard

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.

The inspection was unannounced and was carried out on 17 and 23 January 2017. The inspection team consisted of three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed the information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 13 people and engaged with seven others who communicated with us verbally in a very limited way. We spoke with four relatives and a health professional. We observed care and support being delivered in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the provider's regional director, the regional clinical development nurse, the registered manager, the deputy manager, the second chef, the activities co-ordinator, the hospitality manager, the head of admin, four nurses, five members of care staff and an apprentice. We looked at care plans and associated records for eight people. We also reviewed records about how the home was managed, including, staff duty records, staff recruitment and training, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

The home has previously had a rating inspection. It was last inspected in December 2015. Although we did not identify any breaches of the regulations the home was rated requires improvement overall; rated requires improvement in safe, effective, responsive and well-led; and rated good in caring.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "I don't worry. There is always someone [staff] around if I need them". Another person told us, "I don't like being hoisted but I do feel safe when they do it". A family member told us they did not have any concerns regarding their relative's safety and wellbeing. One family member said, "I can relax because I know [my relative] is safe here". Another family member told us, "I have no concerns whatsoever, I know [my relative] is well looked after".

People experienced care in a safe environment because staff had the knowledge necessary to enable them to respond appropriately to concerns about people's safety. All of the staff and the registered manager had received appropriate training in safeguarding. All the staff we spoke with said they would initially follow the provider's reporting procedure, and raise the issue with the nurse in charge or the manager. They also identified that they could report concerns to the local authority and the Care Quality Commission, if they wished to raise concerns in confidence. One of the nursing staff told us, "We have a whistleblowing policy. [If they had any concerns] the carers would report to me. I would take it to the manager and we would investigate. Safeguarding training is annual. We get face to face safeguarding training; but there is a move to introduce e-learning". A member of care staff said, "I would feel comfortable in reporting poor practice. I would report it to the nurse in charge. I reported another staff member in my previous job. I wouldn't hesitate to report it". Another member of care staff told us, "I would raise concerns with the nurse in charge or the manager. I haven't had any concerns".The registered manager explained the action they would take if a safeguarding concern was raised with them including reporting any concerns to the appropriate authority in a timely manner.

The registered manager had assessed the risks associated with providing care to each individual; these were recorded along with the actions identified to reduce those risks. Individual risks to people were managed effectively and people were supported to take risks that helped them retain their independence and avoid unnecessary restrictions. For example, one person who was at risk of falling was encouraged to mobilise using their walking frame. Staff encouraged the person to stand by themselves and continued to monitored the person when they mobilised and provided additional encouragement and support when appropriate. Other risks were also managed effectively. For example, some people had chosen to use bed rails to prevent them from falling out of bed. These had been discussed with them and appropriate risk assessments conducted to help make sure the rails were safe for them to use. The registered manager assessed the risk of people developing pressure injuries using a nationally recognised tool. They then took action to reduce the risk, including providing special pressure-relieving mattresses and cushions, supporting people to change position regularly and helping them maintain a good nutritional intake. Staff knew the people they supported and were able to explain the risks relating to them and the action they would take to help reduce the risks from occurring. Where an incident or accident had occurred, there was a clear record, which enabled the registered manager to identify any actions necessary to help reduce the risk of further incidents.

The registered manager had also identified risks relating to the environment and the running of the home. They had taken action to minimise the likelihood of harm in the least restrictive way. Call bells were

available to people so that they could alert staff if they needed support or in an emergency. For those people who were not able to operate their call bell, staff carried out regular checks to enhance safety.

People received their medicines safely. Medicines were only administered by nurses and one member of care staff, who had all received appropriate training and had their competency to administer medicines assessed by the registered manager to ensure their practice was safe. During the morning of the inspection the deputy manager was being assessed by the provider's Clinical Development Nurse to ensure they were competent to safely administer medicines. They were also being trained to assess future staff competency.

Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine. Each person's MAR had a sheet with a photograph of the person and information about any allergies. Records showed that people's medicines were consistently available for them. Staff made regular checks of the MARs to make sure people had received their medicines correctly. Staff were aware of the action to take if any mistake was found, to ensure people were protected.

Each person who needed 'as required' (PRN) medicines had clear information in place to support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved. Some people were prescribed creams and ointments. Staff recorded when they applied creams and ointments. The records included body maps to show where staff should apply the preparations.

There were suitable systems in place to ensure the safe storage and disposal of medicines and suitable arrangements were in place for medicines which needed additional security. A refrigerator was available for the storage of medicines which required storing at a cold temperature in accordance with the manufacturer's instructions. There was a medicine stock management system in place to ensure medicines were stored appropriately and a process for the ordering of repeat prescriptions and disposal of unwanted medicines. Staff supporting people to take their medicines did so in a safe, gentle and respectful way. People were given time to take their medicines without being rushed. Staff explained the medicines they were giving in a way the person could understand and sought their consent before giving it to them.

People and their families told us there were sufficient staff to meet their needs. One person said, "There is always someone there if you need them". Another person told us, "The staff come very quickly if you use the buzzer during the night". The home was split into three units, Valentine, Bluebell and Memory Lane. The registered manager told us that staffing levels within each unit were based on the needs of the people within the unit. One of the nurses told us, "I think we are alright with staffing. If someone phones in at late notice it places us under stress. We don't use agency. We ask our own staff. Staff are pretty good at covering". Another member of staff said, "Staff here are flexible, staff from different units cover each other".

Care staff were augmented by other ancillary staff, such as housekeeping, maintenance, catering, activities and administration staff. This meant they were able to focus on providing care and engaging with the people they supported. The staffing level in the home provided an opportunity for staff to interact with the people they were supporting in a calm, relaxed and unhurried manner. Staff responded to people's needs promptly. There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime and bank staff employed by the home. The registered manager and the deputy manager were also available to provide extra support when appropriate.

The provider had a recruitment process in place to help ensure that staff they recruited were suitable to

work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff confirmed these processes were followed before they started working at the home. The registered manager reviewed each staff member's DBS every three years to ensure that their status had not changed. Where staff required additional registration with professional bodies, the registered manager ensured these were completed.

There were plans in place to deal with foreseeable emergencies. Staff had been trained to administer first aid and there was a programme of fire safety training and fire drills in place. Fire safety equipment was maintained and tested regularly. There was an emergency 'grab bag' in the foyer which contained individual personal emergency evacuation plans which detailed people's ability to respond in case of a fire and the support they would need if they had to be evacuated in an emergency.

Good

Is the service effective?

Our findings

People and their families told us they felt the service was effective and that staff understood their needs and had the skills to meet them. One person said, "This is a beautiful place, it couldn't be better". Another person told us, "I have one word to describe this place. Lovely". A third person said, "It is top notch or A* here". A family member told us, "I can't fault the home, its good here and the staff are wonderful, brilliant". Another family member said, "The staff are lovely and know what they are doing".

When appropriate, people's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. We saw staff followed these by consulting with relatives and professionals and documenting decisions taken, including why they were in the person's best interests. For example, there was a record of a best interest decision to determine whether a person should receive a flu inoculation. The discussions involved a health professional and members of the person's family. Best interest decisions were also made in respect of the use of restrictive equipment such as bed rails, pressure mats and the administering of medicines covertly in people's food. Medicine is administered covertly when it is in disguised form; usually in food or drink and as a result the person is unaware that they are taking it. People's families and other representatives had been consulted when decisions were made to ensure that they were made in people's best interests and the least restrictive option. For example where staff were authorised to give people their medicines covertly, they checked with the person first to see if they would take their medicine normally before administering them covertly in food.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. DoLS applications had been made to the supervisory body with the relevant authority. The registered manager carried out a review of the applications on a regular basis to ensure they were still required. Staff had been trained in MCA and DoLS; they were aware of the people that these restrictions applied to and the support they needed as a consequence.

People and their families told us that staff sought their consent when they were supporting them. One person said, "Oh yes, they ask first before they help you". A family member told us their relative "won't do anything [they] didn't want to". We observed staff seeking consent from people, in line with people's needs. When appropriate, they used simple questions and gave people time to respond. One member of staff told us, "We always ask people before we do anything". Another member of staff said, "We say 'would you like to [do something]' before we do anything". Daily records of care showed that where people declined care this was respected.

People were supported by staff who had received an effective induction into their role, which enabled them to meet the needs of the people they were supporting. Each member of staff had undertaken an induction programme, including a period of shadowing a more experienced member of staff who assessed their suitability to work on their own. Staff who were new to care, received an induction and training which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. The registered manager told us, "New staff would primarily do their shadow shifts on the unit they will be working on. They will do some shifts on the other units and with the activities coordinator and other members of my team so they know the standards I would expect of them". A member of care staff said, "I've been here for five to six months. I had a two week induction and spent three days reviewing health and safety".

The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This was in both an electronic format and as a visual representation on a notice board to allow the management team to quickly identify when staff needed refresher training and be aware of what training was occurring. This included essential training, such as medicines training, safeguarding adults, fire safety and first aid. Staff had access to other training focused on the specific needs of people using the service, such as, dementia awareness, end of life care, mental capacity act, continence management and skin pressure care. Staff were supported to undertake a vocational qualification in care. One member of staff told us, "The training is ongoing. I am doing my health and safety training this afternoon. Some of it [training] is on the computer and some face to face. It is my responsibility to ensure my training is up to date. I had done my NVQ 2 years ago. When I came here I asked if I could do it again and they agreed and the amount I got out of it is unreal". Another member of staff said, "We can do further qualifications if we want to do them. I am thinking of doing nursing". Staff were able to demonstrate an understanding of the training they had received and how to apply it. For example, how they supported people who were living with a cognitive impairment to make choices and maintain a level of independence.

Staff had regular supervisions. Supervisions provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. Staff said they felt supported by the management team and senior staff. There was an open door policy and they could raise any concerns straight away. One member of nursing staff told us, "I am supported with my revalidation. Revalidation is the process that all nurses will need to follow to maintain their registration with the Nursing and Midwifery Council (NMC). The manager discusses it with us. I get ad hoc supervision when I ask. I also get bi-monthly formal supervision from the manager". They added, "We have monthly group supervision for all staff. It is part of the monthly team meeting". Another member of the nursing team said, "I get supervision bi-monthly. The manager gives me supervision. I supervise the staff". A member of care staff told us," I do get supervisions regularly. Some are with your supervisor and some are in a group. I like those because you can hear what others have to say".

People were supported to have enough to eat and drink. People told us they enjoyed their meals and there was enough to eat. One person said, "They food here is very good and you get a choice if you don't like something". Staff who prepared people's food were aware of their likes and dislikes, allergies and preferences. The chef told us the menus followed a four weekly cycle. There was also a 'something different' menu available for people who did not want what was on the menu. A member of staff told us, "We have a couple of diabetics. We would be told when people first come in and it would be in their care plan. We weigh people every month and record it". Another member of staff said, "We have a sheet that identifies people's dietary needs".

Meals were appropriately spaced and flexible to meet people's needs. Meals were served at the same time in each unit from a hot trolley, in the kitchenette area joining each dining room and people had a choice from

the menu including the size of their portion according to their preferences. In one of the units, where people were living with severe cognitive impairment, the chef prepared two sample dishes, which were shown to people to help them choose which meal they would prefer. If people did not want what was offered on either of the menus, alternatives were available, such as poached eggs, jacket potato or sandwiches. Drinks, snacks and fresh fruit were also offered to people throughout the day.

Mealtimes were a social event, tables were laid decoratively, with a menu, napkins and table mats. People could choose who they sat with and we heard lots of friendly banter and laughter during the meal. Staff confirmed people's choice before serving their meal. Staff were aware of people's needs and offered support when appropriate. For example, one person was distracted and reluctant to eat their meal. Staff identified their reluctance and supported them with patience in a friendly calm manner, giving them the space and time to enjoy their meal.

People were supported to maintain good health and had access to appropriate healthcare services. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. All appointments with health professionals and the outcomes were recorded in detail. One member of staff told us, "People's welfare is paramount. If people need to see a doctor, the GPs are very responsive".

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. One person said, "I am very well cared for; everybody is kind and caring and gentle". Another person told us, "I would rather be at home still but I know I can't. I am very very happy with everything here". A third person said, "I really like it that the carers and staff always give me a wave and say hello when they go past my room". A family member told us they were very happy with how staff cared for their relatives. One family member said, "The staff really do care". Another family member told us, "I this is a lovely home [my relative] is very happy here".

People were cared for with dignity and respect. Staff spoke to them with kindness and warmth and were observed laughing and joking with them. We observed one member of staff supporting a person to mobilise from a chair into a wheelchair. They provided gentle encouragement to the person to stand and patiently explained "I am going to pull the chair back now, is that okay?" before guiding them to sit safely in their chair. They made sure the person was comfortable before asking them where they would like to go. On another occasion a member of staff became aware of a person who looked unsteady on their feet. They immediately responded and offered to support the person. This was accepted and they offered the person their hand and then supported them to move to a different area in the lounge.

Staff created a calm atmosphere by supporting people in a patient and unhurried way. When people were helped to mobilise, staff allowed them to move at their own pace whilst giving encouragement and reassurance. They also spoke fondly about the people they supported and expressed a commitment to treating them well. Comments included: "I love it here; I like coming to work and working with the residents", "I love the residents; they are like my family", "You have time to chat to people and get to know them" and "They are like my extended family".

Staff understood the importance of respecting people's choice. Staff spoke with us about how they cared for people and we observed that people were offered choices in what they wanted to wear, what they preferred to eat and whether they took part in activities. One member of staff told us, "I offer [people] a choice of what they want to wear and show them a choice, even if they are staying? in bed. It is not nice to just be in your pyjamas or nightie all day so I ask them if they want to get dressed". Choices were offered in line with people's care plans and preferred communication style. Where people declined to take part in an activity or wanted an alternative this was respected. We heard a member of staff explaining to another member of staff that they hadn't "got [named person] up yet as they want to stay in bed this morning". We also heard staff offer other people a choice of whether they "want to get up yet"? And whether they "would you like a shower, or just a freshen up"?

We also observed that personal care was provided in a discreet and private way. Staff knocked on people's doors and waited before entering. Staff took care to make sure toilet and bathroom doors were closed when they were in use and described practical steps they took to protect people's privacy when delivering personal care. These included keeping the person covered as much as possible, explaining what they were about to do and checking people were ready and willing to receive the proposed care and support. One member of staff told us, "I promote people's dignity by closing doors and drawing curtains during personal

care; putting dressing gowns on people when going to the bathroom; and covering them with towels during personal care".

People and where appropriate, their families were involved in discussions about developing their care plans, which were centred on the person as an individual. Care plans, risk assessments and best interest decisions had been signed by family members who had the legal authority to do so. Where care records stated that a relative had Power of Attorney for finance, health and welfare or both, the home held photocopies of this documentation. We saw that people's care plans contained detailed information about their life history to assist staff in understanding their background and what might be important to them. Staff used the information contained in people's care plans to ensure they were aware of people's needs and their likes and dislikes. When asked, staff were able to give detailed information about people and their individual likes, dislikes and life history.

People were encouraged to be as independent as possible within their abilities and to do as much as possible for themselves. For example, they described how they let people attend to their own personal care when they could, but supported them by washing areas they were unable to reach. A staff member told us, "I always try to get them to do something themselves before saying shall I help you". People were provided with appropriate equipment to aid independence, such as walking frames to allow them to mobilise; and plates with raised edges and adaptive cutlery to meet their needs.

People were supported to maintain friendships and important relationships; their care records included details of their circle of support. This identifies people who are important to the person. People and their families confirmed that the registered manager and staff supported their relatives to maintain their relationships. A family member told us, "I can visit anytime, I am always made to feel welcome and they often offer me a dinner". A café area had been created in the foyer to provide a relaxed and friendly environment for people, their families and friends to get together. The registered manager had also arranged for somebody from a local church come visit the home on a Sunday to enable people who wanted to to receive communion.

People's bedrooms had en-suite facilities and were individualised to reflected people's interests and preferences; and included photographs and items from their homes. One person had previously won a number of awards for gardening prior to coming into the home. The registered manager had arranged for these awards to be put together on a display board on a wall in their room. The environment in each unit was appropriate for the people living there. For example, in the unit where people were living with dementia, bedroom doors had the person's names and a picture, as well as things of the person's interests or likes, such as pictures of flowers or animals to help them to recognise their rooms. Doors to bathrooms and toilets were a different colour to bedroom doors and communal areas and these were labelled.

Information regarding confidentiality formed a key part of staff's induction training for all care staff. Confidential information, such as care records, was kept securely within the office and only accessed by staff authorised to view it. Any information, which was kept on the computer, was also secure and password protected.

Good

Is the service responsive?

Our findings

People and their families told us they felt the staff were responsive to their needs. One person said, "I am very happy here. They know what I like and how to look after me". Another person told us, "If you need anything you only have to ask".

Staff were responsive to people's communication styles and gave people information and choices in ways that they could understand. Staff used plain English and repeated messages as necessary to help people understand what was being said. Staff were patient when speaking with people and understood and respected that some people needed more time to respond.

People received care and treatment that was personalised and met their needs. People experienced care and support from staff who were knowledgeable about their needs and the things that were important to them in their lives. Staff's understanding of the care people required was enhanced through the use of care plans, which detailed people's preferences, backgrounds, medical conditions and behaviours. Example included: '[The person] prefers to eat with a spoon/fork in their left hand', 'Staff to speak slowly and clearly to [the person], and use simple sentences and use hand signs to emphasise what is being said. Give them time to register what has been said' and '[The person] likes two pillows'. People's plans also included specific individual information to ensure medical needs were responded to in a timely way. Care plans and related risk assessments were reviewed monthly to ensure they reflected people's changing needs.

People's daily records of care were detailed, up to date and showed care was being provided in accordance with people's needs. They included information about the person's mood, behaviours and any participation in activities. For example, one person's daily record of care stated, '[The person] has been cheerful and happy today', and another said, '[The person] was sleepy today'. Care staff members were able to describe the care and support required by individual people. For example, one care staff member was able to describe the support a person required when mobilising. This corresponded to information within the person's care plan. We observed staff supporting this person to mobilise after their lunch and saw that it was in line with information in the care plan. Handover meetings were held at the start of every shift and provided the opportunity for staff to be made aware of any relevant information about risks, concerns and changes to the needs of the people they were supporting.

Each person had an allocated keyworker, whose role was to be the focal point for that person and maintain contact with the important people in the person's circle of support. They also supported them with their shopping, managing their clothes and maintaining their room.

People were provided with appropriate mental and physical stimulation. There was an activities co-ordinator in place and the home had six activity champions, whose role was to encourage activities when the coordinator was not around. All new staff spent one day with the activities coordinator when they started at the home to reinforce the importance of people's social and emotional needs and their role in supporting this. People were kept updated about activities via word of mouth, weekly printed activity lists and the pictorial activity notice board. Families were sent emails inviting them to activities and to keep them

up to date about what is going on.

People had access to activities that were important to them. These included visits from local organisations; for example, on the day of our inspection there was a visit from representatives of Carisbrooke Castle to the Memory Lane unit to show people old clothes and artefacts. People were given the choice to participate in this and their decisions were respected. People appeared to enjoy this and many showed interest. During the afternoon there was a visit from the PAT dog. The PAT dog also visited people in their rooms if they wished. Other activities included: arts and crafts, knitting club, bingo, outside entertainers including singers and an organist, arm chair exercises, room visits, church services, quizzes and pampering sessions. There were also weekly minibus trips into the community and visits to local attractions. When organised activities were not taking place, staff interacted with people on a one to one basis and during our inspection we observed a staff member engaging with people, looking at books, newspapers or old photos.

Additional events were also held, such as a valentine's meal, where people's loved ones were invited to have a meal together; a belated Christmas party had recently taken place as the original one had been cancelled due to illness; and a summer fair. A family member told us, "There was fabulous Christmas party". There is also involvement with the local community including schools, one of which helped with the garden; the food bank and other local charities.

People and their relatives were encouraged to provide feedback and were supported to raise concerns if they were dissatisfied with the service provided at the home. People had access to advocates who were available to support them if they were unhappy about the service provided. The registered manager sought feedback from people and their families on an informal basis when they met with them at the home or during telephone contact. They also held 'residents meetings' every two or three months. We looked at the minutes of the latest meeting, which included discussions regarding the kitchen and hospitality, Christmas plans and parties, staff changes, entertainment, activities and a quality assurance survey was being undertaken. Prior to each meeting, the activities coordinator visited everyone in the home to inform them of the meeting and identify any issues for discussion. The registered manager also sought feedback from people in respect of the food and menus, through a feedback book and feedback cards left on the table when meals are served.

The provider also sought formal feedback about the home through the use of a nationally recognised independent market research organisation. This was completed on an annual basis and the results were fed back to the provider and posted on-line for people, their families and interested parties to access. A comprehensive report and analysis of the feedback was provided to the registered manager, who developed an action plan to respond to concerns, which was monitored by the provider through the regional director. The headline results of the feedback were posted in the foyer of the home. We saw copies of the free text response of the latest survey which was predominantly positive and included comments such as, 'I am very happy with the Orchard Care Home. All staff are very good, their interactions with the residents is always kind caring and they try very hard to make the residents happy. 10/10'. 'Both my parents are in this home. I know they are well looked after and are safe in this well cared for home' and 'I am very grateful to Orchard House for the way they have looked after [my relative]. Since her arrival five months ago she has regained weight, thoroughly enjoys the social life organised at the home and has settled in happily to her new environment'.

The provider had a new policy and arrangements in place to deal with complaints. They provided detailed information on the action people could take if they were not satisfied with the service being provided. The information on how to make a complaint was displayed on a noticeboard within the home, in the 'service users' guide and included details of external organisations, such as the Care Quality Commission and the

Local Government Ombudsman. One person said, "I have no complaints here; it's lovely". A health professional told us, "I have no complaints; there has been a vast improvement over the last 12 months". The registered manager told us they had not received any complaints since the home was last inspected and was able to explain the action that would be taken to investigate a complaint if one was received.

Good

Is the service well-led?

Our findings

People and their families told us they felt the service was well-led and that the staff all seemed very happy and got on well together. One person said, "The new manager is very good. I like her". Another person told us, "I feel as if I am being looked after by my family. It's wonderful". A third person said, "I don't think I have met the manager, but I know my daughter has". A health professional told us they did not have any concerns over the management of the home. They said, "The manager is really receptive, the staff are more relaxed, they know what they are doing and the relationship between the care staff and nurses is good".

There was a clear management structure, which consisted of the regional director, the registered manager, deputy manager, heads of units, nursing staff and senior care staff. Staff were confident in their role and understood the part each person played in delivering the provider's vision of high quality care. The management team encouraged staff and people to raise issues of concern with them, which they acted upon. One member of staff told us, "The manager is very approachable and the other staff are very supportive and helpful". Another member of staff said, "[The registered manager] listens to you; if you raise a concern they listen. Overall I am very happy here". A third member of staff told us, "The management is very good, very approachable. I feel we are settled now; things are so much better here and we see people [regional management] coming over [to our home]".

The provider was fully engaged in running the service, through the regional director. Their vision and values were built around creating an environment which had a comfortable and homely atmosphere where people were safe and treated with dignity and respect. Staff were aware of the provider's vision and values and how they related to their work. One member of staff told us, "My philosophy is that we work in their home; not them [people] living in our workplace". Another member of staff said, [The registered manager] does a walk round every day to check things are okay. She always says 'hello' and 'how are things'. She is really interested in you and what is happening with people. It is a nice atmosphere when you walk in".

Regular staff meetings provided the opportunity for the registered manager to engage with staff and reinforce the provider's values and vision. Observations and feedback from staff showed the home had a positive and open culture. Staff spoke positively about the culture and management of the service. They confirmed they were able to raise issues and make suggestions about the way the service was provided in their one to one sessions or during staff meetings and these were taken seriously and discussed. A staff member told us, "We have regular meetings; some are just your unit and others include everyone. It is a good chance to see what others have to say".

The registered manager had an open door policy for the people, families and staff to enable and encourage open communication. People told us they were given the opportunity to provide feedback about the culture and development of the service. People all said they were happy with the service provided. The providers had suitable arrangements in place to support the registered manager, for example through regular meetings, which also formed part of their quality assurance process. The registered manager confirmed that support was available to them from the provider.

The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary.

There were systems in place to monitor the quality and safety of the service provided and to manage the maintenance of the buildings and equipment. The regional director carried out a regular detailed inspection of the home. Where areas of concern were identified the registered manager prepared an action plan and this formed part of the discussions during their regular meetings.

The registered manager had arranged for a series of audits to be carried out by key members of her team, such as the hospitality manager who carried out regular audits of the laundry, infection control and cleanliness of the home. Other audits overseen by the registered manager included staff records and hours worked, falls, accidents and incidents, medicine management and care plans. There was also a system of audits in place to ensure that safety checks were made in respect of water temperatures and fire safety. They also carried out an informal inspection of the home during a daily walk round. Where issues or concerns were identified an action plan was created and managed through the regular meeting processes.

The provider and the registered manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. They also understood and complied with their responsibilities under duty of candour. Duty of candour places a responsibility on the provider to help ensure staff acted in an open and honest way when accidents occurred.