The Orchard Trust

Hilltop

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection which took place on the 13 September 2016. Hilltop provides accommodation and personal care for up to four people with a learning disability and a sensory or physical disability and can provide respite care for another two people. At the time of the inspection there were a total of 12 people who were registered to stay for short term care at the home.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission 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.

People received highly individualised care which reflected their complex health needs. Staff had received training to make sure they had the necessary skills to support and care for people. They worked closely with health care professionals to help people stay healthy and well. People's experience of their care shaped the support they received. Key workers, relatives and advocates spoke on their behalf when planning and reviewing their care. Those people able to comment about their care were encouraged to do so. People's rights were upheld and they received safe care. Any hazards had been identified and strategies put in place to reduce risks. Their environment had been adapted and equipment provided to keep them safe and as independent as possible.

People had busy lifestyles which reflected their lifestyle choices and likes and dislikes. Communication passports provided an overview of how they expressed themselves. Staff had a good understanding of people's needs and were observed positively interacting with people. Good use was made of easy to read documents using pictures and photographs to help people understand information. People had access to sensory stimulation in their home and garden. They used local facilities to go swimming, to the gym and to yoga. They were treated with dignity and respect. They had positive relationships with staff sharing light hearted moments as well as being reassured when upset.

People benefitted from staff who had been through a satisfactory recruitment process and who felt supported in their roles. They said management was open and accessible and helped out when needed. There were enough staff who were flexibly employed to meet people's needs. Quality assurance processes were in place to monitor people's experience of the service. This included feedback from people, their relatives, staff and health professionals as well as visits by the provider. External organisations had also audited the quality of care provided. Comments about the service included, "Staff are very caring", "Extremely caring and understanding" and "Staff work well with residents."

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People's rights were upheld. Staff had a good understanding of safeguarding procedures.

People were safeguarded against the risk of harm. Strategies were in place to reduce hazards and to learn from any near misses or accidents.
People were supported by enough staff to provide their care and support. Staffing levels were adjusted according to people's lifestyle choices and their changing needs. Recruitment procedures ensured staff had not been appointed without the appropriate checks taking place.

People's medicines were administered safely.

Is the service effective?

Good

The service was effective. People were supported by staff who had the skills, knowledge and understanding to meet their individual needs. Staff felt supported to develop in their roles through access to training and individual support meetings.

People's consent was sought in line with the essence of the Mental Capacity Act 2005. People deprived of their liberty had the appropriate authorisations in place.

People's nutritional needs had been assessed and reflected their individual dietary requirements.

People were helped to stay healthy and well. Their health care needs were promoted and changes to their needs had been responded to by staff.

Is the service caring?

Good

The service was caring. People benefitted from positive relationships with staff. They were treated with kindness, sensitivity and offered reassurance when needed.

People's privacy, dignity and independence was understood, promoted and respected by staff.

Is the service responsive?

Good

The service was responsive. People's care reflected their complex individual needs and the way they liked their care and support to be provided. Any changes in their health and wellbeing were responded to quickly.

People led busy lifestyles with access to a range of meaningful activities. A sensory environment had been provided.

Complaints systems were in place to handle concerns raised on behalf of people. They were responded to appropriately.

Is the service well-led?

Good

The service was well-led. People benefitted from an open and accessible manager who supported the staff team.

People's experiences of their care and support shaped the service they received.

Quality assurance processes were in place to assess the quality of care provided and to maintain the high standards of care they strived to provide.

Hilltop

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 13 September 2016 and was unannounced. One inspector carried out this inspection. Before the inspection, the provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we have about the service including notifications. A notification is a report about important events which the service is required to send us by law.

As part of this inspection we observed the care being provided to six people using the service and spoke with one person about their care. We spoke with the registered manager, a representative of the provider, seven care staff and joined staff at a handover between shifts. We reviewed the care records for three people including their medicines records. We also looked at the recruitment records for four staff, staff training records, complaints, accident and incident records and quality assurance systems. We observed the care and support being provided to people. We used the Short Observational Framework (SOFI) for inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed feedback which had been received by the provider from relatives and health care professionals as part of their quality assurance process.

Good

Is the service safe?

Our findings

People's rights were upheld. Staff had completed training in the safeguarding of adults and discussed their responsibilities in relation to monitoring and recording suspected harm to people. This included unexplained injuries or bruising. Staff kept detailed records which had been audited by managers to make sure the appropriate action had been taken and people had been safeguarded from further harm. Records confirmed the appropriate action had been taken in response to an un-witnessed fall and a referral had been made to the appropriate health care professional to assess the risk to the person. Safeguarding information was displayed and staff had access to information about local safeguarding procedures and contact details. There had been no safeguarding alerts raised although the registered manager knew which authorities would need contacting should the need arise.

People had been protected against the risks of financial abuse. Records had been kept for all expenditures and receipts kept to evidence income and purchases. Improvements had been made to the recording of expenditure after a provider audit of finances in April 2016. Staff were observed checking these records at handover to confirm the balances were correct. Each person had an inventory of their personal possessions.

People were kept as safe as possible. Any hazards within their home and their local community had been assessed and strategies had been put in place to reduce these. Risk assessments had been reviewed and updated after near misses or accidents and incidents. Care was taken to balance people's wish to be independent and managing the risks to them. Proactive risk taking was promoted and the advice and support from health care professionals had been put in place to reduce hazards. For example, a person had a number of falls when mobilising around their home and after a physiotherapist assessment they were enrolled for yoga classes to help them improve their balance and core strength. Equipment had also been provided for people to reduce risks such as walking frames and overhead hoists in their bedrooms. Accident and incident records had been maintained and were audited to assess for any trends developing which might not have already been dealt with. It was evident action had been taken to address any risks to people.

People were safeguarded against the risk of emergencies. A contingency plan was in place for staff to refer to in the case of utility failure, adverse weather or staff shortages. Each person had a personal evacuation plan which described how to evacuate them during an emergency. People took part in fire drills and fire systems had been checked and serviced at the appropriate intervals. Health and safety systems had also been monitored including legionella testing, infection control, water temperatures and portable appliance testing. The building and grounds had been kept in a good state of repair and long term plans included extending shared areas to provide additional storage and an office for staff.

People benefitted from staff who had confidence in the management team. They said they would raise concerns about staff practice under the whistle blowing procedure and the registered manager would take the appropriate action. Whistle blowing is where a member of staff raises a concern about the organisation. Whistle blowers are protected in law to encourage people to speak out.

People were supported by staff who had been through a satisfactory recruitment and selection process. A

checklist evidenced when documents had been requested and received. Any gaps in employment history had been explored and a full employment history had been provided. Checks had been made with previous employers to find out why applicants had left their employment when working with children or adults. Prior to starting work a Disclosure and Barring Service (DBS) check had been completed. A DBS check lists spent and unspent convictions, cautions, reprimands, plus any additional information held locally by police forces that is reasonably considered relevant to the post applied for. Risk assessments had been put in place for any new staff who started work before all recruitment checks had been completed. The registered manager confirmed they used this time to start their induction programme and if they worked they shadowed existing staff. If needed the probationary period would be extended to make sure staff were competent and confident in their roles.

People were supported by enough staff to meet their needs. Staff acknowledged they could be very busy depending upon the needs of people staying for short periods of time. The registered manager said there was some flexibility in the rota allowing for additional staff to be allocated during busy periods or if a person had more complex needs. The registered manager described how the staff levels would be increased when a new person stayed for short stays at the home. Staff said, "Managers will help out when asked" and "Managers help out." The registered manager said the team helped out when any cover was needed. They had one vacancy which was about to be filled. The registered manager said agency staff were not currently used and that "staff worked really hard".

People's medicines had been administered safely. Medicines administration records (MAR) had been completed correctly and were audited by staff to make sure any gaps were followed up. Handwritten entries had been countersigned and dated. The medicines policy and procedure had been updated to reflect the latest guidance from the National Institute for Clinical Excellence. Staff had completed training in the safe handling of medicines and were observed safely giving medicines to people. Protocols were in place for people having their medicines when needed. This informed staff about the maximum dose and when to contact the GP for advice. Stock levels had been recorded on the MAR; items had been labelled with date of opening and were disposed of within the correct timescales. People had their medicines at times to suit them and staff made sure they took medicines with people when they went out. Records had been kept for logging medicines in and out of the medicines cupboard. One person had a medicines care plan, agreed with their GP, should they need medicine to be given with their food. People staying for short stays had their medicines brought with them from their homes. Staff were strict about following the medicines policy and procedure and refused to give any medicines which had not been sent in their original packaging issued by the pharmacy. Staff checked with people's relatives before they stayed that there had been no changes in their medicines. The supplying pharmacy had inspected the administration of medicines in December 2015 and found systems to be satisfactory.

Good

Is the service effective?

Our findings

People were supported by knowledgeable and skilled staff. Staff had access to an induction programme and the care certificate. The care certificate sets out the learning competencies and standards of behaviour expected of care workers. A member of staff said they had nearly completed the care certificate as well as training considered mandatory by the provider such as fire, first aid and food hygiene. Staff said they had access to training specific to the needs of people using the service for example, training in the management of a percutaneous endoscopic gastronomy tube (PEG), postural care and parental involvement. A training schedule had been devised which highlighted the training needs of staff and when they needed to complete refresher training. The responsibility for this had been transferred to a training department to oversee the training needs of all staff working for the Trust. The registered manager also maintained their own records so they could monitor when staff needed refresher training. The registered manager said they were very aware of the need to keep staff skilled in the care of people with complex needs.

People benefitted from staff who felt supported in their work. Individual meetings (supervisions) had been scheduled to take place three times over the year with an annual appraisal. Each member of staff had attended their annual appraisal and had received two supervisions to explore their performance and training needs. Staff could also attend monthly staff meetings and were encouraged to "speak out". Minutes were produced for those staff unable to attend. The registered manager said morale had recently been low due to staff turnover but the staff had been "brilliant, working together well" and "had worked well as a team". An external organisation who visited the home on behalf of a local commissioning team commented, "Staff work well with residents."

People were supported to make choices and decisions about their day to day lives. The provider information return stated, "Staff are encouraged to give choice, listen and give time to individuals and to act upon their needs, concerns and requests in a person centred way." People were observed being asked how they wished to spend their time and what they would like to eat and drink. People's capacity to consent to their care and support had been 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 made on their behalf must be in their best interests and as least restrictive as possible. Staff had completed training in the MCA and understood the need to assess people's capacity to make decisions. People's care records evidenced who had been involved in making decisions in people's best interests, for example their relatives, staff and health care professionals.

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. When people had been deprived of their liberty, to keep them safe, applications had been submitted to the supervisory body. These had been reviewed when needed. There was evidence wherever possible the least

restrictive solution had been found. The registered manager confirmed she had discussions with the supervisory bodies for people staying for short stays to assess whether DoLS were needed.

People's individual dietary needs were promoted. People who had their nutritional requirements via a PEG were given the undivided support of staff whilst having their food supplements. People's care plans clearly stated if they were allowed to eat or drink anything. People told us they enjoyed the food and the menu was based on their likes and dislikes. Healthy eating was promoted with access to fresh fruit and vegetables. People had been referred to the speech and language therapist for support for example to prevent choking and their eating/drinking care plans referred to their guidance. Health care professionals commented, "Staff are very good at communicating regularly about dietetic input" and "Communication is always effective and with a quick response."

People were supported to stay healthy and well. They had a health action plan which described their medical history, the medicines they took and health care appointments. A hospital passport had also been produced for use in an emergency providing a summary of their health care needs and how they communicated. Records had been kept of all appointments with a summary of the outcome to make sure all staff were kept up to date with people's changing health care needs.

Good

Is the service caring?

Our findings

People had positive caring relationships with staff. People with supported with kindness, sensitivity and concern for their health and wellbeing. A person told us, "Staff are nice, I like it here." Staff were observed spending one to one time with people, just being with them or positively engaging with them. When needed staff offered reassurance responding to people's distress or anxieties. Staff offered personal contact or provided sensory stimulation to ease people's restlessness. Light hearted moments were also shared. Staff understood how to communicate with people. Their communication passports described how to interpret their body language, facial expressions and verbal behaviour. For example, reaching out meant the person wanted something and rocking side to side meant they were happy. Good use was made of easy to read information using pictures and photographs to help people to understand their care and support. Comments received from family and health care professionals included, "Staff are very caring", "Extremely caring and understanding of [name] needs" and "[Name] is happy in their company". Management said about the staff team, "The level of care and compassion staff show to people is bar to none, a really conscientious team."

People's human rights were respected and their individual needs in respect of religion, spirituality, disability and sexuality had been considered when developing their care records. Staff had completed training in equality and diversity and understood how to promote people's rights. People had access to age appropriate and meaningful activities. If they had preferences for the gender of staff supporting them with their personal care this was respected. Adaptations and equipment had been provided to make sure they were cared for safely within their home and when going out and about. People's records were kept securely and confidentiality of information was promoted by staff. People were supported to maintain relationships with people important to them such as family and friends. The registered manager described how one person had been supported to keep in touch with a long standing friend by regular telephone calls and inviting them to visit. People staying for short stays could arrange to stay together at the same time if they wished.

People's care reflected the way they and their families preferred them to be supported. This was based on previous knowledge of people and the way they responded to how their care was delivered. Staff confirmed, "People have good care." Staff used their observations of people to help plan their care making sure relatives and staff were informed if there were to be any changes. For example, a person had been unwell and needed increased hydration. This was done by offering jelly and ice lollies when they did not want to drink. Staff showed concern for the person when passing over information during handover to make sure they received the proper care and attention. The provider information return (PIR) explained that "Key workers, for those who cannot communicate, put forward any recommendations on the individual's behalf."

People had access to advocacy. Information was displayed in the reception area. Two people had personal lay advocates. Advocates are people who provide a service to support people to get their views and wishes heard. There are lay advocates and statutory advocates such as Independent Mental Capacity Advocates (IMCA). The PIR stated, "Advocates are invited to attend people's reviews where appropriate."

People's privacy and dignity was respected and promoted. People were given privacy at times to suit them. People liked to take a rest in the afternoon after lunch which not only gave them quiet time to themselves but also the opportunity to stretch out having spent the morning in their wheelchairs or specialist chairs. People were offered the opportunity of spending time together in the lounge, the dining room or in a sensory room. In the good weather the grounds offered space to relax or wander.

People were supported to be independent. Their care records clearly stated what they were able to do for themselves and what they needed help with. One person liked to help out around the home setting and clearing the table and helping with the baking. The PIR stated, "All residents and respite users are given choice within their lives through independent living skills, activities, education and religion."

Good

Is the service responsive?

Our findings

People received individualised care which took into account their complex needs. People had been assessed prior to moving into or staying at the home to make sure their needs could be met. The registered manager recognised the complexity of people's conditions and health needs which meant staff had to work closely with health care professionals. This also meant the environment; equipment and staff skills had been adjusted to make sure people received appropriate care and support. The registered manager described how "person centred care" was provided by "key workers who focused on the individual whilst making sure the needs of all people are met". The provider information return confirmed, "Staff are encouraged to give choice, listen and give time to individuals and to act upon their needs, concerns and requests in a person centred approach."

People's care reflected their backgrounds, history, life style preferences and how they would wish to be supported. When people were unable to express their views consideration had been given to how they responded to their environment and expressed their happiness or distress. Staff had built up a picture of what people enjoyed doing and what they engaged positively with. Their care plans recognised this providing a clear picture of what worked well for them. They also included recommendations from health care professionals about how to maintain their physical wellbeing. Some information had been produced using photographs to illustrate how best to support people using their specialist equipment and how to position them correctly, safely and comfortably.

People's changing needs had been responded to and their care records kept up to date. People's records had been reviewed each month and then more formally every three months to ensure they reflected people's current needs. The provider information return confirmed, "The health and wellbeing of individuals is a prime concern and any issues are quickly raised with the appropriate people." The registered manager described how staff had observed changes in the wellbeing of one person including increased falls and changes to their personality. A quick referral to health care professionals resulted in a thorough health check and strategies being introduced to help them cope with these changes.

People were encouraged to lead busy lifestyles. People had access to a range of activities both within their home and in their local communities. Sensory environments had been developed for people in their bedrooms as well as in a small lounge. These made good use of sound, visual images, lighting and soft furnishings. Outside in the garden a large swing had been provided and the landscaped grounds provided a sensory garden. People who lived in the home had a schedule of activities which reflected their preferences and interests. They went swimming, trampolining and to a small holding owned by the Trust. They also visited local places of interest as well as going further afield on day trips and on holiday. Some staff thought the costs of some activities impacted on what people were able to do. People were no longer able to use a learning centre but had drop- in facilities they could use. People staying for respite were encouraged to participate in activities offered by the Trust as well as visiting local places. People went to social clubs and college to meet up with friends. An external organisation who visited the home on behalf of a local commissioner stated, "There are lots of different activities."

There were arrangements to listen to and respond to any complaints. Accessible complaints information had been provided for those people able to understand the easy read formats. People's experiences of their care were shared in annual surveys, reviews of care and feedback from staff and advocates. These provided the registered manager with an overview of any issues or concerns. The registered manager said no complaints had been received but a concern had been raised by a relative. This had been addressed by having a face to face meeting with the relative and sharing their knowledge to help staff better understand the person's needs.

Good

Is the service well-led?

Our findings

People's experience of their care and support influenced the way in which the service developed. Changes had been made in response to the complexities of people's needs. For example, environmental adaptations included overhead hoists and a specialist bath. Staff had received additional specialist training to help them with people's individual needs. In addition, house meetings were held when possible, which encouraged feedback from people able to give their opinions about the service provided. The views of relatives, staff and health care professionals were sought and responded to. For example, feedback about the menu for people staying for short stays was reviewed following feedback about lack of choice and record keeping had also been improved. Feedback also included, "She is well cared for", "Excellent staff" and "Great working here."

Quality assurance processes monitored the standard of care provided to people. A representative from the provider carried out monthly visits to people which they had recorded identifying actions for improvement. These included producing easy to read versions of care plans. Monthly reports had been produced for the board of trustees so they could monitor the quality of the service. Improvements being made included setting up a text messaging service for staff so they could request additional cover without intruding on their personal time. This would also be used to prompt staff about training. New quality assurance systems had been introduced to monitor the health and safety of people and services. Robust records were in place confirming health and safety checks had been completed. Accident and incident records had been monitored to make sure no trends had developed without the relevant action being taken.

The registered manager recognised the challenges of making sure the complex needs of people coming to stay for short periods of time could be met. This involved reviewing the environment, adaptations, staff skills and staff levels and support from health care professionals. They also considered the dynamics of people living in the home and the impact of people coming to stay for short periods. They recognised for staff it could be hard adjusting to the needs of people being looked after and the strengths of team work and good communication. The registered manager was aware of the need to submit statutory notifications. They had submitted statutory notifications when the deprivation of liberty safeguards had been approved but not when they had been rejected. These notifications were sent to CQC during the inspection.

The registered manager promoted an open culture. Staff said she was "accessible and approachable" and "managers help out". Staff said they were confident any issues raised would be dealt with appropriately. Staff would be confident using the whistle blowing procedure. Staff commented resources could be an issue (activities and staffing) but there were "strategies in place to make sure people have the support they need". The provider's vision "to be excellent in all that we do" and values "we can do it, treat people as you would like to be treated" had been adopted by staff. Staff told us, "People have good care" and "It is great working here."

The registered manager kept up to date with current best practice and changes in legislation through provider management meetings where information was shared by representatives of the provider who attended a local care provider's association, the local safeguarding board and activity champion networks. The provider information return stated they also kept their policies and procedures up to date in line with

national guidance and CQC updates. The Orchard Trust had achieved the Investor's in People Gold Award which recognises the standard for people management. They had also been awarded the Positive about Disabilities Award which recognises people who make a difference for people with disabilities.