Roseville Orchard Court Limited

Orchard Court

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection of Orchard Court took place on 29, 30 June and 5 July 2016 and was unannounced. At the last inspection on 5 August 2014 the service met all of the regulations we assessed under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The 2010 regulations were superseded on 1 April 2015 by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and it is these regulations that we have used to inspect the service.

Orchard Court is a care home registered to provide accommodation and personal care for up to 42 older people, including those living with dementia. It is situated in South Cave, a village in the East Riding of Yorkshire and is purpose built over two floors, with two lounges, a dining area and other small seating areas. The service does not provide nursing care. All bedrooms are single occupancy and fifteen of them have an en-suite toilet, with six of those also having shower facilities. The service has a garden and car parking for eight cars. At the time of our inspection there were 37 people living there permanently and one person staying there on respite.

The registered provider was required to have a registered manager in post. On the day of the inspection there was a manager that had been registered and in post for the last two years. 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.

The registered provider had systems in place to identify, monitor and report potential or actual safeguarding concerns. Staff were appropriately trained in safeguarding adults from abuse and understood their responsibilities in respect of managing potential and actual safeguarding concerns. However, there was a minority of staff whose actions were not always appropriate and which were perceived by people that used the service as 'bullying', which meant not all staff fully understood their responsibilities with regard to their behaviour. Risks were managed and reduced on an individual and group basis so that people avoided injury of harm whenever possible.

There was up-to-date electrical safety certificate and people were at risk of being locked in their bedrooms and unable to exit independently in an emergency. The registered manager arranged for an electrical safety check to be carried out soon after the inspection, but evidence of this was still unavailable three weeks later and was only sent to us when we requested it a second time.

We contacted the registered provider after the inspection, using our formal systems for requesting further information, and on 10 August 2016 we received a copy of an electrical installations inspection that had been carried out on 9 July 2016. We also received information that sneck locks had been removed from all bedroom doors and personal emergency evacuation plans had been produced for those people that required them.

Other utilities and the premises in general were safely maintained and there was evidence of this in the form of maintenance certificates, contracts and records.

Staff understood the principles of the Mental Capacity Act 2005 and the management followed these in relation to making applications for Deprivation of Liberty authorisations. On the day of the site visit we found that people were at risk of having their liberty deprived if their bedroom doors were locked when people were in them; this was rectified following this inspection. People were at risk of financial abuse because of inadequate management of their money held in safe keeping.

We saw that the service was not always well-led. People did not always have the benefit of a positive and empowering culture and although the management style of the service was positive, it was found to be very informal. We had a number of concerns about the culture of the service, which we shared with the local authority safeguarding team and asked the registered provider to investigate. This area of concern will be reported on at a later date when the registered provider and safeguarding team have concluded their findings.

There was a system in place for checking the quality of the service using audits, satisfaction surveys and meetings but these had not been used effectively enough to ensure risks were mitigated, people were properly consulted and the need for improvements were identified and made.

There was insufficient information obtained from people and what information was gathered was not analysed and used effectively to identify concerns that people had but were reluctant to express. All of this and the issues of minor concern identified in earlier sections of the report all added up to general ineffective management of the service. Risk assessment, monitoring and assessing of service provision and improving the quality of life for people through improvements in the service were inadequately addressed.

Staffing numbers were sufficient to meet people's need and we saw that rosters accurately cross referenced with the people that were on duty. However, people expressed concern that their calls for assistance were not always answered quickly enough and they were resigned this would not improve. We made a recommendation about this.

Recruitment policies, procedures and practices were followed to ensure staff were suitable to care for and support vulnerable people. We found that the management of medication was generally safely carried out and so people were not at risk of harm from receiving medicines incorrectly, but receipting new medicines into the service and storing those that were unused and waiting to be disposed of, was not safely managed. We made a recommendation about this.

We saw that people were cared for and supported by qualified and competent staff that were regularly supervised and appraised regarding their personal performance. Communication in general within the service was satisfactory but the management team were not aware of some medication practices or of some money that was missing and so communication was not always adequate.

People that used the service commented upon the approach and attitude of a small minority of the staff and the strength of these comments ranged from a view that some staff were 'bullying' to some staff were 'controlling' and 'sharp tongued.' This did not apply to all staff, however, but those people who raised concerns were clearly unhappy about it.

People's privacy, dignity and independence were monitored and respected and the majority of staff worked to maintain these wherever possible. There was a minority of staff that did not ensure people's general

wellbeing because people inferred in their comments that staff 'oppressed' them into a way of thinking that removed some of their autonomy and resolved them into believing it was not worth challenging. This did not always ensure people felt respected or satisfied and were enabled to take control of their lives.

People were involved in most aspects of their care and were always asked for their consent before staff undertook care and support tasks.

People received adequate nutrition and hydration to maintain their health and wellbeing. The premises were suitable for providing care to older people and to people living with dementia.

People had person-centred care plans in place, which reflected their needs and which were regularly reviewed. Care files were adequate and told staff how best to meet people's needs. Some minor re-formatting of care plans was taking place. People had the opportunity to engage in some pastimes and activities if they wished to in order to maintain an active mind. People had very good family connections and support networks and accessed the community via their relatives.

Equipment in the service was suitably and safely used and while most people preferred to mingle with each other some enjoyed the isolation of their bedrooms. However, we found that they expressed displeasure at not being visited regularly enough by staff. People were offered choice in most areas of their lives by the staff.

We found that there was a complaint procedure in place and people were able to have complaints investigated. Not everyone we spoke with felt they could complain without reprisals and so there was a dual belief among people that used the service. Therefore complaints to the service were few because people told us they felt it was useless to complain. People that used the service, relatives and their friends were encouraged to maintain healthy relationships together by frequent visits, telephone calls and sharing of one another's news. We made a recommendation about this.

We found breaches of regulation in relation to good governance, safeguarding people from abuse and safe care and treatment. You can see what action we told the provider to take at the end of this report.

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 were protected from the risk of harm because there were systems in place to identify, monitor and report potential or actual safeguarding concerns and staff were trained in safeguarding issues. Risks were managed and reduced so that people avoided injury, but not all risks had been properly assessed and reviewed in respect of electrical safety. There was also a risk that one person was being financially abused.

The rest of the premises were safely maintained. Staffing numbers were sufficient to meet people's needs but staff did not always answer call bells in good time.

People's medication was safely managed but there were areas for improvement with receipting and storage.

Is the service effective?

Good

The service was effective.

Staff understood and followed the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards.

People were cared for and supported by qualified and competent staff that were regularly supervised and received appraisal of their performance. Communication was not always effective.

People received adequate nutrition and hydration to maintain their levels of health and wellbeing.

The premises were suitable for providing care to older people and to those living with dementia.

Is the service caring?

Requires Improvement

The service was not always caring.

People received kind, compassionate care from the majority of the staff, but there was a small minority of staff that people said

'bullied' or were 'oppressive' towards them. This did not always ensure people felt in control of their lives.

People were involved in most aspects of their care and got on well with most of the staff.

People's privacy, dignity and independence were monitored and respected and staff worked to maintain these wherever possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were supported according to their person-centred care plans, which were regularly reviewed. They had the opportunity to engage in some pastimes and activities.

There was a complaint procedure in place, but people told us they did not feel confident in raising concerns and did not feel confident that if they did these would be acted upon.

People were encouraged to maintain strong relationships with family and friends.

Is the service well-led?

Requires Improvement

The service was not always well led.

People did not always have the benefit of a positive and empowering culture. Although the management style of the service was positive, it was too informal. Systems in place for checking the quality of the service had not been used effectively enough to ensure risks were mitigated and people were properly consulted. The need for improvements was not always identified and acted upon.

Orchard Court

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 of Orchard Court took place on 29, 30 June and 5 July 2016 and was unannounced at the outset. One Adult Social Care inspector carried out the inspection on the first two days and an ASC inspector and an Inspection Manager visited the service on the third day.

Information had been gathered before the inspection from notifications that had been sent to the Care Quality Commission (CQC). Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also requested feedback from local authorities that contracted services with Orchard Court and reviewed information from people who had contacted CQC to make their views known about the service. We had also received a 'provider information return' (PIR) from the registered provider. A PIR 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 spoke with 26 people that used the service, six relatives and the registered manager. We spoke with five staff that worked at Orchard Court and we contacted another twelve relatives of people that used the service, via the telephone, in the days following the site visits. We looked at care files belonging to five people that used the service and at recruitment files and training records for four staff. We looked at records and documentation relating to the running of the service, including the quality assurance and monitoring, medication management and premises safety systems in operation at the time. We looked at equipment maintenance records and records held in respect of complaints and compliments.

We observed staff providing support to people in communal areas of the premises and we observed the interactions between people that used the service and staff. We looked around the premises and saw communal areas and people's bedrooms, after obtaining their permission to do so.

Requires Improvement

Is the service safe?

Our findings

Across the three days that we visited we spoke with 26 of the 38 people that used the service. People we spoke with told us they felt physically safe living at Orchard Court, but some said they felt a little undermined with regard to their autonomy. Two people described this as feeling 'bullied' and 'oppressed'.

People's comments included, "No one has harmed me. But not all staff are one hundred per cent you know", "It's alright but staff can be sharp with their tongues", "I've been bullied. And it still goes on. It is worse at the weekend because the manager and deputy manager don't work then" and "Some care staff are very good. Others have their faults. Sometimes at night when I've used my buzzer once or twice they've come in and said, not nasty, but 'What's the matter?' It's their attitude. You expect some good and some bad, don't you?"

One person said, "No I don't grumble. Cos then you don't get well treated do you. Others (service users) grumble a lot. I don't know what happens to them." Two people said that staff had raised their voice to them more than once and a third person said they had heard staff raising their voices to other service users.

Relatives we spoke with had mixed views and said, "I am happy with [Name's] care, staff are nice, friendly and there are no faults with the place", "I've never had any problems with [relative's] care, they seem happy enough", "Things seem to be fine. I heard one staff be a bit abrupt with someone once. They said a couple of things I felt were not right, so I reported it to the manager and it hasn't happened since" and "I think it is lovely here, [relative] is always well cared for." These concerns were shared with the local authority under their safeguarding adult's procedures.

People had risk assessments in place to reduce their risk of harm from, for example, falls, poor positioning, moving around the premises and inadequate nutritional intake. Following our inspection, we were sent copies of personal emergency evacuation plans (PEEPS) for evacuating people individually from the building in the event of a fire, should they require assistance.

We were told that small locks on the outside of bedroom doors were to provide people with security of their belongings when they left their bedrooms and to discourage any uninvited callers. However, there was a potential for people to be at risk of harm in the event of a fire because they might be locked in for whatever reason. The registered provider had not considered more appropriate alternative mechanisms, for example, self-releasing integral locking door handles that enabled people to lock their bedrooms with a key from the outside but release the lock mechanism from the inside in an emergency by just pulling down on the door handle. Following our inspection the locks were removed from people's doors.

We saw that the service had maintenance safety certificates in place for utilities and equipment used in the service, but not all of them were up-to-date. The last periodic electrical safety certificate was dated 2008 and covered a five year period, which meant the next certificate should have been produced in 2013 or sooner following a safety check on all electrical installations at that time. The registered manager and deputy manager were unaware that this had been omitted and undertook to have the premises electrical

installations checked immediately after the inspection.

When we checked this with the registered manager after the inspection they told us that a lengthy periodic electrical safety check had been carried out on all electrical installations within the premises and that some remedial work was required. On 20 July 2016 we asked the registered manager to send us a copy of the safety report, as they had not yet done so. There were other maintenance certificates seen at the inspection that were in date, which included those for fire systems, gas appliances, lifting equipment and the passenger lift.

These inadequate arrangements for peoples' safety were each of relatively minor concern in isolation, but when considered collectively were of overall moderate concern. A copy of the periodic electrical safety certificate was not seen, and people were at risk of being locked in their bedrooms and so we assessed there was an overall potential risk of harm to people that used the service at the time of our inspection, which had not been identified and mitigated.

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

We therefore contacted the registered provider after the inspection, using our formal systems for requesting further information, and on 10 August 2016 we received a copy of an electrical installations inspection that had been carried out on 9 July 2016. We also received information that sneck locks had been removed from all bedroom doors and personal emergency evacuation plans had been produced for those people that required them. Therefore some of the risks had been mitigated.

People had small amounts of money held in safe keeping by the registered provider. This was stored in individual pouches in an unlocked filing cabinet in the medication room. While there were individual simple accounting records of money held and money taken by people or spent on their behalf, the security arrangements for holding the money in safekeeping were inadequate.

Anyone having access to the medication room also had access to people's money. Sample checks were carried out on five people's balances and we found that one person's account balance did not correspond with the accounting sheet held. The sheet stated no money had been spent since December 2014 when a specific amount of money had been obtained from the Court of Protection on behalf of the person. However, there was actually only half the amount of money in the pouch. The registered manager, deputy manager and senior in charge of people's money on the day we inspected were unable to account for the lack of this money but felt sure the person had used some for hairdressing and chiropody in the last 18 months. However, there were no receipts to show this. We passed this information to the local authority safeguarding team.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the service had systems in place to manage safeguarding incidents and that staff were trained in safeguarding people from abuse. Staff demonstrated knowledge of what constituted abuse, what the signs and symptoms of abuse might be and how to refer suspected or actual incidents. Staff said, "I've had safeguarding training and know the types of abuse that can happen such as physical, emotional, financial, sexual. I would report anything I saw or heard to the manager" and "I would look for signs such as, poor hygiene, dirty and dishevelled clothes, loss of weight, depression or withdrawal and suspect neglect, say. I know how to report incidents to the manager or to the safeguarding board at East Riding."

We saw evidence in staff training records that staff were trained in safeguarding adults from abuse. We also saw the records held in respect of handling incidents and the referrals that had been made to the local authority safeguarding team. The provider told us in their 'provider information return' that there had been no safeguarding referrals in the last year and the service held details of one safeguarding referral, which was two years old.

Systems in place and staff having been trained in safeguarding adults from abuse ensured that people who used the service were protected from the risk of harm or abuse wherever possible, but we were not confident that people were not being emotionally 'controlled' by a very small minority of staff that disregarded the systems in place and the training they had received in safeguarding people from abuse.

When we looked at the staffing rosters and checked these against the numbers of staff on duty during our inspection we saw that they corresponded. People and their relatives told us different information about staffing numbers. They said they thought there were enough staff to support people with their needs, but staff did not always respond in a timely way. One relative said, "I think [relative] is cared for when they need it" and one person that used the service said, "I pull the cord when I want something but I don't often need to. The staff are busy as there are a lot of people in here." Another person said, "When I pull the cord staff take a long time to answer it. They are short staffed. They don't say so, but they can't get here quick enough."

Several other people expressed the view that call bells were not always answered quickly enough. One said, "They respond to the call bell if they are not busy. Sometimes they are busy and they're a long while coming but I can't do anything about it", "I don't think there are enough staff, I have to wait for the bell answered" and "They have a lot of people to see to. I don't grumble, unless I really do want to go to the toilet at night and then I shout if I see the staff. They say 'I'll come back." Staff told us they covered shifts when necessary and found they had sufficient time to carry out their responsibilities and take time to assist people with particular requests.

We recommend the registered provider reviews their staffing provision so that people are responded to promptly.

The registered manager told us they used thorough recruitment procedures to ensure staff were right for the job. They said that job applications were completed, references taken and DBS checks were carried out before staff started working. We saw this was the case for three staff recently recruited.

We also saw that files contained evidence of staff identities, interview records, health questionnaires and correspondence about job offers. We assessed that staff employed by Roseville Orchard Court Limited had not begun to work in the service until all of their recruitment checks had been completed which meant people they cared for were now protected from the risk of receiving support from staff that were unsuitable.

We looked at how medicines were managed within the service and checked a selection of medication administration record (MAR) charts. The service used a monitored dosage system with a local pharmacy. This is a monthly measured amount of medication that is provided by the pharmacist in individual packages and divided into the required number of daily doses, as prescribed by the GP. It allows for the simple administration of measured doses given at specific times.

We saw that medicines were obtained in a timely way so that people did not run out of them, but that they were not receipted into the service quickly enough. New medicines had been delivered on 24 June 2016 but five days later had not yet been receipted into the service. Medicines in use were stored safely and were

administered on time and recorded correctly. Unused medicines were disposed of appropriately by returning them to the supplying pharmacy but medicines awaiting disposal were not safely stored before being returned, as they were all gathered together in one large crate.

While this was the chosen method of storing unused medicines they were not individually booked into the returns book immediately they were put into the crate. The senior staff member in charge of medicines management told us that returns were stored in the crate and then gone through in one session to record them in the returns book before the pharmacy came to collect them. This did not provide a robust audit trail for unused medicines and there was potential for some of them to be misused before they were logged in the returns book.

We recommend the registered provider follows the National Institute for Health and Care Excellence guidelines on the management of medicines in care homes, to ensure a complete and robust audit trail is used in the service.

We saw that the controlled drugs held in the service (those required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001) were safely managed. The drugs where checked against the stock control record in the controlled drugs register that was in place and found to be accurate.

We found that the service had accident and incident policies and records in place should anyone living or working there have an accident or be involved in an incident. Records showed that these had been recorded appropriately and action had been taken to treat injured persons and prevent accidents re-occurring.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called 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. We were told by the registered manager that two people were the subject of a DoLS authorisation. There was appropriate documentation in place in respect of these.

We were told that small locks on the outside of the majority of bedroom doors were to provide people with security of their belongings when they left their bedrooms and to discourage any uninvited visitors when people were in their bedrooms asleep. However, there was potential for people to be deprived of their liberty because of them. One person was happy with the lock and said to us, "Will you lock it please when you leave" and although they consented to this and knew they were locked in their bedroom they were not free to leave the bedroom without seeking staff assistance first. Another person was not happy with the lock and said, "I don't want to be locked in...phew no. I had them take it off." They were therefore happy to risk having unwanted visitors in their bedroom. We saw that a third person had a safety gate across their door instead of the lock and were told that this was their preference.

There were many different reasons for people's need to have their belongings secured and their privacy respected but the locks in place did not resolve them effectively. Following our inspection the locks were removed from people's doors.

We saw that people consented to care and support from staff by either saying so, by conforming with staff when asked to accompany them or by accepting the support they offered. There were some documents in people's files that had been signed by people or relatives, for example, to give staff permission for care plans to be implemented and changed with changing needs or medication to be handled for people.

People we spoke with felt the staff at Orchard Court knew what was expected of them and had the knowledge to care for older people. They said, "You receive the level of care you need", "We are well looked after, I would say" and "I think I am well cared for."

We saw that the registered provider had systems in place to ensure staff received the training and experience they required to carry out their roles. A staff training record was used to review when training was required or needed to be updated and there were certificates held in staff files of the courses they had completed. The registered provider had an induction programme in place and reviewed staff performance

via one-to-one supervision and an annual appraisal scheme.

Staff told us they had completed mandatory training (minimum training as required of them by the registered provider to ensure their competence) and they had the opportunity to study for qualifications in health care. They said, "I've completed mental capacity and deprivation of liberty training, safeguarding adults and management of medicines training" and "Some of us have completed training in dementia awareness, end of life care, moving and handling, Parkinson's disease awareness, and first aid."

We saw three staff files that confirmed the training staff had completed and told us about, including person-centred care, health and safety, food hygiene certificate, infection control, challenging behaviour and falls awareness as well. We saw evidence of some of the qualifications staff had achieved, including NVQ Levels 2 and 3 in Health and Social Care.

We saw that communication within the service was not as good as it could be between the management team, the staff, people that used the service and their relatives. This was demonstrated by examples such as the registered manager and deputy manager being unaware of the medication practices with regard to receipting and recording medications and in respect of handling of people's finances. Some communications methods used by the management and staff included daily diary notes, meetings, notices and face-to-face discussions. People told us they could ask staff for whatever help they needed or whatever items they required and staff usually responded to their requests and supported them.

People's likes and dislikes, allergies and medical diets were discussed with them to ensure the service met people's nutritional needs. Where necessary the service had sought the advice of a Speech and Language Therapist (SALT) to ensure people were supported with their nutritional needs. The service provided three nutritious meals a day plus snacks and drinks for anyone that requested them, particularly at supper time. There were nutritional risk assessments in place where people had special dietary needs, difficulty swallowing or where they needed support to eat and drink.

People we spoke with told us they generally liked the meals on offer, although mid-week menus and food provision were better than the food provided at weekends. Menus were on display for people to see what was on offer.

People's health care needs were met by the service because people had been consulted about their medical conditions and information had been collated and reviewed with changes in their conditions. We were told by staff that people could see their GP on request and that the services of the district nurse, chiropodist, dentist and optician were obtained whenever necessary. Health care records held in people's files confirmed when they had seen a professional, the reason why and what the instruction or outcome was. We saw that diary notes recorded where people had been assisted with the health care that had been suggested for them.

Requires Improvement

Is the service caring?

Our findings

Ten of the people we spoke with told us they got on well with each other and also with the staff. However thirteen other people we spoke with said they did not always get on with staff and indicated that a minority of staff had a 'bullying' approach.

People said, "Some staff get the better of me. I can't say anything 'cos if I cuss and swear they swear back", "The majority of staff are fine, it's just the minority that are not", "I've been bullied. And it still goes on. It is worse at the weekend because the manager and deputy manager don't work then", "Some care staff are very good. Others have their faults" and "They have a lot of people to see to."

We observed different approaches from staff during our visit. We observed some staff that were very personable with people that used the service and showed genuine concern, affection and consideration. These staff stayed with people until their needs were met. Other staff concentrated on 'tasks' throughout their day and did not ensure they included people in the decisions about the care and support people needed. For example, we saw that when one person requested a positional change this was done with only a few words to the person. We saw on several occasions when staff brought food or drinks to people or took away dirty crockery that they merely stated what they had come for, carried out the task and left.

We observed the management team, who led by example, were polite, instructive and informative in their approach to people that used the service and their relatives. Management and the majority of staff gave the sense that they were there to help people with whatever care and support they needed or whatever they required.

Discussion with the staff revealed there were no people living at the service with any particular diverse needs in respect of five of the seven protected characteristics of the Equality Act 2010 that applied to people living there: disability, gender, marital status, race and sexual orientation. We were told that some people had religious needs but these were adequately provided for within people's own family and spiritual circles and ministers of certain faith denominations visited for a service on occasion. The seventh characteristic, age, may have been an area where people were discriminated against in that some of them generally spoke about being 'controlled' by some of the staff and feeling disempowered because of their age and dependency. We saw no physical evidence of this but had concerns with what people told us.

We saw that people who used the service had their general well-being considered and monitored by many of the staff who knew what incidents or events would upset their mental health, or affect their physical ability and health. For example, one of the management team spoke with a person who expressed anxiety that day and reminded the person of the strategies they used to distract themselves from anxious thoughts.

People were offered some pastimes in the afternoon which meant they were able to interact with the staff a little. This aided people with their overall wellbeing, as some activity and entertainment lifted their spirits. On one of the days we visited there were armchair exercises facilitated by a person whose services were bought in from the outside the organisation. However, we also found that people were not always

experiencing a satisfactory level of well-being and were not always positive about their experience in care. Some people presented as subdued and while they indicated some dissatisfaction about a minority of the staff, they were unable to fully express themselves, because they were anxious there would be reprisals if they did.

For example, three people told us, "I don't want you to say anything because I have to stay here", "Staff treat me alright. They don't treat me as someone special, I would like it if they did, but there are too many of us here. Staff are not always polite to me, but it's me, I get frustrated and go off the deep end" and "Staff come when I ask for help and say 'What's the matter?' and I think well I wouldn't have pulled the cord if I didn't want something. I feel safe yes, but I still don't like it here and I shall never like it."

Another person told us they had been unhappy living at Orchard Court for about three or four years but they were going to live with it because, as they said, "Why should I move?" A fifth person said, "We have resident meetings but not often enough. A lot of people are not happy about speaking out, but I am." A sixth person said they were fearful of talking to us in case someone overheard them.

We have shared our concerns with the local authority safeguarding team and have asked the registered provider to carry out their own investigation in regards to the concerns raised during our visit. We recommend the registered provider works with the safeguarding team on this matter to understand and address the concerns some people expressed to us.

People we spoke with told us they thought their privacy, dignity and independence were respected by staff when it came to providing personal care. We saw that staff only provided care to people that was considered personal in people's bedrooms or bathrooms. Staff knocked on bedrooms doors but did not always wait for a response before entering. Staff ensured bedroom and bathroom doors were closed quickly if they had to enter or exit, so that people were never seen in an undignified state. Staff we spoke with said, "I make sure people are covered up where possible" and "It is important to make sure people feel comfortable with you when helping them with personal care, so giving them privacy is everything."

Requires Improvement

Is the service responsive?

Our findings

People we spoke with felt their needs were being adequately and appropriately met, on the whole. One person felt they would have liked more company and greatly appreciated a spontaneous act of having their hand held, when they told us they felt low. Some people said that sometimes staff took a while responding to their calls, but on the whole staff eventually came to assist them. People expressed that they thought staff were not always able to answer their calls quickly because of the numbers of people they supported and the volume of tasks they were required to carry out.

We saw that some people, unable to move because of physical disability due to advanced dementia, spent most of their day sitting in the main lounge, watching the world go by and watching or listening to the television. Meals and drinks were brought to some of them where they sat, but a few were assisted to sit at table in the dining area to eat. These people, living with advanced dementia, expressed few occasions when they had a particular need and so they were generally left by the staff to sit quietly.

We looked at five care files for people that used the service and found that the care plans reflected the needs that people appeared to present. There was one omission for one person, however, which was that they had ceased using particular continence aids and this had not been reviewed in the care plan and the risk assessment for this care need had not been removed or reviewed. A second person had not been referred to the 'falls team' following three falls since December 2015 and there was no information to show what alternative action had been taken.

Care plans were person-centred and contained information about fifteen areas of need to instruct staff on how best to meet people's individual needs. They contained personal risk assessment forms to show how risk to people would be reduced, for example, with pressure relief, falls, the environment, moving and handling and nutrition. We saw that care plans and risk assessments were reviewed monthly or as people's needs changed. Some minor improvements were being made to standardise the care plan format across the organisation.

We were told that there were activities held in-house with staff, whenever they had time to facilitate them. Posters advertised activities that were planned, but apart from one afternoon when we saw an armchair exercise class taking place, we saw no other organised activity. People were observed receiving visitors, watching television or listening to the radio in their bedrooms, reading newspapers and sitting out at the front of the property. One person had a visit from the handyperson and when we asked them about this they told us that family visits were rare and so they enjoyed a chat with the handyperson from time to time.

We saw that some people used equipment for mobilising and transferring around the premises and that this was used effectively and appropriately. Staff told us that people were assessed for its use and there were risk assessments in place to ensure it was used correctly. Bed rail safety equipment was in place on beds belonging to some people and these had been risk assessed for safe use. Where it was considered appropriate people were asked if they would like the use of adaptive cutlery and crockery aids so that they could maintain their independence. All of the equipment used aided people in their daily lives and

encouraged independence.

Eleven people preferred to remain in their bedrooms and only mixed with other people that used the service at meal times. Two of these people told us they were only visited by staff to bring food and drinks or assist them in the bathroom when they called for support. They said that staff didn't check on them at any other time to see if they needed anything.

One person required regular positional changes and had to request these. However, we saw no positional change charts being maintained for this person. The registered provider confirmed after the inspection that re-positioning charts were available for people.

The majority of the staff understood that it was important to provide people with choice so that people continued to make decisions for themselves and stay in control of their lives. People received a choice of main menu each day and if they changed their mind the cook usually accommodated them. People chose where they sat, who with, when they rose from bed or went to bed, what they wore each day and whether or not they went out or joined in with entertainment and activities. However, some people that were more independently-minded thank others told us their choices sometimes conflicted with what a minority of staff expected them to make, which people thought inconvenienced these staff. Therefore some people's needs and choices were respected, but not everyone's.

People were assisted by staff to maintain relationships with family and friends. Staff who key worked with people (that is who offered additional support to specific people allocated to them) got to know family members and kept them informed about people and their needs. Some staff encouraged people to receive visitors or telephone them on occasion. Some staff spoke with people about their family members and friends and encouraged people to remember their birthdays, by helping them send cards.

We saw that the service had a complaint policy and procedure in place for everyone to follow and records showed that complaints and concerns were handled within timescales. Compliments were also recorded in the form of letters and cards. People we spoke with told us they knew how to complain. Three people said it was no use complaining however, because it got them nowhere and they did not want to be responsible for staff getting into trouble. They said, "People get on. It's no good grumbling because when you want to be looked after you need to be grateful" and "I told the manager about the people coming in my room but they haven't much backbone to do anything." One person said they had complained to the registered manager and the issue was adequately resolved. People had different experiences of making complaints or trying to have their views heard.

Staff we spoke with were aware of the complaint procedure and had a positive approach to receiving complaints as they understood that these helped them to get things right the next time. No staff could recall a complaint they had dealt with. Details in the 'provider information return' (PIR) showed that the service had handled two complaints in the last year. We were told that complainants had been given written details of explanations and solutions following investigations.

The PIR stated the registered manager planned to improve the complaint system by keeping a record of any verbal/informal complaints to identify themes that needed addressing. However, our overall assessment was that people who used the service were reluctant to complain, because they implied that complaining didn't achieve anything other than 'bad feeling' from some of the staff. People that used the service were resigned to a way of life that did not include making complaints. Therefore, although the service had procedures to respond to people's complaints we found that people had not complained for some time.

We recommend that the registered provider seeks advice and guidance from a reputable source in regards to managing complaints and works with staff to develop processes that ensure raising issues and concerns is a widely recognised option for people using the service.

Requires Improvement

Is the service well-led?

Our findings

Across the three days we visited we spoke with 26 of the 38 people that used the service. People we spoke with had differing views of what they thought about the quality of the care and support. Three were quite dissatisfied, and one of these three said they were unable to pass their views to the management team. Eleven people were non-committal but indicated they were not entirely satisfied with the support they received from a small minority of staff. Eight people were relatively happy with the care they received. Four people were indifferent about the service.

We looked at documents relating to the registered provider's system for monitoring and quality assuring the delivery of the service. We saw that there were quality audits completed on a small selection of areas and that satisfaction surveys were issued to people that used the service, relatives and health care professionals, but these were not pro-actively supplied and so very few had been completed.

It was evident that people had not been properly consulted or surveyed about the service or asked about their satisfaction for some considerable time. The registered manager was unable to show us any satisfaction surveys from people that used the service and there were only two that had been received from relatives in September and November 2015. These showed positive responses to questions and one comment had been made that Orchard Court was excellent. However, surveys from people that used the service would have ensured people were given an opportunity to make their views known and anonymously if they wished. The most recent 'resident' meetings had been held in November 2015 with seven attendees, September, July and June 2015. The most recent staff meetings had been held in October and July 2015.

Some audits had been carried out in June 2016 on the condition and content of people's care files, staff understanding of safeguarding responsibilities (via spot checks), accidents/incidents and bathroom cleanliness. Others had been carried out in August 2015 on kitchen practices and hygiene, medication management, health and safety and infection control. Some areas had not been audited for almost a year and so were ineffective at identifying current practice and issues. There was no analysis of information gathered, but action plans were in place and were ticked off as and when completed. There was no linking of all of the quality assurance and monitoring information into an annual report or feedback document. This would have ensured that any people who contributed to the information gathered were told about the improvements made as a result of the systems in place.

The service had been quality monitored by East Riding of Yorkshire Council contracts monitoring team in June 2016. There were thirteen recommendations made and one of these included the need to set up action plans and give people feedback about the improvements made following consultations and audits. While action plans were seen, not all of the recommendations had been fully addressed yet.

The systems for quality assuring and monitoring the service were sporadically implemented and did not show that people were effectively consulted about their care and support.

Staff we spoke with said they thought the culture of the service was, "Family-like", "Happy" and "A second

home." Staff said they thought they did a fairly good job of looking after people so that people felt in control, involved and cared for.

However, we found that the service operated two opposing cultures, depending on who was on duty and whether or not the management team were there, particularly at the weekend. One culture was led by the majority of staff who treated people kindly and included them in their support choices and decisions and encouraged independence. The other culture was led by a minority of staff who had gradually imposed a feeling among people that they would be much better off if they did not complain about anything or challenge what staff decided was best for them. This other culture was described by people in terms of such words as 'bullying', 'no time for us', 'opinionated' and 'rushed.'

People expressed the view that they believed staff were too busy to do anything differently and so they (people) were powerless to do anything about their feelings of dissatisfaction. They said, "Can they (staff) make any improvements? Not really", "I might have heard others shouted at but I don't bother, I keep out of it. I am left on my own most of the time. It is lonely sometimes. We've got to put up with these things. I've got used to it now" and "Sometimes they (staff) are busy and they're a long while coming but I can't do anything about it."

This difference was clearly identified by a number of people (fifteen or so) that used the service as they said or inferred that Orchard Court was alright, but could be much better. Two of them told us they did not want to make a complaint or have their comments passed on as they felt there would be reprisals. Several other people were reluctant to tell us how they felt and we considered that this may have been because of the same reason, if they spoke candidly with us. We experienced pauses, a long time thinking about answers to questions and people saying they did not want to get anyone into trouble, along with an overall apprehension to speak up, when these fifteen or so people were speaking with us.

In contrast to this there were eight people who stated they were happy at Orchard Court. Of the extra twelve relatives we spoke with via telephone after the inspection, eight were quite happy with the care their family members received. Four people made comments that while the service was generally satisfactory there were some observations they had made that would improve the experience for those that used the service, if action were taken.

Relatives told us that these issues related to the following:- repeated requests being made to ensure a family member was assisted to take sufficient fluids all through the day; soft furnishings on garden furniture not taken in when it rained and so could be wet when people wanted to use them, younger staff sometimes found sitting around the foyer and messaging on their mobile phones; a staff member being asked if they could support someone whose call bell was not being answered, and their response being "I am on my break"; and staffing ratios were not always as high at the weekends as they were throughout the week.

Relatives also told us there were occasionally misunderstandings between people that used the service and staff whose first language was not English. Staff did not always take time to listen to people who had speech difficulties and pre-empted what they wanted to say, which was frustrating for people. Sometimes their family members reported to relatives that staff took a while to answer call bells. One relative said, their loved one was often independent minded so staff tended to persuade them into accepting the care they required, which the relative thought was good. However, independence of mind in people that used the service was not always being encouraged and views and wishes respected, unless there was a risk of harm or injury.

Overall we found that had the registered manager consulted people and their relatives more effectively and

nurtured an open culture among the staff where reprisals were not feared then the dissatisfaction among people that used the service could have been more readily expressed and issues dealt with. The combination of an ineffective quality assurance system and an established culture of apprehensiveness meant that the service had not enabled people to express concerns or make comments to show their dissatisfaction. People had learnt to accept things the way they were even if unsatisfactory and so the registered manager had not been aware of what people were unhappy about or why.

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

We passed details of these concerns to the registered provider and to the local authority safeguarding team to ensure these issues were looked into and addressed.

The registered provider was required to have a registered manager in post and on the day of the inspection there was a manager in post, who had been registered manager for the last two years.

The registered manager and registered provider were aware of the need to maintain their 'duty of candour' (responsibility to be honest and to apologise for any mistake made) under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We saw that notifications had been sent to us over the last year and so the service had fulfilled its responsibility to ensure any required notifications were notified under the Care Quality Commission (Registration) Regulations 2009.

We found that the management style of the registered manager and deputy manager was open and approachable. Staff told us they could express concerns or ideas any time and that they felt their views were considered by their management team. We also found that the management style was perhaps too trusting of staff in that the registered manager and deputy manager enabled staff to make many day-to-day decisions about their own care practices, without clear guidance as to what constituted 'best practice.' There were few checks on staff practice and daily activity as seen from the point of view of the people that used the service. Managers were not pro-actively instructive in how they wanted care and support to be delivered.

The service maintained links with the local community through the church, schools and clubs and it encouraged family and friends to visit regularly and whenever they wished. Relatives played an important role in helping people to keep in touch with the community by visiting regularly, taking people out shopping or to health care appointments and by joining in with organised activities and events.

The service's core values, as depicted on the Roseville Orchard Court Limited website, were 'respect, independence and dignity and providing high standards of personal care in a supportive and homely atmosphere'. It stated that staff were committed to maintaining these core values, but when asked, staff were not too sure of the company's values. They were able to explain how they respected people's dignity and tried to create a homely atmosphere.

Using the information we obtained from people that used the service, however, our analysis was that there was a small core of staff that clearly did not uphold these values and were letting the rest of the staff down to the extent that several people were dissatisfied with their care and support. The service had a 'statement of purpose' and 'service user guide' that it kept up-to-date, documents explaining what the service offered; these contained the aims and objectives of the service.

We were told by the registered manager that the service was registered with the Skills For Care Network and

was aware of the Dementia Friends programme (a national initiative to encourage carers and the public in general to learn a little bit more about what it's like to live with dementia and then turn that understanding into action).

The management team kept records on people that used the service, staff and the running of the business and we saw that most of these records were appropriately maintained, generally up-to-date and securely held. There were some examples of inconsistency in this however, as evidenced in examples we have given throughout the report. One person had not been referred to the 'falls team' after having three falls since December 2015. When we asked about this the deputy manager stated there was no need for a 'falls team' referral as a medication review had been arranged by the person's GP. This had not been made clear in the file.

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 People who used services were not protected against the risks associated with unsafe premises. Regulation 12 (1) (2) (a) (b) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People who used services were not protected from financial irregularities. Regulation 13(6)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who used services and others were not protected against the risks associated with ineffective operation of monitoring, assessing and mitigating risks relating to the health, safety and welfare of people and of service provision and feedback from people had not been sought. Regulation 17 (1) (2) (a) (b) (e)