Care Quality Commission

Parkcare Homes (No 2) Limited

Orchard House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

Orchard House is a care home which provides accommodation for up to six people who require personal care. Orchard House provides a service for people who have a learning disability and/or autistic spectrum disorder. There were four people living in the service at the time of our inspection.

This inspection took place on 13 October 2014.

We inspected Orchard House on 19 May 2014 and found the provider was not meeting all the standards. We had moderate concerns about the planning and delivery of care; we also had minor concerns because the provider did not have an effective system for monitoring the quality of the service. We carried out a further inspection on 4 September 2014 and found improvements in both these areas.

At the time of our inspection there was no registered manager at Orchard House. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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.

We found that people with complex needs were at risk of these needs not being met safely because staff had not received relevant training. You can see what action we told the provider to take at the back of the full version of the report.

We found to the management of the service had been inconsistent and there was insufficient support by the provider to ensure arrangements in place for managing the service were appropriate. Processes for providing staff with the training and support they needed were not in place so that they could understand the specific and complex needs of the people they were supporting. You can see what action we told the provider to take at the back of the full version of the report.

Relatives of people who used the service were consulted about their family member's care but did not always feel that managers and staff communicated well with them. People did not always have their social needs met

Some improvements had been made to processes for supporting people with their medicines, further areas for improvement had been identified and actions were being taken.

CQC monitors the operation of the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS), and to report on what we find. DoLS are a code of practice to supplement the Mental Capacity Act 2005. These safeguards protect the rights of adults by ensuring that if there are restrictions on their freedom and liberty these are assessed by appropriately trained professionals. The service was meeting the requirements of the DoLS.

Staff understood what they should do if they saw or suspected abuse. People were supported to access health care according to their individual needs.

People received care and support from staff who were caring and treated them with respect.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

Systems and procedures for supporting people with their medicines had not always been followed, so people could not be assured they would always receive their medicines as prescribed, but improvements were being implemented.

Staff did not have the guidance to understand how to support people safely when they became anxious or displayed physically challenging behaviour.

Improvements to the environment reduced the risk of harm to people. Staff understood their responsibilities to safeguard people from the risk of abuse.

Requires Improvement

Is the service effective?
The service was not consistently effective.

Staff did not receive effective monitoring and training to ensure they had the right knowledge and skills to carry out their roles and responsibilities.

People had sufficient food and drink to meet their needs and relevant professional was sought when people had specific nutritional needs.

Where a person lacked capacity Mental Capacity Act (MCA) 2005 best interest decisions had been made. The Deprivation of Liberty Safeguards (DoLS) were understood and appropriately implemented.

Requires Improvement

Is the service caring?
The service was caring.

Staff respected people's privacy and dignity and we observed caring interactions between staff and people who used the service.

Relatives were consulted about their family member's care and were involved in making decisions.

People were supported to maintain important relationships and relatives felt their family members were treated well.

Good

Is the service responsive?
The service was not consistently responsive.

People's needs social preferences were not being properly assessed, planned and delivered.

Staff did not always communicate effectively with relatives.

Requires Improvement

Is the service well-led?
The service was not consistently well led.

Requires Improvement

Summary of findings

There was not a registered manager in post and the management arrangements were not consistent.

The culture of the service was not always open and transparent and relatives did not always receive reliable information about their family members.

Staff did not receive the necessary guidance to understand what was expected of them when providing care and support.

Orchard House

Detailed findings

Background to this inspection

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

This inspection took place on 13 October 2014 and was unannounced. The inspection team consisted of two inspectors.

Before our inspection we spoke with three social care professionals. We also gathered and reviewed information we had about the service such as notifications and information from previous inspections. A notification is information about important events which the provider is required to send us by law.

None of the four people who used the service was able to communicate with us. However, we were able to carry out some discreet observations of care and support to help us understand how people's care needs were being met. During the inspection we spoke with four care staff, the manager and someone from the local authority who was at the service in an advisory capacity.

Following the inspection we spoke with the relatives of all the people who lived at Orchard House and we also spoke with a health professional who had carried out a monitoring visit to the service.

We looked at three people's care records and information relating to the management of the service including evidence of staff training.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection on 4 September 2014 we identified issues in the environment that posed a risk to people who lived at Orchard House. We saw that some improvements had been made to the environment since the last inspection to make it safer. For example a cutlery storage drawer had been repaired so there was secure storage for knives, which reduced the risk of harm when people were in the kitchen. There had also been improvements to fences and gates to make the outside of the property more secure so that people could enjoy using the garden more safely.

Appropriate arrangements were not in place regarding the safe and lawful use of restraint. The provider had not trained staff to support people who might present with anxiety and physically challenging behaviour safely. A member of staff told us that they had experienced aggressive behaviour that had hurt staff on, "three or four occasions." They said, "You rely a lot on your own common sense to keep yourself and your service users safe." This could result in staff unlawfully restraining people or injuring people or themselves. People's care records also showed no guidance for staff on how to support people who might require the use of restraint to support them safely. This lack of information , training and guidance meant that people were not protected against the risk of avoidable harm or abuse because the provider sis not have suitable arrangements in place to ensure that restraint was lawful and not otherwise excessive.

This is a breach of Regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010.

People had their needs assessed and there were care plans and risk assessments setting out how each person's individual needs were to be met. Staff explained that each person needed consistent support by staff who had a good understanding of their complex needs and related behaviours. A member of staff told us that staffing had been one of the biggest problems; often staff had to work on a one-to-one basis with one person and then with someone different which meant there was no consistency for people receiving care and support.

One person who required one-to-one support was receiving care and support from a member of staff from an agency. They said they had no prior training or support and on their first shift at the service they were, "Just left to get on with it." During the course of our inspection we noted that on occasions this member of staff left the person unsupported for a short time.

On the day of our inspection we noted that there were sufficient staff to provide the support hours that had been identified for each person through the assessment process. Recent changes to the day-to-day management of the service had resulted in better management of staffing levels. The interim manager was able to explain how they reassessed staffing levels taking into account the specific one-to-one support hours required for people.

A recent external audit had identified concerns with the systems for supporting people with their medicines. The audit concluded that the service had some clear medicines policies and procedures but these were not always followed by staff. Also that there was no clear audit trail to confirm if medicines were always administered as the prescriber intended, either at the correct dose or at the correct time. On the day of our inspection the acting manager was able to demonstrate what they had done to address the issues raised in the recent audit report.

The manager had worked with staff on a one-to-one basis to ensure they had a better understanding of what constitutes abuse or poor practice. All the staff we spoke with understood the different kinds of abuse and knew what they should do if they saw abuse or poor practice. We saw from records that these discussions took place and were recorded.

Requires Improvement

Is the service effective?

Our findings

Although the care staff were delivering care that met people's overall needs, we found that staff training was not effective in all areas and did not always provide staff with the information they needed to support people's more complex care and support needs. Relatives told us that they had some concerns because they felt that their family members did not always get consistent support. A relative said that they understood that there were, "some concerns about staff training in [specific health conditions]" but they saw that staff had, "developed an understanding" of their family member's needs in these areas. Another relative told us they were not confident about how well trained the staff were.

The provider sis not have an effective induction programme to ensure that staff were ready to start work. A member of staff said that when they commenced working at Orchard House they, "Had four days shadowing other members of staff" but "the formal training let them down." They said this made staff fell vulnerable. They said that they got most of their information from other members of staff who, "pass on tips."

Staff felt they had a lack of training in some areas and in others the training had not always been effective in preparing them for their role. Two members of staff were working together to support a person with complex support needs that could result in them becoming anxious and physically challenging. One of the members of staff explained they had no knowledge of conditions such as autism and did not have a background in working with people who had learning disabilities. The only training they had had was a one day training course for supporting people with behaviour that could be challenging, and they felt this was, "insufficient." They also said that the training was, "not easy to apply" to the person they were working with on an individual basis because the person's behaviour was, "so unpredictable." In addition they had no training in safe methods of preventing people from hurting themselves or others.

A person was supported by two members of staff who had received minimal training in the person's specific health condition. Bothe members of staff were able to demonstrate an understanding of the person's health needs but one said, "Well we watched the DVD they asked us to that was our training really."

Another member of staff working with the person with complex support needs had been supplied by an agency. They had worked at the service for a few months. They said they had not had training in the specific areas they were supporting people with but had worked regularly with the same person and had got to know them.

Staff also told us that they had not received any formal supervision in the time they had worked there and that staff morale was, "at an all-time low."

People could not expect to receive consistency of care because not all staff providing support had the knowledge, skills and experience to meet people's needs at all times. Staff had not received the training and support they needed to understand the specific and complex needs of the people they were supporting.

This is a breach of Regulation 23 of the Health and Social Care Act (Regulated Activities) regulations 2010.

People had sufficient food and drink to meet their needs. Where any issues were identified for an individual a nutritional risk assessment was carried out and advice sought from relevant health professionals. We saw that staff understood people's likes, dislikes and preferences around eating and drinking.

We saw that people were supported to access health professionals where relevant for any specific health condition. Staff were able to demonstrate a knowledge and understanding of individual's health conditions, although a member of staff told us they had not received formal training in epilepsy.

We discussed the Mental Capacity Act 2005 with the manager, who was able to demonstrate that they understood how to protect the rights of people who were not able to make or to communicate their own decisions. The manager explained that they had policies and procedures to follow and they had external training in the Deprivation of Liberty Safeguards (DoLS). The manager said that applications for DoLS assessments for all the people who lived at Orchard House had been sent to the relevant local authorities. We saw confirmation from one local authority that an assessor had been appointed for one person.

Good

Is the service caring?

Our findings

A relative said that from their observations their family member was, “Well liked” by staff and also that they appeared contented living at the service.

Staff treated people in a caring way. One member of staff said that they had seen how much people had progressed and that was the best part of their job. They said, “That’s the part that is really rewarding.”

We saw caring, positive relationships in which people were treated with kindness and compassion by members of staff who supported them. People’s complex needs and behaviours meant that they received support on a one-to-one or a two-to-one basis when they were at home. Staff told us it was important to respect people’s dignity and privacy and staff understood that people also needed some time alone.

We saw that staff providing support for someone discreetly and in a way that promoted their independence. Staff did not intrude when the person was doing an activity they enjoyed. Staff observed from some distance away so that they were on hand if support was needed but the person was able to carry on their activity uninterrupted by staff.

We observed an incident where one person became upset and a member of staff quickly and calmly reassured them. The staff member knew what to say and to do to reduce the person’s anxiety. The person used a form of signing to communicate their needs and the staff working with the person understood how to use this method of communication. The person had a good connection with this member of staff and they smiled when the staff member talked with them.

Requires Improvement

Is the service responsive?

Our findings

There were mixed views from relatives about how the service managed concerns and complaints. One of the issues was a lack of information about upcoming changes to the service that meant people had to move out. Two of the four relatives spoken with told us that they had not been made aware of any issues regarding the service until September 2014 and one relative said they were not aware of, "how dire the situation had become." Relatives felt the issues about poor communication were because the acting manager did not receive the necessary support and information from the provider to enable them to deal with concerns. One relative told us, "[The acting manager] did not have any clear guidelines. It's not [their] fault."

One relative told us that when they had raised issues they felt staff had addressed their concerns. They said, "[They were] not serious problems overall." A relative explained that their family member communicated using a system of pictures and symbols. They said, "There were problems initially with communication but these were sorted out."

Relatives expressed concerns that their family members did not always get appropriate support to take part in the social activities that they enjoyed. One relative told us that when their family member moved to the service they were promised that they would have a comprehensive package of recreational and educational activities but, "This did not subsequently happen." Another relative said, "They were not doing activities for [our family member]"and they were often unaware of which member of staff was providing the necessary one-to-one support.

A member of staff said that there was no budget for arranging activities so it was not always easy to make activities meaningful. However, staff said they arranged activities in house and took people out when possible. People were encouraged, where possible, to be involved in preparing food. For example, on the day of our inspection staff were baking cookies with one person and they appeared to enjoy the activity. The member of staff providing support told us that it was hard to find things to do with this person as there was no structured plan.

Although relatives and staff told us that activities could have been more meaningful, we saw that some activities were taking place. During the course of the day we saw that all four people who lived at the service went out on separate occasions. Three people went swimming, one person went for a drive and later in the day one person went into town. We saw that people appeared happy to go out.

Relatives told us that sometimes communication could be better, but they felt that when they raised concerns they were dealt with. A relative explained that if they had concerns, they dealt with them directly with the home but these generally were because of differences in the family's view of how things should be done and what the service offered.

Requires Improvement

Is the service well-led?

Our findings

Prior to our inspection there had been inconsistent management of the service, with no registered manager in post. One relative told us they were disappointed that they were not informed when the previous manager had left. "At that point I was not clear on who was in charge." A member of staff had stepped into the role of acting manager but stepped down from the role a few days before our inspection. Relatives told us that they felt the acting manager had not received the necessary support to manage the service. One relative said, "[The acting manager] did not have any clear guidelines. Another relative said, "[The acting manager] took over a sinking ship and did not have the support from above." and "The problems at the home stem from higher management. All we wanted from day one was a quality life for [our family member]. Staff have not been given proper training or direction."

When the acting manager stepped down from the management role, the provider had arranged for the manager from another service to step in and manage Orchard House on a day-to-day basis. This interim manager was supported by an operations manager

The service did not have an open and inclusive culture. Relatives expressed concerns about how staff and management communicated with them about issues affecting their family member. Another relative said they sometimes felt that they were receiving conflicting information and sometimes felt that staff fed back conflicting stories about their family member's day just to "pacify" the relative. Another relative told us they had not had replies to emails sent to the manager and said, "I feel the management are somewhat casual in their approach."

Staff attitudes, performance and culture had been affected by the inconsistency in management over the previous months and staff felt that this had had an impact on morale. However, staff felt that things had, "Improved recently."

One relative told us, "I think when the management changed, staff got into bad habits." They explained that when staff were working on a one-to-one basis with someone, they were often asked to support other people and, "Sometimes there was no sign of them at all as they were in the conservatory drinking coffee."

Relatives told us of the effects of what they described as, "A weakening in the management since earlier in the year." One relative said that because of this there was a reduction in their family member's activities. They said at that time they had observed staff spending more time together and not as much with the people living in the service although this had improved.

Since their commencement in post staff said that the acting manager had tried to be as supportive as possible. One member of staff believed the acting manager had "done a good job" but had not been supported by senior management in the organisation. They also said that some of the systems to manage the home were not clear. One member of staff said the paperwork was never there because management in the home did not know "how to put it together." However, they felt that there had been some more support for the manager in recent months which had previously been lacking. They said, "Things have got better."

As a result of on going concerns, the interim management team brought in by the provider was developing processes to monitor the quality of the service. At the time of our inspection the team was being supported by a manager from the local authority. We saw that gaps in auditing had been identified and they were working on actions to address these. Other areas for improvement included the training needs of staff so that the quality of care people received could improve.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse How the regulation was not being met: People who use the service were not protected against the risks of inappropriate or unsafe care. The provider did not have effective systems to in place to ensure staff delivered care in such a way as to meet people's individual needs and ensure their welfare and safety. Regulation 11 (2) (a) (b)

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: The provider did not have suitable arrangements in place so that persons employed received effective induction, monitoring and training to provide them with the knowledge and skills to carry out their roles and responsibilities. Regulation 23 (1) (a)