Stillness 929 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

We inspected the service on 9 and 14 July and 11 August 2015. This was an unannounced inspection and the first for the service since registration.

Orchard House is registered to provide accommodation and personal care for up to nine adults with acquired brain injury, stroke and other neurological conditions. It provides rehabilitation services within a community setting. At the time of inspection five people were using the service and one person was staying at the service on respite for two weeks.

The registered manager had left the service shortly before the inspection. 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. A manager was due to begin working at the service the week after our inspection. In the absence of a manager, the service was managed by the Deputy Manager and the Group Operations Director.

There were not enough staff to meet people's needs or to keep them safe. People told us there were not enough staff to meet their needs and the rotas showed that target

Summary of findings

levels of staff had not always been achieved. Although preferred activities for residents in the service were stated on their care plans, staffing levels meant these activities often did not take place.

People were not always cared for by staff who had kept up to date with current best practice because not all staff had attended training or received adequate supervision and appraisal.

Some staff understood their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions. However, staff knowledge in this area required improvement.

The service was not following legislation and guidance in respect of consent to care and treatment in line with the Mental Capacity Act 2005.

The service did not have effective systems in place to ensure infection control was adequately monitored and managed.

Some records in relation to medication were not always accurate and so people did not always receive their medicines in line with their prescription.

The service did not have an effective system which allowed them to identify where improvements were needed.

People told us they enjoyed the meals and we saw there was a choice of meals. Observations at the mealtime showed good interaction and appropriate support provided.

The service had a system in place for dealing with people's concerns and complaints and had followed these.

People's privacy and dignity was maintained during care tasks. People were assessed regularly and care plans were detailed. A range of other professionals were involved in people's care to ensure their needs were met but people who use the service were not always involved in decisions around their care.

People felt safe and told us they liked living at the home. People who used the service and their relatives were complimentary about the staff and felt staff did their best to support them in a friendly and caring way.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we took and what action we told the provider to take at the back of the full version of the report.

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 always safe.

People were at risk because there was not enough staff to ensure people received the care required.

There were times when people did not receive their prescribed medicine.

The service did not have enough information to keep people safe in an emergency.

Staff understood their responsibilities in protecting people from the risks of abuse.

Requires improvement

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

Consideration of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were not effective to ensure that people's human and legal rights were respected.

Staff did not always get the support and training they needed to meet people's needs.

People had the involvement of health care professionals to support them with their well-being.

Requires improvement

Is the service caring?
The service was caring.

People that used the service and their relatives stated that the staff were kind and caring.

People's dignity and independence had been respected.

Good

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

People had not been fully involved in decisions about their care or supported to pursue their interests both in the service and the community.

Individuals had restrictions due to the service being task centred and therefore not able to respond to people's needs and preferences.

People told us they were aware of how to make a complaint and were confident they could express any concerns.

Requires improvement

Is the service well-led?
The service was not always well-led

Requires improvement

Summary of findings

The service did not have a registered manager.

The service did not always use audits, people's views and staff's views to make improvements to the service.

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 was 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 the 9 and 14 July 2015 and was unannounced. The inspection team consisted of two inspectors and a specialist advisor in head injuries.

Prior to our visit we reviewed the information we held about the service. This included notifications, which is information about important events the service is required to send us by law.

During the inspection we spent time with people. We looked around the home and observed the way staff interacted with people. We spoke with five people who used the service and three of their relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with six members of staff including care staff, ancillary staff, and the chef. We looked at records, which included three people's care records, the medication administration records (MAR) for three people at the home and four staff files. We also looked at records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

People who use the service and staff told us there were not always enough staff. The area manager told us “staffing is based on people’s needs. We take into account dependency and whether people require one staff or two staff for support. The manager then decides how many staff are required”.

Three people required one member of staff to support them at all mealtimes because they were at risk of choking. Other people required two staff to support them when out in the community. This meant staff were not always available to enable people to take part in activities outside the home without compromising other people’s safety. One record in a communication book stated “letter from [one person] stating reduction in number of staff was negatively impacting on people as one day there were only three staff.”

We saw a staff rota for July and there were two occasions when only three staff were scheduled to work. Concerns around staff numbers have been discussed in team meetings and in supervision notes. We were told “there have been a couple of times where we’ve not been able to facilitate people’s requests due to staffing.”

The communication book highlighted eight occasions where people's care needs were not met because enough staff had not been deployed. One person told us “They don’t always come when you’re sat out here shouting your head off. It’s because they have lots of people on one to one support.”

A relative stated that on a few occasions their relative living at the service missed visits planned due to lack of staff to take her. She felt disappointed about this as it happened at short notice and her relative was also upset at not being able to visit.

One person stated “I miss my daily walks out in the countryside.” When asked if they could still do these they stated “I don’t think I could because they don’t have enough staff”.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had plans in place to keep people safe during an emergency. However, no fire drills had taken place over the past year. The ‘grab folder’, which contained important information about people and their mobility needs as well as an emergency evacuation plan for use in the event of a fire, did not have up to date information on all people. It stated one person was on the ground floor but she was they were on the second floor. One person did not have a personal evacuation emergency plan and their details were not in the grab bag. This would mean in the event of a fire emergency services may not have the correct information to evacuate all people safely. This was brought to the deputy manager's attention and he said this would be rectified immediately.

Records showed that there were some missed doses of medicine and topical creams. These had been picked up by the monthly medicine audit that started in March 2015 but at the time of inspection errors were still evident. There were regular recordings in the communications book to request staff to ‘please sign the MAR.' We were told this was to remind staff to ensure good practice. Despite this the audit showed mistakes were still being made. These mistakes present a potential risk as it is unclear whether the medication has been administered or not.

In the medication room, a sharps box was in a cupboard with the lid unsecured and no date of assembly. A sharps box is a container that is filled with used medical needles or other sharp medical instruments. Staff said it was not in use but on inspection, needles and used razors were found in the box. Staff were alerted to this and ensured the sharps box was secured and a pedal bin put in place. This presented a risk of infection if staff were to cut themselves with the contents. It was also noted that shelves in the room were covered with dust and pieces of paper. There was no cleaning schedule in the room. This was highlighted to staff and the situation was rectified upon inspection later in the day.

Staff working at the service were not consistently applying infection control practices. Colour coded mop heads were not stored separately. There was no details of who the infection control lead for the service was and no record of any infection control audits. Staff were not aware of infection control risks in relation to one area. This was addressed the day after inspection with a staff member undertaking a full infection control audit and taking on the infection control lead role for the service.

Requires improvement

Is the service safe?

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe. Comments included, "Oh yes, I feel safe." A relative told us they had no concerns regarding safety.

Care plans contained relevant risk assessments with guidance for staff to follow to reduce risks. For example, risks around choking at mealtimes and the need for 1:1 support at these times.

Recruitment records showed that all relevant checks were carried out before staff began work. Checks included Disclosure and Barring Service (DBS) check. These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. References had been sought and were in the files.

Staff we spoke with understood different types of abuse and their responsibility to report any concerns immediately. One staff member had raised a concern about someone's personal care with the deputy manager who addressed the issue effectively resulting in an improvement.

Requires improvement

Is the service effective?

Our findings

The service was not following legislation and guidance in respect of people consenting to care and treatment. The Mental Capacity Act 2005 (MCA) states that individuals are assumed to have capacity, unless they have an assessment showing they do not. If the assessment shows the person does not have capacity then any decisions must be made in a person's best interests. The process of assessing people's mental capacity was not evidenced in line with this. We spoke with someone who expressed concern that a person at the service was being restricted without the proper process being followed. We saw evidence of two decisions in relation to this person which had not followed the guidance to ensure all options had been looked at to consider the best interests decision.

We also saw that a contract was signed by people who use the service to say they agreed to have medication managed; not be issued with key fobs and agree to observations. These were signed without capacity being assessed first. One resident stated they would like to self-medicate and there was no capacity assessment or best interest decision completed to see if this was possible. We spoke with a relative who stated they felt the management was "risk averse" and was not applying the principles of the MCA procedure correctly. Another relative stated they were only allowed to visit at certain times.

Staff did not demonstrate an understanding of the Mental Capacity Act 2005 and why it is important. Training on this was provided in staff's induction. Staff also did not have knowledge of which residents had a Deprivation of Liberty Safeguards (DoLs) in place. DoLs ensure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. It is important for staff to understand why this is needed because they must not make decisions for someone unless they have a reasonable belief the person no longer has the capacity to make that decision themselves, otherwise this could affect a person's choice and freedom.

These issues were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Evidence of training was not found for all staff. One member of staff had certificates from a previous job but none for their current post. We were unable to find any training completed for this member of staff on records. We were told that this member of staff was currently completing the training.

Some staff had regular supervision and had notes on their personnel file. However, one member of staff had not received any supervision for many months. Another member of staff's supervision notes stated concerns over staffing and not having adequate breaks between shifts but there had been no follow up to these concerns.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff underwent a three day induction programme with the company. This included training in relation to acquired brain injury and neurological conditions as well as moving and handling, safeguarding and infection control. Therapists at the service are involved during induction with practical training specific to acquired brain injury. Medicine training was completed through a pharmacy e-learning package and was followed up by direct training to staff by the deputy manager.

Staff understood people's needs and were supported by professionals to meet those needs. There were guidelines on Percutaneous Endoscopic Gastrostomy (PEG) feeding. A PEG tube is a feeding tube which passes through the abdominal wall into the stomach so that food, water and medicines can be given without swallowing. We observed a staff member carry out this procedure and all appropriate measures were taken. They took care and attention to ensure that the resident was comfortable before leaving the room.

The staff told us that a multidisciplinary team including an occupational therapist, psychologist, physiotherapist, speech and language therapist and dietician provided guidance to them on how to support people. A therapist technician had been recruited to enhance the roles of the multidisciplinary team.

The staff told us that the residents were all registered with the local GP and that they were taken to the GP as the need arises and for annual checks.

People at the service spoke positively about the food and drink. One person said the lunch he had the day of the inspection 'made a difference, but then I always have

Requires improvement

Is the service effective?

plenty to eat.' On the first day of the inspection there was no chef on duty. Staff prepared frozen meals for residents. On the second day of the inspection we spoke with the chef who ordered the food and created a four week menu plan. The chef told us although this is usually followed "sometimes they ask me for different things." The chef spent time with people and chatted with them and discussed food requests. The chef showed knowledge of people's dietary needs and preferences, for example, cooking a person's vegetables for longer so they were softer. One person said "The chef is good, he asks what you do and don't like."

Good

Is the service caring?

Our findings

People told us staff were caring however they would like to spend more time talking to them. One person said, “the staff were nice and kind, but most of the time they are too busy.” Another person said “they work very hard, they never stop. [Staff] makes a lovely cup of tea.” A relative we spoke with thought the staff were caring and commented: “can’t fault the staff, they are very good.”

We observed staff showing good listening skills and always answering people’s questions fully and clearly. We spoke with one person who said the staff were “excellent.” She confirmed staff understood what her needs were. Another person stated “overall staff are caring - the way they speak to you and give a full explanation.”

The staff showed patience and a calm approach when they were attending to the residents, this contributed to a very calm and relaxing environment. We saw friendly and warm interactions. Staff got down to eye level with people and communicated clearly, offering choices and respecting people’s wishes. A staff member told us, “we have very good relationships with people as a team. We know them really well and talk to them as much as we can. We know how to make people laugh and smile and we know when something’s not right.”

Staff sat down to eat with people and engaged them in conversation. A person commented “the food’s nice, the company is nice and the staff are pleasant.” Staff encouraged one person to be involved in laying the tables and serving up drinks for other people.

People were treated with dignity and respect. One staff discretely pulled someone’s t-shirt back down when they were sitting down at the table to maintain their dignity. We observed staff engaging with people and call them by their preferred names. . A person had had their nails done by a member of staff the day before our visit and was very happy with how they looked.

People were involved in their care by the staff supporting them. For example, we observed staff explaining quietly before they supported people. For example, “can I move your chair in for you.”

Staff explained how they had tried all sorts of different communication methods with one person including speaking to them in their first language. She said they found that “gestures worked best.”

We observed staff respecting choice. One person wanted to sort their money from a shopping trip prior to having their lunch so the staff member did this.

On arrival for the inspection, staff told us about one person who may be unsettled by our visit. We heard staff reassuring people about what we were doing and took time to explain our role. Staff knew the people they were caring for and supporting, including their preferences and personal histories. The staff was very welcoming and polite during the visit. They were helpful to provide information when requested to assist the inspection.

An external healthcare professional gave feedback that the care staff were the “best team they had ever worked with.” They said they were “caring” and “committed.”

Requires improvement

Is the service responsive?

Our findings

The service did not always involve people in their care plans. People told us they were not involved with contributing to their initial care plans when they moved to the service. One person told us she had not seen her care plan but would like to see it. Relatives told us they were not involved with care planning.

People's care plans were regularly reviewed and informed by the organisation's multidisciplinary team who met weekly at the service. The therapy technician and manager attended these meetings but residents were not routinely involved. People's rehabilitation was reviewed and six weekly goals set for the therapy technician to discuss with the resident and update staff and care plans. A consultant neurologist reviewed residents on a regular basis and this further informed rehabilitation plans.

We saw minutes from residents meetings which took place every other month. These mentioned requesting outings such as: "would like to go fishing, do gardening and swimming." "Have a trip to the seaside", "Like to do some swimming and table tennis on the Wii." We asked if any of these had happened and were told that due to the number of staff on duty none had taken place.

A person stated their relative was unable to go out for more than three hours as the service felt there was "there was a risk of falls" if they used toilet facilities outside of the service. A best interest meeting regarding lack of capacity had been cancelled but the relative was not informed and turned up to find it would not take place.

A relative stated they were disappointed that there was no equipment in place to assist rehabilitation, such as an exercise bike, which had been in use when their relative was in hospital. They felt their relative was not getting the rehabilitation needed to improve their mobility or enough access to the community due to low staffing.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assistant psychologists visited the home twice a week. No psychological group activities were taking place at the time of inspection but we were told group meetings were planned to deal with issues such as art therapy and self-esteem.

One of the people who used the service, had done some gardening in the raised beds and had planted some sunflowers and daffodils with support. Staff were supporting a person to do a word search puzzle which they were enjoying.

The service had a clear complaints procedure that people and their relatives knew about. A complaint by one person had been responded to by the area manager effectively and the person confirmed this had been dealt with satisfactorily. Relatives told us that they would discuss any concerns they had directly with the staff. We did not find a record of this but on enquiring a copy was put in the file by the deputy manager.

The service had reviewed and responded to behaviours presented by a person who uses the service by increasing care to the person with constant 1:1 support to protect the other residents and staff.

Requires improvement

Is the service well-led?

Our findings

There was not a registered manager in post. The last registered manager left their post in May 2015. A new manager had been appointed and was due to start the week of our second visit. The provider was awaiting a DBS check and the new manager was attending induction training. This manager was due to take on all management responsibilities for the service once they had fully started.

Staff told us not having a registered manager in post had an impact on them. Staff told us “morale is low due to not enough staff being able to do activities with people other than care tasks.”

Staff did not feel their views were sought or valued and described team meetings as being “told things.” They said the system of putting comments and suggestions in the communications book meant they often didn’t get to know the outcome of their concerns. Staff did not know the new manager was starting the following week. Issues raised in supervision were not followed up, for example, when they said staffing levels were affecting the level of support people were receiving. Staff said they did not feel the service was “proactive”, for example, there were times when therapy sessions were cancelled due to low numbers of staff to do the caring.

Meetings for people who used the service were taking place, however, for the issues they raised, such as doing more activities, we saw no evidence that these had been considered or acted upon by the service. The service had not done any surveys to get feedback from people who used the service, their relatives or health professionals with a view to improving the services offered.

Quality monitoring audits of the home had not been regularly undertaken so the quality and safety of the service could not be assessed. We were told some audits had not taken place since the registered manager left. This meant that a number of issues, for example, infection control and staff supervision, had not been identified or responded to. The service had not identified risks in respect of fire safety.

Audits for medicine management were in place and these had identified errors, but comments in the communications book evidenced errors were still occurring.

The culture of the service was expressed by a professional as "task focussed" on physical rehabilitation. Therefore, the needs of people’s emotional recovery to take positive risks towards gaining independence and being involved in decision making were not taking place as part of their rehabilitation.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All staff we spoke with felt able to raise concerns and were aware of the whistleblowing procedures in place to challenge poor or unsafe practices. We had been informed of reportable incidents as required under the Health and Social Care Act 2008.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The service was not doing everything reasonably practicable to make sure people who use the service received person-centred care to meet their needs and reflect their personal preferences. Regulation 9(3)(a-f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service had not ensured the premises were safe in the case of an emergency and who was located where in the building. Regulation 12(2)(d) The service had not ensured the grab bags used in an emergency were up to date with the correct information. Regulation 12(2)(e) The service had not ensured the proper and safe management of medicines. Regulation 12(2)(g) The service had not assessed the risk, prevention, detection and controlling the spread of infections. Regulation 12(2)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not have systems such as regular audits of all services provided. Risks had not been identified. Records in respect of consent were not accurate and did not make reference to discussions with people or their carers. Regulation 17(2)(a)(c)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not enough staff to make sure that people's care and treatment needs were met. Regulation 18(1) Staff had not received appropriate training or supervision in order to carry out the duties they are employed to do. Regulation 18(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The service had not ensured the care and treatment of people was provided with the consent of the relevant persons. Staff were not familiar with the principles and codes of conduct associated with the Mental Capacity Act 2005. Regulation 11(1) and (2)