The Willows Care Home (Worcester) Limited

Orchard Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Summary of findings

Overall summary

We inspected Orchard Court on 13 March 2018. The visit was unannounced.

At the previous inspection on 23 November 2017, we found breaches of legal requirements and the service was rated inadequate overall and the service was put into special measures. We imposed urgent conditions on the registration which prevented new admissions to the service and required the provider to submit regular reports to prove the safety of people using the service.

After the comprehensive inspection, the provider was asked to provide an action plan to tell us what they would do to meet legal requirements in relation to breaches in person centred care, safe care and treatment, safeguarding service users from abuse and improper treatment, staffing and good governance. The service was also in breach of the registration regulations failing to notify the Commission of events affecting people. The provider wrote to us to say what they would do to meet legal requirements in relation to the breaches identified.

At this inspection we found the service had made some of the required improvements. However, the rating for the service remains Inadequate and the service remains in special measures. We found three continued breaches and three further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Orchard Court is registered to provide residential and personal care for up to 20 people. There are three separate units within the service with six to seven people living on each unit. At the time of this inspection there were 20 people living in the service. There were people using the service who could not always express their needs and wishes because they had a mental health condition or because their ability to communicate was impaired. Many of the people using the service had complex needs which, at times, needed one to one or two to one support from staff who were trained in specific and specialised areas of care delivery. During our inspection it was not evident that support was being provided to the level people needed, to provide both meaningful activities or ensure their safety.

The service had a registered manager. 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.

The staff team had received training on the safeguarding of adults and were aware of their responsibilities for keeping people safe from avoidable harm. The provider's safeguarding policy had not always been followed when a safeguarding concern had been identified.

The risks associated with people's care and support had been assessed though not all of the assessments had been personalised to cover the individual needs of the person.

The deployment of staff was ineffective and people were not being provided with the support they needed at a time that suited them. The way in which shifts were organised and the necessity for the staff team to carry out cleaning duties meant the people using the service missed out on participating in activities and interests that were important to them.

Appropriate checks had been carried out on new members of staff to make sure they were safe and suitable to work at the service and an induction had been provided. Whilst the staff team had received a number of training courses since our last inspection, some staff members had yet to receive training on specific health conditions people lived with.

People were not always supported with their medicines as prescribed by their GP. Not all of the staff team were aware of which of the people using the service were receiving their medicines covertly. [Disguised in food].

The premises were not clean or hygienic. The staff team were required to carry out cleaning and laundry duties as well as providing the complex care and support people needed. It was evident that this arrangement was not working. Chairs were stained and dirty and floors and surfaces were sticky to the touch. Not all areas of the service were well maintained. This included people's bedrooms and the outdoor spaces people had access to.

The registered manager explained that lessons were learned when things went wrong however, records held did not demonstrate this.

The staff team supported people to make decisions about their day to day care and support and were aware of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Where people lacked the capacity to make their own decisions, documentation to show decisions had been made for them in their best interest was not always completed. Where people required additional support to make decisions, advocacy support was available to them.

The menus seen did not demonstrate that people had been involved in their development or they catered for people's individual needs or preferences. The provider and taken away the opportunity for people to be involved in the cooking of both the main meal of the day and the evening meal by introducing a cook to prepare these meals and have them served at set times. People's choice of what and when they wanted to eat was not promoted and the provider was not working to current guidelines in providing people with individualised care.

The service has not been developed and designed in line with the values that underpin Registering the Right Support. This was because the service was created a number of years before Registering the Right Support was published. However, people using the service were not enabled to have choice, are not able to live as independently as they could and do not live as ordinary a life as any other citizen.

People had access to relevant healthcare services and they received on-going healthcare support.

The staff team were kind and caring, though did not always treat people with thought or consideration. People's preferences, likes and interests had been identified but there was little evidence to demonstrate that these were promoted or encouraged.

People were not able to spend their time engaged in activities they enjoyed and spent long periods of time with little or nothing to do. There was a lack of emphasis on people's goals and aspirations and people were

not living fulfilled lives.

People had plans of care that, on the whole, reflected their care and support needs. The staff team knew the needs of the people they were supporting well but were not always able to support people in line with their plan of care because of the deployment of staff. Plans of care had been reviewed, though not with the involvement of the people using the service.

The provider's complaints process was displayed for people's information and this was available in picture form.

The staff team had completed training on end of life care and people using the service were supported to help them understand when a person passed away. The registered manager was working to ensure they understood people's wishes at the end of their life.

Monitoring systems were ineffective and failed to identify the issues and concerns found during our inspection.

The provider had not taken into account the needs of the people using the service and had not worked in line with best practice regarding individualised support for people with a learning disability. The opportunity to provide individual care and support and been taken away from the staff team resulting in people not getting their care or support in an individual way or in a way they preferred.

The staff team did not always feel supported by the management team and continued to lack confidence in the provider and how the service was being run. Regular staff meetings had been held, however concerns and ideas raised had not been taken into consideration.

Whilst surveys had been used to gather relatives thoughts of the service provided they had not been used to gather the views of either the people using the service, the staff team or professionals involved with the service.

The provider had a statement of purpose and the relevant policies and procedures in place however; these were out of date and included incorrect information.

The service remains 'Inadequate' in well led therefore remains in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

For adult social care services the maximum time for being in special measures will usually be no more than12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Further information about our concerns are detailed in the findings below.

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 safe.

Inappropriate deployment of staff meant people's care and support needs were not being routinely met.

Not all areas of the service were well maintained, clean or hygienic.

Medicine records did not always accurately reflect the support people required.

The staff team understood their responsibilities for keeping people safe from avoidable harm.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Not all of the staff team had received the necessary training to enable them to meet people's specific care and support needs. Staff competency was not being checked.

People were not being provided with a nutritionally balanced diet that reflected their needs or preferences.

Whilst the staff team understood the principles of Mental Capacity Act 2005, required documentation was not always completed.

People were assisted to access health care services when they needed them.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The staff team were kind and caring though didn't always involve people in meaningful conversation.

The staff team understood the needs of the people they were supporting though were not given the time to provide support in

a compassionate and personal way.

People's relatives and friends were able to visit at any time.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not engaged in activities they enjoyed and their goals and aspirations were not being fulfilled.

There was a lack of emphasis on people reaching their potentials and leading fulfilling lives which encouraged and supported their independence.

People's care records were not regularly reviewed with them or their representatives.

The provider's complaints process was displayed and people knew how to raise a concern.

Is the service well-led?

Inadequate

The service was not well led.

People were at risk of organisational abuse because of how the service was run.

The provider had taken away the opportunity to provide people with individual care and support.

Monitoring systems used to check the quality of the service were ineffective and had failed to identify shortfalls within the service.

The staff team felt unsupported by the provider and continued to lack confidence in them and how the service was being run.

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.

This inspection took place on 13 March 2018. Our visit was unannounced. The inspection was carried out by three inspectors and a registration inspector.

As part of the inspection we contacted health and social care commissioners who monitor the care and support of people receiving care at Orchard Court to obtain their views of the care provided. We also contacted Healthwatch Leicestershire, the local consumer champion for people using adult social care services to see if they had any feedback about the service. We used this information to inform our inspection planning.

At the time of our inspection there were 20 people living at the service. We were able to speak with one of the people living there. We were unable to speak with more people due to their complex communication needs. We also spoke with the registered manager, the deputy manager, the cook, five support workers and one senior support worker. We also spoke with a support manager who had been employed to support the registered manager in making improvements at the service.

We observed support being provided in the communal areas of the service. This was so we could understand people's experiences. By observing the care received, we could determine whether or not they were comfortable with the support they were provided with.

We reviewed a range of records about people's care and how the service was managed. This included five people's plans of care. We also looked at associated documents including risk assessments. We looked at records of meetings, recruitment checks carried out for three support workers and the quality assurance audits the management team had completed.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 23 November 2017 we found three breaches of the Regulations. Regulation 12, Safe care and treatment, Regulation 13, Safeguarding people from abuse and improper treatment and Regulation 18, Staffing. We rated the service as inadequate; people were not consistently protected from risks relating to their health and safety. Safeguarding incidents were not being adequately monitored at the service and had not been responded to appropriately as a result. People were not being adequately protected from the risk of abuse and staffing levels were insufficient to keep people safe.

At this inspection we found the provider had made some of the required improvements. However, further improvements were still required and we found other areas where improvements were also needed. We found two continued breaches and a further breach of the Regulations.

People continued to have complex needs and many of those we reviewed continued to need one to one and sometimes two to one care. This level of support had been assessed and agreed with the funding authority. Whilst it was acknowledged that staffing levels had increased since our last inspection, the deployment of the staff team was not effective. The staff team had not been deployed in a way that met people's individual needs, either at the times they needed or wanted. For example at meal times or with personal care. The staff team were not all aware of who had one to one hours. A senior support worker told us, "We have two resident's each, I don't sort the one to one, I don't know who does the one to one." A support worker explained, "Everyone has elements of one to one. I couldn't tell you what hour's people have. There are three people who need two to one support on the blue unit. We can always shout for others."

There were three staff members on each shift with one person floating between all three units. The provider was not able to provide information about the one to one and two to one support people received and the times they needed this. Information received following our visit showed the weekly dedicated one to one and two to one hours people were provided with but not specifically how and when they were offered on a daily basis. The rota did not show the specified hours people had been assessed as needing in order to meet their needs. The hours were provided as and when staff were available. The information from the provider showed us there were additional hours within the working week to enable the staff team to carry out cleaning and cooking duties and provide meaningful activities. Observations made and comments received during our visit did not evidence these additional hours. No meaningful activities were offered during our visit and areas of the service were found to be unclean and unhygienic.

During our inspection we found staff were unable to spend any meaningful time with people during the course of the day. One of the people using the service told us, "They don't really offer activities, that is something they don't do. Staff will chat but they are too busy to do that, it is something they could improve on." The registered manager explained that the staff team were trying to get people to go out but this was proving difficult due to the staffing levels and people not wanting to go out.

Staff member's thoughts varied with regard to the numbers of staff on duty. Whilst some felt there were enough staff available to properly meet people's needs and keep them safe, others felt there were not. One

staff member told us, "It used to be a lovely family home. We still have to cook at teatime and clean the toilets and bathrooms and do the laundry. Most of the time we don't have a break because we don't have time and there is nowhere to go. We can leave the building but that would leave them vulnerable, because if [person] wanted to use the toilet (who is on two to one support) and one person was on a break that would leave no one [staff member] for [person] who is on one to one support." They went on to tell us, "It is not identified on the rota who is to do the cleaning, that is low on the list of things to do as the people come first." People were observed during our inspection sitting for long periods of time without interaction and with nothing to do. The last report received from the provider as part of the conditions imposed stated that more staff had been employed and daily activities were taking place. However, this was not reflected in what we found on inspection.

The provider and registered manager failed to ensure staff were effectively deployed to meet the needs of people. This indicates a continued breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

People continued to live in a home that was not being cleaned or disinfected adequately. There were issues with the cleanliness of the service. The support workers were expected to clean the service and carry out laundry duties. They had received training in infection control however; it was evident that not all areas of the service were clean or hygienic. A shower room in the pink unit had a strong odour both during the morning of our visit and later in the day. We were unable to identify the source. The registered manager said they would tell the provider, however, did not consider a deep clean of the area. There were a number of chairs in the service that were stained and dirty. Throughout the service windows were dirty and had a black mould around the inside frame. This was caused by condensation and apart from being unsightly, could have led to breathing difficulties for people in those areas with health problems. We found personal protective equipment (PPE) left on window sills in the communal areas and there was a general lack of good housekeeping in the service.

In some of the bedrooms and lounges curtains were damaged or hanging from their rails and cobwebs were present. Floors and surfaces were sticky to the touch and in one of the units a person had spilt their Weetabix on the floor. This had not been cleaned up and presented a slip hazard. It was evident the staff team had little time to carry out the cleaning duties required due to the complex needs of those they were supporting. A staff member told us, "Cleaning is the bottom of our agenda. We put caring for the people first. We make sure the toilets are done but everything else comes last." The recent action plan submitted by the provider and registered manager stated that the registered managers daily walk round would identify any issues and action would be taken. They also stated that an infection control champion would be appointed by the end of February 2018 and training sourced, however, we found this had not taken effect at the time of our inspection.

We were informed following our visit that the provider was actively recruiting to the position of cleaner for 15 hours a week. However, the cleanliness of the home had not improved since our last inspection in November 2017.

The service had a large garden. Each unit could access it from their own lounges. However, the pathway was uneven and in some areas the paving slabs were badly cracked making it unsafe for people with mobility issues. Also the area around the raised garden beds was narrow. This would mean people who were wheelchair users would struggle to move around the area safely. In front of one of the lounge patio doors were some old dining chairs that had clearly been there for some time as they were beginning to rot and discolour.

The patio doors in the lounge on the blue unit did not open properly. According to the registered manager it had been like this for some time. If there had been a fire in the corridor, staff would not have been able to lead people to safety from that room. No attempt had been made to ensure this was repaired. People continued to live in a dirty home which was not being cleaned properly or adequately maintained which was a risk to people and could cause harm.

The provider failed to ensure the premises was clean and properly maintained. The above evidence indicates a breach of Regulation 15(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment.

Medicines were stored in lockable cupboards in people's individual bedrooms. The staff member responsible for administering medicines held the keys to these. Temperatures of the rooms in which medicines were stored were taken and recorded. However, the thermometers used were often by the bedroom door and the cupboards on the other side of the room. This meant the temperature may not have been correct as it was not the temperature of the place where the medicines were stored. The member of staff agreed they would discuss this with the registered manager.

One person had paracetamol in their cupboard. This was not in a box and merely loose in the cupboard. It was not possible to determine this was this person's medicine and they had been prescribed it by a medical practitioner. Another person used inhalers. The dose counter was checked but not recorded so there was no record to show this was being given as prescribed.

Protocols for medicines given as and when required (PRN) had all been updated. However, these did not offer clear guidance to staff. For example, one medicine was prescribed one to two tablets up to four times a day with no more than eight in a 24 hour period. The protocol said, 1g in four divided doses in 24 hours as the maximum to be given. This was not clear and not written as prescribed. Also it was not identified if one or two tablets should be given. The protocol suggested two but the prescriber stated one or two. One person had a cream which should be applied twice a day on the affected area. This had not been signed as being administered for the previous two weeks. There was a protocol in place for this and the person in charge of medicines thought it was a PRN but this was not in line with prescribers instructions on the Medicine chart.

One person was prescribed their medicines covertly, (disguised). This was given in food. The guidance simply said in food stuff (Breakfast and pudding). Advice had been sought from the GP and the decision had been made in the person's best interest with the necessary assessments taking place. The registered manager told us they had spoken with the pharmacist and were waiting for guidance in writing as to whether there were any potential contra-indications because of the medicine being put in food. However, the medicines were still being put in food until such time as they received guidance from the pharmacist which was a risk to its efficacy if it reacted with any particular food type.

There was confusion with regard to the numbers of people being given their medicines covertly. We were originally told one person, then following a conversation with the registered manager it was identified that two people had their medicines covertly. The second person had their medicines disguised in a Rolo. We were told the registered manager was waiting for guidance in writing from the pharmacist as to whether there were any potential contra-indications. We were told that a capacity assessment would be completed as the person did not understand their medicines were disguised in the Rolo.

Liquid medicines and creams were not consistently dated when opened. This included liquid paracetamol. This is important because there is a risk that these types of medicines could be used for longer than the manufacturers recommended guide lines and their efficacy affected if used for longer than recommended.

Medicines audits had been completed weekly. This included checking for missed signatures on the medicine charts. We noted where omissions had been identified; actions to be taken had been recorded though timescales for completion had not always been included.

The above evidence indicates a breach of Regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

People who were able to speak with us told us they felt safe living at the service. One person told us, "I feel safe; they test the fire alarms every so often."

Staff members were aware of their responsibilities for keeping people safe from abuse and avoidable harm. They had received training in the safeguarding of adults and knew the process to follow if they were concerned for anyone. This included reporting their concerns to the registered manager. One staff member told us, "I would report anything straight away. [Registered manager] would deal with it."

Safeguarding systems and processes were in place however, it was evident that these had not always been followed. On 1 January 2018 an incident involving one of the people using the service had occurred and the registered manager shared the findings of their investigation with us. Whilst a safeguarding alert had been made to the local safeguarding team, their investigation did not show that actions in line with the providers safeguarding policy had been followed for the member of staff. The investigation showed that a staff member had not shared information with other staff about where a person who required one to one support was when they finished their shift. The person was at risk of putting inedible objects in their mouth which they did. This put the person at serious risk of injury. The records did not show what learning had ensued as a result of the incident. The registered manager told us that as a result of the incident, they had changed how the staff shifts changed over and where objects which presented a risk to the person were stored in communal areas. This had not been recorded so we could not be assured that the incident would not happen again. The registered manager and providers last updated action plan stated that there was a new handover sheet in place for staff, implemented on 5 January 2018, to ensure effective handover between shifts took place. However, we found this to be ineffective at preventing incidents of potential harm.

We looked at the accident and incident records completed since the last inspection and it was not evident what learning had been made as a result of any incident. We discussed this with the registered manager who told us they would amend the records to show the changes in practice made following each incident.

The risks associated with people's care and support had been assessed. Risks assessed included those associated with people's eating and drinking habits and specific health conditions such as epilepsy and Pica. Pica is an eating disorder which involves the persistent eating of substances that have no nutritional value. Where people had been identified at risk of falls, this had also been assessed and a referral to the person's GP had been made. We did note that whilst risk assessments had been produced, not all of these had been personalised to cover the individual needs of the person. Some risk assessments had the same hazards regardless of what the risk assessment was for. For example the hazards identified were, physical injury to self, other people using the service or staff and emotional distress. The control measures were also often generic and did not identify clear guidance for staff which was based on individual needs. The registered manager acknowledged this and explained this was an area they would work on to address.

At our last inspection a new staff member had a poor reference that would indicate they were not suitable to work in care. There had been no risk assessment completed to explain the rationale for their employment. We checked the staff members file during this visit. The registered manager had carried out a risk assessment to say why they had employed the member of staff and what action they were taking to monitor

them. The registered manager reported they were working well as part of the staff team. Other staff files had the appropriate checks in place including references and a Disclosure and Barring Scheme (DBS) check. A DBS check provided information as to whether someone was suitable to work at this service.

Requires Improvement

Is the service effective?

Our findings

At our last inspection carried out on 23 November 2017 we found one breach of the Regulations. Regulation 18, Staffing. We rated the service as requires improvement, staff were not suitably skilled to meet the needs of the people using the service and keep them safe.

At this inspection we found the provider had made some of the required improvements. However, further improvements were still required and we found other areas where improvements were also needed. We found one continued breach of the Regulations.

New staff members had received an induction into the service when they had first started working and an opportunity to meet with a member of the management team to discuss their progress had been provided. A new staff member explained, "I had an induction with [staff member] she showed me round and told me what to do." The staff team had received a number of training courses since our last inspection. However, some staff members had yet to receive training on specific health conditions people lived with such as epilepsy and the eating disorder Pica. This is important to make sure people receive the care and support they need to keep them safe in line with current standards and guidance.

A number of staff had received training in infection control, challenging behaviour, food hygiene, equality and diversity and nutrition and hydration. Whilst the staff team had received training in dealing with behaviour that challenged, they had yet to receive the training they needed to show them the difference between lawful and unlawful restraint. The registered manager explained that training in positive behaviour had been arranged with Leicestershire County Council and would further enhance the staff teams understanding of dealing with people's behaviours. One staff member explained, "I have done fire training and moving and handling with [registered manager]. I have done a lot of training on line, I find it quite good. I did first aid a couple of weeks ago and that was really good."

Not all of the staff had received training in first aid. This meant there was not always a trained member of staff on shift to ensure the ongoing safety of the people using the service. The registered manager explained that nine staff members had been trained in first aid and the remaining staff were booked for training on this subject on 3 April 2018. This was an area of concern identified by the local authority as needing urgent attention, as some night shifts did not have a trained first aider on shift. This posed a risk to people who were at risk of ingesting inedible objects.

Whilst it was evident that some training had been provided to the staff team, it was not clear how their competency had been checked. A staff member explained, "The training is mostly on-line. Nobody checks our understanding, they just check the score." By checking people's competency the registered manager would assure themselves that the staff had understood the training provided and be able to effectively put this into practice. The registered manager and provider's latest action plan stated that a number of staff had undergone training to administer medicines at level two and level three. Competency assessments would take place through observations of medicine rounds. However, there was no record of how or how many staff had been assessed as being confident and competent to administer medicines.

The provider failed to ensure that there were staff in place who were knowledgeable, experienced and competent to care for people. The above evidence indicates a continued breach of Regulation 18(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

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 the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found they were.

Where people were not able to make their own decisions, some mental capacity assessments had been completed. The information in the capacity assessment was detailed and considered the decision in line with the MCA. Other documents identified decisions had been made in people's best interests but no capacity assessments had been completed to evidence this was in line with MCA. This shortfall was also identified at our last visit.

These matters constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Need for Consent.

The majority of the staff team had completed training on the MCA and DoLS and those we spoke with during our visit understood its principles.

People were supported to make day to day choices whenever possible. One staff member explained, "We always give people two choices, we make sure we don't give too many options that would confuse them."

People had access to both indoor and outdoor spaces. There were spaces available for people to meet with others or to be alone. Whilst these spaces were available, not all of them including the enclosed gardens, main garden, or certain areas within the service, were well maintained and potentially posed a risk to people living at the service.

The provider's statement of purpose stated: We will do the following: 'Provide meals which constitute a wholesome, appealing and balanced diet in pleasing surroundings and at times convenient to residents.' We observed people's mealtime experiences. These did not correspond with the provider's statement of purpose or encourage healthy eating and a good balanced diet nutritionally.

Individual kitchens were available on each unit. These were fully functional and had a fridge, freezer, cooker and all equipment needed to support people to be involved with choosing and preparing their meals. Staff members explained they used to prepare meals with people in these kitchens but a cook had been introduced to prepare the main meal of the day for the whole service from a centralised kitchen. A staff member explained, "We used to try and involve people and cook what they wanted and at the times they wanted." This meant people's choice of what and when they wanted to eat was not promoted. The service was not working to current guidelines in providing people with individualised care.

The service had been rated a 3* rating by the foods standard agency in October 2017. The registered manager explained this was because each individual kitchen lacked separate handwashing facilities. These had now been installed in each of the kitchens but these were still not being used to support people with their main meals. The centralised kitchen used for cooking people's meals was functional but required updating. Food was stored correctly and there appeared to be plenty of food available for people.

The registered manager told us people had been involved in choosing the menus because staff knew them well and so knew their likes and dislikes. We found the menus to be carbohydrate heavy and did not offer people a variety of healthy options. A staff member told us, "The new menu is quite stodgy and has a lot of pastry." They went on to say, "People do like some of the food but not all. They will just leave it. We used to be able to cook what they liked." One of the people using the service was identified as obese and needed to be encouraged to follow a healthy diet. They also had high cholesterol and this should be controlled with a low fat balanced diet. The menus offered did not provide this. Therefore the food was not nutritional or suitable to maintain good health for people living at the service.

A two week menu had been developed and this provided people with six planned meals throughout the day. Staff explained the lunchtime meal was served between 12 midday and 12:30pm and the evening meal at 5.pm. They explained they still prepared people's breakfast in the individual kitchens. They added that some people did not have their breakfast until later and therefore lunch was often too early for them.

A cooked breakfast was only an option on the first Monday of the two week menu and not on any other day. We saw fish was the main meal three times in that week, Fish cakes twice and fish on the Friday. A staff member told us, "We tried to tell [provider] it was not right and we are not an older person's service. We got told we were trouble makers." One of the people using the service told us, "The food? Sometimes it can be good, sometimes it can be bad and sometimes it can be awful."

The cook was aware of who was on special diets. For example, where people needed softened diets these were provided. We did note that good practice guidance had not been followed when serving pureed meals. These meals had been pureed altogether rather than as individual items on the plate. Where people had cultural food requirements these were sometimes catered for and vegetarian options were available. The menus mainly catered for European style food with little Asian food being provided for the people from an Asian background.

At lunch time the tables in the dining room were not properly set. People were not offered condiments such as salt and pepper and serviettes were not available. One of the people using the service had their lunch in their room. The staff member placed their meal on the table without explaining what they had brought them. No interaction was heard with the person.

We looked at the records kept for people who had been assessed at risk of not getting the food and drink they needed to keep them well. Those we looked at were on the whole up to date and showed the amounts of food and drink people had taken though not all of the fluid charts had been totalled at the end of the day as recommended.

At our last visit it was evident that people's weight had not been monitored and people had lost large amounts of weight with no action being taken. At this visit we found that people's weight was monitored monthly or more frequently if required. Where there were concerns about a person losing or gaining weight, advice had been sought.

The staff team monitored people's health. People had access to healthcare services and received on-going

healthcare support. Appointments had been made for people to see their GP, an optician, a dentist and a chiropodist. We did note for one person however their regular routine appointments hadn't always been arranged. This included a three monthly appointment with their chiropodist.

The staff team knew the needs of the people they were supporting. For example a staff member spoke with the registered manager about [person] who they felt was not 'themselves'. A referral to the GP had been made and they were placed on a course of anti-biotics eventually going into hospital with a severe chest infection. The staff team made sure the person received the healthcare support they needed.

Requires Improvement

Is the service caring?

Our findings

At our last inspection carried out on 23 November 2017 we found one breach of the Regulations. Regulation 9, Person centred care. We rated the service as requires improvement; people were not treated with respect and compassion due to the levels of staff on shift. People did not receive person centred care.

At this inspection we found the provider had made some of the required improvements. However, further improvements were still needed. We found one continued breach of the Regulations.

During our visit people were not always treated with thought or consideration. One of the people using the service were showing staff members things that were important to them. This included a model of a digger and a book of trains. They regularly stood up and walked across to the staff members showing them the pictures. Rather than entering into conversation the staff member merely agreed with what they were being shown stating, "Yes it's a train." When the person pointed to the digger, rather than asking about it, the staff member stated, "Yes it's a digger." These were missed opportunities to engage in meaningful conversation and talk with the person about their interests.

In one of the units we observed a person on the floor playing with a musical instrument. Whilst there was a staff member in the lounge area, no attempt was made to interact with either them or the other people in the lounge.

People's plans of care included details about their personal preferences and their likes and dislikes. However some were more comprehensive than others. The staff team had the information they required to provide the care and support people needed.

Whilst what people liked to do had been identified there was little evidence to demonstrate people were supported to enjoy these interests. One staff member explained, "Since your [CQC] last visit we are not able to go out as much. We used to leave one staff member with more people so that we could go out with people and we can't do that now." This meant people were not enabled to follow their hobbies, or take part in meaningful activities as there were not enough staff to support people to do this. The registered manager and provider's latest action plan stated that daily activities to support social participation would take place and be planned, however, this was not evident during the inspection and from staff and peoples comments.

The provider and registered manager failed to provide care and treatment that was person centred, appropriate and met their identified preferences and needs. The above evidence indicates a continued breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

We were told the staff team were kind and caring. One person explained, "[Staff member] is my keyworker, I get on with her, she is very nice. The others are alright as well."

The staff team knew the people they were supporting well. They knew people's preferred routines and the

people who were important to them. They knew their likes and dislikes and personal preferences. This included the names people preferred to be called. However, it wasn't always evident that people's personal preferences were promoted or observed despite staff knowing people.

The staff team gave us examples of how they ensured people's privacy and dignity was respected. One support worker explained, "I always make sure the doors are closed and when I take them to the bathroom, I make sure they put their house coat on." Another told us, "I always cover them [people using the service] up to maintain their dignity."

The registered manager explained how they promoted compassion amongst the staff team. They explained they observed how staff members were with people and how people reacted to them. For example, if people appeared happy and relaxed in their company or if they appeared unhappy and uncomfortable in their company. The registered manager ensured staff knocked on doors and closed doors when personal care was taking place. They explained if they saw poor practice they would remove the staff member from the floor and speak with them and look to retrain them. If an incident occurred again they told us they would follow the disciplinary procedure. We observed staff members knocking on people's doors and asking for permission to enter during our visit.

Advocacy services were made available to people who were unable to make decisions regarding their care and support, either by themselves or with the help of a family member. This meant people had access to someone who could support them and speak up on their behalf if they needed it.

A confidentiality policy was in place and the staff team understood their responsibilities for keeping people's personal information confidential. People's personal information was stored and held in line with the provider's confidentiality policy.

People's visitors were made welcome and were free to see them as they wished. One person told us, "My family can visit me any time and they do."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection carried out on 23 November 2017 we found one breach of the Regulations. Regulation 9, Person centred care. We rated the service as requires improvement, people were not receiving care to meet their individual needs and preferences. People were not getting the care and support they required and were not able to spend their time in the way they would have liked. People were not involved in ongoing assessments of their care and support needs and were not supported to live their lives in the way they would choose at the service.

At this inspection we found the provider had made some of the required improvements. However, further improvements were still needed. We found one continued breach of the Regulations.

Plans of care had been developed when people had first moved into the service and these had been updated regularly. Some people had been involved in this and their input had been recorded in the plan. Other people's plans did not show they had been involved in developing these. The registered managers and providers latest action plan stated that people and their relatives would be involved in reviews where possible. This piece of work was ongoing and had not progressed as far as we would have liked since the last inspection. The local authority was providing a lot of support for the registered manager with regard to the plans of care following their ongoing review of people.

The dependency tool used to identify people's needs was not fit for purpose as it referred to frail elderly and elderly mentally infirm (EMI). Both terms are no longer used in adult social care and not appropriate for people with learning disabilities who were living at Orchard Court. The dependency tool did not take into account the differences in people's individual needs or any specialist care that some people may have needed.

People's plans of care varied in content with some being more comprehensive than others. They included the actions to take to meet people's needs though some information was omitted. For example, one person had consented to the use of bed rails though this information was not included in their plan of care. Another person's plan of care did not include they were at risk of choking due to them regurgitating their food even though this risk had been identified through the risk assessment process.

The provider's statement of purpose stated: 'Our aim is to provide a lifestyle for a resident which satisfies their social, cultural, religious and recreational interests and needs.' People's experiences did not reflect the provider's statement of purpose. The latest action plan submitted by the provider stated that a review and update of the Statement of Purpose and Service User Guide would take place in line with current Ownership and service delivery. This was ongoing with the local authority Quality Team. This is a concern that it has not changed since the last inspection. Many of the people living at the service have lived there for a number of years.

Whilst people's plans of care identified how they liked to spend their time and the activities they liked to do, there was little evidence to demonstrate they were supported to enjoy these. For example one person's plan

of care showed they enjoyed swimming, physical activities, water based activities, relaxation, sensory therapy and playing musical instruments. There was no structured plan for them to follow in order to regularly attend/enjoy these activities. Another person's plan of care showed they enjoyed art work, dancing, keep fit, walks and going out for meals. There were no planned activities for the person and a member of staff told us, "People here don't enjoy activities. They walk in and walk out again after two minutes." Staff did not plan ways to offer people the individual or group activities they enjoyed doing, or ways to engage them in participating in activities within the service.

One person's plan of care stated, 'To offer activities that amount to approximately 2 hours a day to promote good mental health and physical health. The monthly review carried out on 7 March 2018 stated, 'Requires a timetable to be implemented to ensure activities are conducted consistently.' There was no timetable recorded within their plan of care and the staff members spoken with confirmed there was no timetable currently in use. A staff member explained, "Activities are not planned ahead, [person] has no time table." Another told us, "We used to take people to the seaside every week but we are not able to do this anymore because of the staffing situation."

Some people's bedrooms were well decorated and reflected people's cultural needs and interests and hobbies. For example one bedroom was decorated with trains and had a train line running around the top of the room. The person whose room it was showed us the trains and was able to turn them on at a socket and watch them move round. Others however, were very bare and stark with locked cupboards and no pictures or belongings. One room in particular showed a lack of care in the way it had been decorated. The room had been painted blue and the furniture white. There was an outline of white against the wall where whoever had painted the furniture had missed and not bothered to clean it away. In another room we saw the person had been provided with a double bed but due to the way the rest of the furniture had been laid out, the person would not have been able to access their sink. Some rooms had not been decorated for a long time and were painted in very bright colours. When asked if the person had chosen the colours the staff responded, "No, it was chosen by their key worker." When asked if these were due to be decorated we were told they should be done at some point.

Each unit had their own laundry area and these were domestic in style. We were told by the registered manager that staff were to encourage people to be involved in doing their own laundry. However, a member of staff told us, "We try to get people to help out with cleaning or the laundry but they are not interested." Throughout our visit we observed little meaningful activities being provided to the people using the service or active encouragement to maintain or develop new skills.

The registered manager and provider have not considered Building the right support - and best practice guidance when providing a service to people living at Orchard Court. The above evidence indicates a continued breach of Regulation 9 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

The registered manager explained whenever possible, people's care and support needs were assessed prior to them moving into the service so their care and support needs could be identified. We looked at one person's records who had moved in the previous year and whilst information had been received from the local authority, an initial assessment had not been carried out by a member of the management team. We were told this was because the person had been admitted as an emergency placement and therefore an assessment had not been carried out. This meant staff did not have detailed information about how to support the person and meet their needs.

The majority of the plans of care had been reviewed (though not with the involvement of the person using

the service). Where changes to people's health had been identified, these had been recorded. The registered manager explained that families were being invited to the next reviews in April 2018 to support the people using the service in the review process.

The registered manager looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The service looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. For example documents such as the complaints procedure and the provider's service user guide were available in picture format. However, there was little evidence of this being expanded further for people who may have enjoyed different activities.

The provider's complaints process was displayed for people's information and this was available in picture form. We noted the process referred to the previous provider. We brought this to the registered manager's attention and this was amended during our visit to show the correct details of the current provider.

When people were at the end of their life the registered manager involved the community nurse to ensure medicines were in place to minimise pain. Staff had completed distance learning courses on end of life and people using the service were supported to help them understand the loss. The registered manager told us this was an area they were working to develop to ensure they understood people's wishes at the end of their life.

Inadequate

Is the service well-led?

Our findings

At our last inspection carried out on 23 November 2017 we found two breaches of the Regulations. Regulation 17, Good governance and Regulation 18 of the Registrations Regulations 2009. Notification of other incidents. We rated the service as Inadequate. The provider had failed to inform CQC of safeguarding incidents that occurred at the service. There was no adequate management oversight to ensure the safe running of the service and ensure that people were adequately protected from the risk of harm. The systems and processes in place did not enable people to receive a quality service and resulted in a number of concerns being raised.

At this inspection we found the provider had made limited required improvements though these had not been sustained and further improvements were still needed. We found one continued breach of the Regulations.

At our last inspection we identified systems were not effective which led to people being put at risk of not being safe. Whilst systems had now been put in place to assess, monitor and improve the quality of the service, these had been ineffective in ensuring compliance with the regulations. Health and safety audits had been completed but these had failed to recognise and resolve the issues identified during our inspection. These included the concerns raised regarding the condition of the garden areas and the general decoration within the service.

The premises had not been maintained and on-going hot water issues, including the lack of available hot water, which had been identified at our last inspection were still a concern and had not been addressed. This was raised as being a high concern at the last inspection due to the cold weather and continued to expose people to risk due to the on-going cold weather and recent snow.

The provider had failed to safeguard the people using the service from the risk of organisational abuse because of how the service was run. The provider had not taken into account the needs of the people using the service and had not worked in line with best practice regarding individualised support for people with a learning disability. This put people at risk of abusive practices by the provider. This was not recognised and measures were not in place to reduce the likelihood of this happening. Building the right support - and best practice guidance had not been considered when providing a service to the people living at the Orchard Court.

The provider had taken away the opportunity to provide individual care and support. Changes to how people were supported with their meals meant the staff team were no longer able to support people in an individual way or in a way they preferred. Mealtimes, particularly the main meal of the day, were not provided in line with best practice and was viewed as institutional in nature. The meals provided did not offer any choices to people and were at a set time. This was more in line with an elderly residential setting rather than for people with a learning disability. Documentation used to identify how many staff were needed was based on out-dated assessments of an entirely different group of people and was not designed to assess the support people who lived at Orchard Court needed.

The deployment of staff was ineffective. This meant the people using the service did not get the care and support they needed at the time they needed it or the opportunity to enjoy meaningful activities that were important to them. The staff team were expected to complete additional tasks such as cleaning which diverted their time away from supporting people using the service.

Staff still had limited ways to communicate with each other between the units. One member of staff was designated to float between the units, however was predominantly in one unit. A member of staff told us, "I would shout someone from another unit if I needed help." There had been no risk assessment carried out in relation to this. There were people in each unit who needed two staff to help them with moving or personal care. The staffing levels and lack of communication between units put people and staff at risk at night time when there was reduced staff available.

At our last inspection the provider was not able to tell us how many hours one to one and two to one support each person was assessed as needing. At this inspection the registered manager showed us how many hours support each person was having. However, they had not assessed people's needs to show when they would need additional staff support and then deployed the correct numbers of staff to meet the needs of each person. Staffing levels were three staff per unit and a floating member of staff. This did not take into account people's preferences for when they would want to participate in activities, or have their personal care. This meant the provider was not able to show people received the additional hours they were assessed as needing, and these were only offered to people when they could be fitted in with everyone else's hours.

Procedures had not been followed when a safeguarding concern had been identified. This included not following proper investigatory processes to ensure the ongoing safety of the people using the service.

Not all of the staff members we spoke with felt supported by the management team. One explained, "You can't fault [registered manager] he is kind. When we try to talk about things he tries to help but the provider does nothing." They added, "[Registered manager] tries to talk to him [provider] but he doesn't listen." Another told us, "You can't raise a concern with the provider he doesn't listen to you. We have complained about the hot water but we have to wait for it to warm up so we can't take people out." Staff appeared demotivated and were not engaging with people using the service. Staff continued to lack confidence in the provider and how the service was being run.

Regular staff meetings had been held. Whilst the staff team told us they were able to share any issues or concern's regarding the service, they felt they were not always listened too. One staff member told us, "We have staff meetings, no longer than four weeks apart. They ask if there are any problems or any concerns you want to bring up. We sometimes feel listened to but not all the time."

The minutes of a staff meeting held on 9 February 2018 recorded the staff team sharing their concern with regards to the size of the dining room and the need for a cook at the weekends, not just Sundays. The minutes from another staff meeting held on 19 February 2018 recorded that the staff team had raised concerns regarding the choices and quality of meals available to people and they wanted to be able to cook individually with people. No actions had been taken regarding these concerns.

Throughout the report we have identified areas where the registered manager and providers updated action plan sent to us has not actioned all the areas as quickly or effectively as we would have hoped. Whilst they are providing us with the information it is clear that the actions taking place are not enabling the provider to meet the regulations.

The above evidence indicates a continued breach of Regulation 17 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014. Good governance.

There was a registered manager in place. 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.

The registered manager was now aware of and understood their legal responsibility for notifying CQC of deaths, incidents and injuries that occurred for people using the service. This was important because it meant we were kept informed and we could check whether the appropriate action had been taken in response to these events.

There was a statement of purpose but this was out of date. The registered manager attempted to update this during our visit. However, it still failed to reflect the type of service expected or the service people wanted. We noted this document did not reflect the aspirations of the people using the service. It was very generic and not individual to the service or appropriate for people living with a learning disability.

Policies and procedures were in place. The policies we reviewed referenced the previous provider and made reference to the Commissions predecessor organisation and so was out of date. These had not been updated or reviewed since our last inspection in November 2017 and had been in place since the provider registered with us in February 2017.

The registered manager had failed to follow the provider's disciplinary process when a safeguarding incident had occurred. On 1 January 2018, a person using the service had been placed at risk of harm. The registered manager had not suspended the staff member involved pending their investigation and no evidence was seen of any disciplinary action being taken, despite the investigation clearly showing the staff member had put the person at risk of avoidable harm.

The registered manager had carried out relative surveys since our last inspection. All of the surveys returned had included positive comments and showed satisfaction with the service their relative received. Surveys had not been used to gather the views of either the people using the service, the staff team or professionals involved with the service.

The registered manager worked positively with the local authority and their quality team. However, they had not made sufficient improvements to the service despite the support being provided to them at times on a daily basis.

The registered manager was aware of their responsibility to have on display the rating from their last inspection. We saw the rating was clearly displayed within the service. The provider is required to display their latest CQC inspection rating so that people, visitors and those seeking information about the service can be informed of our judgments.