Fordent Properties Limited

Orchard Manor Care Home

Inspection report

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20 April 2018

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an inspection of Orchard Manor on the 16, 18 and 20 April 2018. The first and second days were unannounced and on the third day, the registered provider was aware of our intention to visit.

Orchard a Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Orchard Manor accommodates 93 people in one building which is divided into two distinct units: Maple and Willow. At the time of our visit, 85 people were living at Orchard Manor.

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 registered manager was present during the days of our visit.

We previously carried out an unannounced comprehensive inspection of this service on 12 June 2017. At that inspection we rated the service as requires improvement as a track record of a sustained quality of care was required at that time. No breaches in regulations were identified at our last visit.

Initially we found that the premises were not always safe. A cleaner's cupboard containing chemicals, a sluice room and rooms used for storing equipment were not locked. Staff were observed entering these rooms and then leaving them unsecured. This could potentially pose a risk to people who used the service. Subsequent evidence was provided to us by the registered provider outlining the action taken to ensure people were not at risk of harm.

In addition to this, we found initially that information was not always stored securely. This related to the security of personal, sensitive information relating to people who used the service. Cupboards containing sensitive information located in one communal area were not locked. In addition to this, some confidential information had been left on a desktop. Evidence given to us subsequently by the registered provider outlining the action to ensure that all personal information was kept secure.

Prior to our visit, we received complaints about the service which would suggest that people did not receive positive outcomes. We did not see any evidence during this visit to confirm the concerns raised in the complaints. We referred the complaints to safeguarding prior to our visit and the outcome of the investigations was not available at the time of writing this report.

We observed that the was a delay in serving some people their meals and also an instance where a member of staff feeding a resident had to leave few times without explanation to attend to other tasks in the dining

room. This was not a reflection on staffing levels which were maintained to reflect the needs of people who used the service. The registered provider subsequently made arrangements to ensure that mealtimes were enjoyable for all.

People told us that they felt safe and that there was always staff around to attend to their needs. They also told us that they received their medicines when required.

Staff were aware of safeguarding procedures and how to raise concerns. They had received training in this and outlined the types of abuse that could occur. Responses to taking action in the event of safeguarding concerns were not consistent and could compromise any police investigations.

Equipment and other systems in the building were regularly serviced to ensure that they were safe for people to use. The decoration of some areas was beginning to experience wear and tear and the registered provider was aware of this. The premises were clean and hygienic.

New staff coming to work at Orchard Manor were recruited robustly with checks carried out to ensure that they were suitable to work with vulnerable adults.

Risk assessments were in place outlining the hazards faced by people from the environment, risks faced in the support they received as well as risks faced by malnutrition or pressure ulcers, for example. Emergency plans to aid the safe evacuation of people in an emergency were in place and reviewed regularly.

Medicines were robustly managed. Audits were in place to ensure that stocks never ran out and that people received the medicines they required. Staff had received training in medication administration. Medication was given to people in a supportive manner. Consideration had been given to enabling some people to partially self-administer their medication as an aid to encouraging independence.

The registered manager had measures in place to look at lessons learned. This was done in response to specific incidents within the service and whether these could have been responded to in a different and more effective manner.

Staff received the training they required to meet the needs of people. This related to mandatory health and safety topics as well as training in dementia care and safeguarding. Nursing staff were provided with training in clinical issues such as catheter care and tissue viability. Staff received supervision to support them in their role.

The registered provider worked within the principles of the Mental Capacity Act 2005. Applications had been made to the local authority identifying those people who required safeguards to partially deprive them of their liberty in line with their best interests and safety. There was evidence that people's capacity had been assessed and that a best interests process had been followed to ensure that staff practice was mindful of people's limitations.

The health needs of people were promoted with health professionals being routinely involved in dealing with health issues as well as routine health checks.

The registered provider had sought to plan the environment in such a way that orientated people so that they could find their way around. Whilst steps had been taken to orientate people within the building, we recommend that the registered provider refers to good practice guidance to ensure that the environment is fully dementia friendly. The inclusion of staff workstations and desks in communal lounges and dining

rooms potentially intruded on people's personal space, howver, subsequent steps had been taken to ensure that workstations had been located elsewhere and did not impact on communal space.

Staff adopted a caring approach when supporting people. Their approach was kind, friendly and informative. When people were distressed; staff adopted a patient and reassuring approach to assist people. Staff described how they would promote the privacy and dignity of people in their care practice. We observed this being adhered to.

The communication needs of people were taken into account. Effective arrangements to communicate with people with sensory limitations were in place. Advocacy was supported within the service with information signposting to local advocacy services available.

Information in relation to activities was incoherent and not necessarily accessible to those who used the service. Two activities coordinators were employed by the registered provider. No specific activities were observed during our visit although evidence was provided to us subsequently to confirm that activities had taken place. Activities coordinators had an extended role in assisting at lunchtime.

Assessments for those coming to live at Orchard Manor covered all their main needs. Care plans were person centred indicating people's personal preferences. Social care plans were in place.

A complaints procedure was in place. Compliments were displayed in the communal areas.

A range of audits were carried out by the registered provider to check on the quality of the service provided. These included walkarounds undertaken by senior staff. These had not always been effective given that, for example, inconsistencies in the mealtime experience and issues with the safety of the building had not always been identified.

People connected with the service such as health professionals, people who used the service and their families were given the opportunity to comment on the quality of support provided.

Staff commented that the registered manager was supportive and approachable and understood the needs of people. The registered manager was aware of their responsibilities as a registered person. This extended to notifying CQC of specific incidents and displaying the current CQC rating.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Some areas of the home that posed a risk to people were not always kept secure. Subsequent evidence was provided to confirm this had been addressed.

Medication management was robust.

Equipment used at the service was well maintained.

New staff were appropriately recruited.

Is the service effective?

Good

The service was effective.

The dining experience for people was not consistent. Remedial action was taken to address this.

Staff received training and supervision appropriate to their role.

The registered provider operated within the principles of the Mental Capacity Act.

Is the service caring?

Good

The service was caring.

Confidential and personal information was not securely stored. Subsequent action was taken to ensure this was addressed.

Information about activities was not always accessible to the people who used the service.

Staff adopted a patient and kind approach to the people they supported.

Is the service responsive?

Good

The service was responsive

Care plans were person centred.

An effective process was in place for dealing with complaints

People's individuality was promoted.

Is the service well-led?

Good

The service was well- led.

Risks to people's safety in the environment had not identified. Subsequent action was taken to address this.

Confidential information had not been kept secure. Subsequent action was taken to address this.

A wide range of audits were available to measure the quality of support.

Stakeholders such as people and their families had their views sought.

Orchard Manor Care Home

Detailed findings

Background to this inspection

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

The inspection was carried out to assess if any improvements following our last inspection in June 2017 had been made.

This inspection took place on the 16th, 18th and 20th April 2018. The first two days were unannounced with the registered provider aware that we would visit on the last date. The inspection team consisted of one Adult Social Care Inspector and an Assistant Inspector who attended on the 16th April 2018.

Before our visit, we reviewed all the information we had in relation to the service. This included notifications, comments, concerns and safeguarding information. Our visit involved looking at ten care plans, training records, policies and procedures, medication systems and various audits relating to the quality of the service. We also observed care practice within the service. In addition to this we spoke to six people who used the service and three relatives. We also spoke to the registered manager, registered provider and six members of staff. We also observed care practice and general interactions between the people who used the service and the staff team.

We spoke to the local authority contracting team and safeguarding team to gather information they had on the performance of the registered provider. No recent visit had been undertaken by the Local Authority contracting team yet a visit from them was imminent.

A Healthwatch visit had been conducted in October 2017 Healthwatch is an independent consumer champion created to gather and represent the views of the public. Their visit concluded that good levels of care were being provided at the service.

Good

Is the service safe?

Our findings

Our tour of the premises initially found that they were not always safe, as there appeared to be an inconsistent approach to maintaining a safe environment. Some unused bathrooms were used to store items such as hoists and walking frames, and a sluice room had not been locked. These could easily be accessed by people who used the service. We saw staff leaving one sluice room without locking it.

We found that a cleaners' cupboard on the first floor, which contained chemical products, was left unlocked. We alerted the registered manager to this straight away, as it posed a risk to people's safety. Remedial action was taken to ensure that the lock was replaced and reduced the risk of harm.

Another room had a notice displayed on the door for 'staff only'. This was left unlocked and contained items such as equipment that potentially could be a risk to people who used the service.

The registered provider provided evidence subsequent to our visit which outlined the action that had been taken to minimise the risk to people and to promote good practice within the staff team. Some remedial work in respect of the replacing of door locks had been completed during our visit.

The service had been the subject of an infection control visit. This was generally positive although did indicate that some improvements were needed to the décor of the building. The registered provider employed domestic staff who were seen cleaning the building during our visit. Relatives told us that the premises were always clean and odour free. No offensive odours were noted in the building.

There were sufficient stocks of personal protective equipment (known as PPE) such as disposal gloves and aprons available for staff to use. There were hand sanitisers located throughout of the building. The kitchen had been awarded a five star rating for cleanliness. We were asked to wear protective clothing and wash our hands before we entered the kitchen.

There had been an outbreak of influenza within the building in the weeks leading up to our visit. The registered manager had notified us of this. The outbreak had resulted in the service being closed to visitors and new admissions. We saw evidence of reflective practice being used to assess what lessons had been learned and how the service could have responded differently. Local health groups had commended the service on their handling of the outbreak.

The decoration of the building was generally in good repair although some unused bathroom/shower areas were in need of attention, especially to ceiling tiles and floors. Some work was also needed in corridor areas which showed signs of wear and tear. Some door frames and walls had been hit by wheelchairs or hoists resulting in the need for some repainting to these areas. This had been identified in the recent infection control inspection. A programme of redecoration was planned for the future.

Hoists and other equipment had been serviced to the required frequency. This also extended to portable electrical appliances. Firefighting and fire detection equipment such as fire extinguishers and fire alarms had

been tested to ensure that they would operate in case of emergency. The building had also been risk assessed to prevent the spread of fire and had had water systems tested for legionella.

People who used the service and relatives told us "There are always staff round and about", "I can always find someone if I need them" and "Staff are very good. If it was not for them, I would not be happy here. Because of them, I am as happy here as I would be anywhere." Observations noted that staff were available to attend to the needs of people. Call alarms and other motion sensors were responded to in a timely manner. A staffing rota was in place. This outlined the staffing levels required to best support people and meet their needs. Many people who used the service required one to one support from staff and certain times of the days. These levels were maintained. In some instances agency staff had to be used to supplement the staff team. Agency staff were mainly used for supporting people on a one to one basis but it was reported that this was diminishing gradually. The registered manager told us that the same staff were utilised to ensure continuity of care. The registered manager told us that staff retention was good and that they were continuing to recruit new staff to work at Orchard Manor.

Risk assessments were in place and were regularly updated. These outlined general risks that people could face from the environment as well as risks staff needed to be mindful of during support with personal care. Additional risk assessments were in place in respect of nutrition, the likelihood of falls and the risks associated with developing pressure ulcers. Nutrition risk assessments (known as MUST scores) identified the risks of people becoming malnourished and detailed action such as weighing people more frequently or referring them to a dietician. We saw evidence of the involvement of dieticians with supplements being provided to ensure that people's nutrition was promoted. Where people were identified as being at risk of choking, risk assessments detailed the thickeners that could be used with food and drink to ensure that the risk of choking was minimised. Information was available to staff in kitchen and dining areas outlining what was the most appropriate consistency of thickener to be used, how this consistency could be achieved and the people that required this as part of being assisted with eating and drinking.
Personal evacuation plans had been devised for all people who used the service. These are known as PEEPS, and these provided staff with detailed information on how individuals could be evacuated in the event of an emergency. These included the physical support that people would require in such an event but also how staff could provide information and reassure people at what could be potentially a distressing time. All PEEPS were up to date and had been reviewed regularly.

People told us, "I always get my medicines and I get them on time". We observed medicines being administered by nursing staff who wore tabards and requested that they were not disturbed during this task. Medicines were administered in a personalised manner with explanations being given to each person as to what the medicines were for. Medication administration records had been signed appropriately each time medicines were administered. Records indicated that people with a diagnosis of diabetes had their blood sugar levels monitored regularly. Where prescribed creams were required records included a body map indicating where these creams needed to be applied. Staff responsible for medication administration told us that they had received training in this and that their competency had been checked on a regular basis. We noted where appropriate people had the opportunity to self-administer their medication. This was accompanied by a relevant risk assessment to ensure that this could safely be achieved. Where people had been identified as requiring their medicines to be administered covertly, this was only done once there had been a process of accountability to ensure that this was in their best interests where they lacked capacity.

Controlled medication was stored appropriately with a register maintained to ensure that stock levels were correct. Controlled medicines are those drugs which are subject to controls by law. An effective auditing system was in place to ensure that medication stock levels, ordering, administration and disposal of medicines were managed appropriately. The medication management of the service had been assessed by

the clinical commissioning support team in August 2017 on one unit and was found to be satisfactory with no concerns.

Staff were able to outline the types of abuse that could potentially occur. Not all staff demonstrated a thorough knowledge of the action they would take and some responses indicated that if an allegation of abuse occurred; action by staff may compromise any subsequent police investigation. We fed this back to the registered manager who told is they would address this. Staff were aware of how to report any allegation of abuse and were confident that the management team would take action in response to their concerns. Policies and procedures were in place for reporting allegations of abuse. The registered manager reported to the Local Authority safeguarding team any 'low level' incidents that had happened. These are incidents that do not meet the threshold of significant abuse.

Staff were aware of how to raise concerns about the registered provider. They understood whistleblowing and were aware of the agencies they could report any concerns to. People told us "I feel safe living here" and relatives told us that they had no concerns about the safety of their relations; "staff are very kind and my relation is well looked after"

The service recorded any adverse incidents or accidents that occurred. The patterns of these were analysed to ensure that future reoccurrence was minimised. Where applicable, pressure mats and motion sensors had been introduced into people's rooms were it was assessed that they were at high risk of falls. Patterns had identified, for example, that there was a high prevalence of falls in the evening. Action has been taken to minimise this where possible through staff supervision and assistive technology.

We found that staff had completed an application form before their interview. Applicants had provided at least one professional reference, which they received from their last employer. The home had carried out a Disclosure and Barring Service (DBS) check before new staff started working at the home, regardless of their role. The DBS checks applicants' records, including criminal and barring registers. The checks helped to protect people using the service and support employers to make safer recruitment decisions. Information confirming people's identity had also been provided.

Good

Is the service effective?

Our findings

People told us "I like breakfast when I get it. I am always ready for lunch." And "The food is very good. There is a good assortment. The meat is tender". We observed lunchtime in each of the two dining rooms. We found that the experience of people who used the service in one dining room area was better than in the other. We found that overall people's mealtime experience in the Orchard Café appeared calm and relaxed and it was well staffed. A senior carer and the unit manager were present to oversee lunch there, but actively helping people at the same time.

The unit manager kept an oversight of the lunchtime meal and noticed where people were not eating their food in a timely manner. Once pointed out, staff offered an alternative meal and helped people to eat in a supportive manner. This meant that people did not have plates of untouched food sitting in front of them.

An overview of people's dietary needs was kept in the kitchen next to Orchard Café. Staff knew people's special dietary needs without checking the list. We found that a person with a special dietary need kept checking the menu to see that their choice was recorded on there. An observation at our last visit noted that this area had been crowded with many people remaining in wheelchairs and as a result making it difficult for them to get close to the table and eat their meal. This had now improved.

However, in the Maple dining room, we observed that some people had to wait for their meals for 30 minutes. During this time, other people in this area had been served and were eating their meals while others had had to wait longer. One person was being assisted to eat. The member of staff sat with the person appropriately at their level. However on several occasions, the member of staff kept leaving the person to attend to other tasks in the dining room and did not offer an explanation to the person as to why they had to leave them for a short time. This meant that the mealtime experience was disjointed for this person and that they had not been offered an explanation as to why this was the case. In contrast to this in the same dining room, there were examples of good practice to ensure that people got the meals they wanted. We observed two people stating that they did not want what was on the menu. In both cases, staff suggested alternatives to each person and when they agreed to this, this was specially prepared for them. The registered provider subsequently provided us with evidence outlining the action they would take to make the mealtime experience more consistent and enjoyable for everyone within the dining room in Maple Unit. This included using best practice observed in the Orchard Café to be extended to Maple. This included ensuring people were offered meals at the same time and that people who were supported with eating were appropriately supported.

Care plans outlined the nutritional needs of people. The likes and dislikes of people were also recorded. Care plans provided a clear indication of those who required supplements to aid nutrition and those who required thickeners to their drinks to ease swallowing. Clear information was provided to staff on what consistency to mix thickeners to and those people who needed them. This information was discreetly placed in dining areas for staff to refer to.

People's weights were monitored in line with recommendations leading from their nutritional risk assessment. Any weight loss was identified and appropriately referral to a dietician made.

The kitchen was a clean and well equipped facility. Information on people's nutrition and likes and dislikes in relation to food was available. There were sufficient stocks of food available within refrigerators, freezers and dry stores. The kitchen had received a five star rating following the most recent food hygiene inspection.

We looked at the design of the premises. We asked the registered manager what she thought was the biggest area with needs for improvement. The registered manager told us the environment could be better and outlined action taken to address this subsequent to our visits. We found that the environment would benefit from further improvements. Corridors were quite dark and we found that most handrails were not in contrast to the wall. The registered manager told us subsequently that steps had been taken to assess the lighting within areas of the building. Contrast in colours of handrails can help people living with dementia to see them more easily.
While the registered provider had taken steps to better orientate people, we recommend that good practice guidance be used to assess the effectiveness of the wider environment to meet the needs of people living with dementia.

We saw that staff work stations had been placed in lounge and dining room areas. These consisted of a desk, cupboards, computer and in some cases a printer. These potentially detracted from the primary purpose of these rooms which was to offer a homely living space to individuals. The registered provider subsequently provided evidence that these had been removed from communal areas.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff confirmed that they had received training in the Mental Capacity Act and were able to provide an overview on how this impacted on the daily lives of people. There was evidence that where applicable, deprivation of liberty safeguards had been applied for. Once granted, these remained current with a clear date of expiry in place. Care plans included evidence of best interests decisions which had been included in deprivation of liberty orders. These related to restrictions; for example in people leaving the building, the use of covert medication and the use of motion sensors to assist in supervising people.

The service sought to respond quickly to those instances where people had health problems. All people living at Orchard Manor were registered with a GP. There was evidence of routine health checks made as well as those appointments made in response to an ongoing health condition. Other agencies such as opticians and chiropodists were also involved in people's care

A training matrix was available enabling the registered manager to oversee what training had been undertaken and when refresher training was due. Staff were able to outline the training they had received. This included mandatory health and safety topics as well as safeguarding training, Mental Capacity Act awareness and dementia awareness. Registered Nurses had received training which had involved clinical

issues such as medicines management, phlebotomy, catheter care and tissue viability. Staff told us that they considered the training they received to enable them to carry out their role. Staff received supervision. This involved one to one meetings with their line manager.

Once recruited, staff underwent a structured induction process. The care certificate was used as a basis for induction. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. This included health and safety training and safeguarding. Staff shadowed care staff for a period of time until such time as they were considered competent to perform their role.

Good

Is the service caring?

Our findings

People told us that they felt "Cared for" and felt "happy with the staff". They told us that staff "Went the extra mile" and relatives commented that "They took my needs into account as well" and "[Staff] were very sensitive to my relations needs at all times".

Records used by the staff team were stored in lounge and other dining areas. These contained confidential information about people who used the service. We found that cupboards which stored personal and private information were not locked and in one lounge area, confidential information had been left unattended. This undermined the security of those records being kept and that sensitive information could be accessed by anyone entering that area. The registered provider subsequently presented evidence to us that all sensitive documents containing personal information had been relocated into a designated locked room which could be accessed by the staff team when needed.

Two complaints were received by CQC prior to this inspection. These outlined experiences that were not positive for the people concerned. They stated that there had been a lack of attention paid to the needs of two separate people and that the staff team had not provided a positive outcome for them.

While our observations showed people were treated in a kind and considerate manner during our visit; complaints received by us prior to our visit indicated that this had not been the consistent experience for everyone who had previously used the service. We did not find any evidence of this during our visit.

We saw that staff interactions with people who were distressed were positive and reassuring. We observed interventions needed in one instance. The staff spent a long time with the person and interacted with them in a quiet, kind and patient manner. The staff team sought to identify positive steps they could take to ease the person's distress and after time this was successful. During lunch, some people who lived at the service began to raise their voice towards each other. Staff responded in a calm manner to resolve this. We observed caring and compassionate interactions between staff and people who used the service. This extended to the manner in which staff spoke with family members who had been recently bereaved. Staff spoke with kindness and warmth.

Information was available about the service to people. This included meals provided, for example. Other information included a summary of people's needs with appropriate symbols to assist in their understanding. This information was kept confidential within people's own bedrooms.

An activities board was on display; however, this was located in an area where few people who used the service accessed. In addition to this, the board used symbols which did not clearly indicate what activities were on display. This had been identified during a recent manager walk around. A calendar was on display in one lounge unit but was designed more for young children and was not age appropriate. The time, date and weather were put on display on notice boards near lounge areas.

We looked at how the registered provider recognised the communication needs of people so that effective

interactions between people and staff could occur. For example, those who were registered as deaf had appropriate methods of communication were in place. One person was able to lip read and both they and staff wrote notes down to enable effective communication. This was documented within the persons care plan. Another person who did not use English as their first language was still able to communicate their needs verbally. Their cultural history and their journey coming to live in England had also been reflected in their care plan.

Care plans included people's preferred terms of address. A notice had been made available to staff in respect of one person who preferred their name to be used in full and not shortened. This was in response to comments made by the person.

Two people received the support of advocates. An advocate is a person who supports individuals to have their views and wishes considered when decisions are being made about their lives. These individuals visited regularly. Information was available on other advocacy services for people to refer to if required.

The privacy of people was upheld. Staff knocked on bedroom doors before being invited to enter and people were treated in a dignified manner. Staff gave us practical examples of how they promoted the privacy of people who used the service. Those who were being supported with personal care had bedroom and bathroom doors closed while this took place.

People were encouraged to be as independent as possible. People were able to mobilise through the building either independently or by using aids such as walking frames. Other people had been assessed as being able to partly self-administer their medication and this had been encouraged by the staff team. People were also encouraged to become involved in a 'residents committee'. This group met on a regular basis to discuss aspects of the service.

Compliments such as cards and letter were on display for people to see. Recent comments had included "[Staff] are very kind", "I am grateful for the staff's caring approach".

Good

Is the service responsive?

Our findings

No one we spoke with commented specifically on the responsiveness of the service to their needs or the needs of their relation. One person did say that "Everything is great" and a relative stated that "Staff responded really well to her needs and the family's when my relation passed away". We used observations of care practice to assess the experiences of people. One person complained about feeling cold at lunchtime. Staff took immediate steps to get them one of their cardigans and the person was happy with this. Staff responded in a timely fashion to when call alarms were activated. The response time to call alarms had been audited by the registered manager.

The registered provider employed two activities co-ordinators who were present during our visit. An activities board was available but was not located in the reception area away from lounges. In addition to this, the activities board contained symbols and it was not clear what activities were on offer. During our visits we did not see any activities taking place although did hear discussions offering a manicure session that was to take place during the first day of our visit. Subsequent evidence was provided confirming that activities had taken place on the days of our visits.

Activity co-ordinators had an extended role. They were involved in ensuring that menus were up to date and were involved in assisting at lunch time. One activities co-ordinator told us that they had been compiling memory frames and still had many to assemble. The memory frames once completed were placed outside of people's bedrooms and contained pictures and symbols referring to people's social history such as their place of origin, their part employment and other interests they had. The co-ordinator stated that they had had a backlog in ensuring that all of these were complete. We confirmed the accuracy of them through discussions with one person.

Once completed, the memory frames acted as a point of reference for staff to appreciate the social history of each person. The memory frames that had been completed evidenced that the individuality of people had be taken into account. Residential areas displayed photographs of past activities. These included St Patrick Day and Halloween celebrations as well as pet therapy days. It was not clear how recent the photographs were.

People were given choice. This either related to where they wished to sit or what meals they wanted to have. This was done verbally by the staff team and they always ensured that the wishes of people were respected.

Assessment information was in place. This include documents from local authorities as well as the registered providers own assessment. The registered provider's system included a general overview of the medical and social needs of each person. This was then translated into a plan of care. All assessments were undertaken by the registered manager which enabled them to make a decision on whether needs could be met by the service.

Care plans were electronically stored. Staff accessed this information via a computer which in turn was password protected. All staff told us that they were happy with the system and could access it easily. Care

plans were person centred and included the personal preferences of each person. These had been reviewed on a regular basis. On occasions, for example, where a health condition arose; a short term care plan was introduced with a view to aiding support during that time.

Care plans included details of maintaining a safe environment, susceptibility to falling, medical history and social history. A document relating to life history had been completed but not in all cases. Other areas of care plans covered issues relating to the daily lives and routines of people. Summaries of care plans were also available in bedrooms. Summaries covered the main ways in which people should be supported. One care plan did contain a discrepancy within it. This related to a person's behaviour and advised that de-escalation techniques be used but did not give any further detail. The previous care plan did offer staff more instructions on how to manage such situations.

The service supported some people who required a pressure relieving mattress to ensure that their skin integrity was maintained. We checked pressure mattresses to see if these were kept at the required pressure as outlined in care plans. These were found to be accurate in all cases.

Care plans were accompanied by daily records. These were appropriately recorded. Daily handover sheets were provided to care staff which recorded information about key issues that had arisen during different shifts and considerations that they needed to make while supporting people. Staff had access to computers in order to log into care plans.

The end of life wishes for people were recorded. These included do not attempt resuscitation forms as well as their preferred wishes after their death. One relative told us that their relation had recently passed away and was able to give a very positive account of how the person had been treated in a dignified manner and how the needs of the family had been fully taken into account by the staff team. Training had been provided to staff in end of life care.

A complaints procedure was available. This outlined the registered provider's timescale for investigation. Two complaints had been received by the service and there was evidence that these had been investigated and responded to. CQC has also received a complaint from a relative and they were directed to follow the registered provider's complaints procedure. We asked the registered manager for an update in respect of this complaint. They were aware of the concerns and were awaiting more information from the complainant.

We saw potential complaints being dealt with in a proactive manner. At lunchtime in one dining room, one person with a special diet complained about their meal being unappetising. Staff responded by offering an alternative straight away to the satisfaction of the person. The same issue arose in the other dining room and staff were quick to respond once again.

Good

Is the service well-led?

Our findings

One person we spoke to was not aware who the registered manager was. Others were aware of the registered manager and said "We have no concerns about how the service is run". Relatives told us "The service is well run" and "I know who the manager is and I think they are doing a good job".

A registered manager was employed by the registered provider. 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 present during our visit.

The registered manager and other senior members of staff conducted walk around visits. These consisted of a tour around the building identifying those areas of good practice as well as those areas requiring improvement. A recent walk around visit had identified that the activities board needed to be clearer but this had not yet been actioned. The issues we identified on this visit such as confidential information being unsecure and unlocked sluice rooms and the mealtime experience in one dining room. These have now been addressed.

The registered provider had a series of audits in place. These were designed to ensure the quality of the service provided. An infection control audit had been recently undertaken and while a high percentage had been achieved, required improvements in decoration had been identified. An audit was in place focussing on the standards within the environment. Other audits focussed on medication systems, care plan reviews and ensuring the correct pressure setting on mattresses designed to prevent pressure ulcers. The registered manager was aware of any weight loss experienced by people and a process was in place to ensure that they were referred to appropriate agencies such as dieticians. Checks were also made on recruitment files and whether deprivation of liberty safeguards were within date and current.

Further comments on the quality of support provided by the service were made through visits by the area manager. The nominated individual for the service also visited regularly and was present during the first day of our visit. Their visits consisted of touring the premises, observing care practice and gaining the views of people who lived at Orchard Manor. This enabled the registered provider to gain a first-hand account of people's experiences of their care.

A newsletter had been introduced. This gave families and people who lived at Orchard Manor the opportunity to keep up with any developments within the home, for example, staff promotions, information in respect of changing door codes and other items.

The registered manager had sought to adopt a transparent approach to reviewing events that had an impact on service delivery and how these could be improved on in future. Reflective practice was available in respect of two events. One related to pressure care a person had received and a full report had been submitted to the local clinical commissioning group and also a recent influenza outbreak. The registered

manager analysed both events to see if anything else could have been done better to deal with both situations. This was positive practice.

Staff told us that they considered the registered manager to be supportive and approachable. They commented that their roles had been evaluated and in some cases additional responsibilities had been given to enhance their expertise. This included the areas of additional responsibility such as medication. One staff member told us that they were about to start this additional role and were pleased with it. Another registered nurse told us that they had been asked to develop links with external tissue viability nurses in response to ensuring that pressure ulcer care within the service was responsive to people's needs. We saw that the manager had written a 'Letter of Recognition' to one member of staff to acknowledge their good performance and compliments they had received.

People who used the service were involved in influencing the running of the service. Residents meetings took place as well as family meetings with the registered manager. These gave the opportunity for issues within the service to be discussed. In addition to this, surveys had been sent out to all stakeholders. The results of these were located in the reception area. There was also evidence that were any comments had been made; actions had taken place in response to these.

The registered manager explained to us that they had worked on different formats for 'resident questionnaires'. This was to take the needs of people with cognitive impairment into account as current symbols did not seem to be appropriate to their needs at present.

All registered providers are now by law, required to display the ratings from their last CQC inspection. This includes information on display within the building as well as on the registered provider's website if applicable. The rating was on prominent display within the reception area.

The registered manager was aware of their responsibilities to notify CQC of those events that adversely affected the wellbeing of people. Our records indicated that this was done when appropriate.