Sutton Nursing Homes Limited

Orchard House Nursing Home

Inspection report

35 Hallmead Road
Sutton
Surrey
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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

Orchard House Nursing Home 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 House Nursing Home accommodates up to 44 people in one adapted building. The service specialises in providing end of life care. At the time of our inspection 35 people were using the service.

At our last comprehensive inspection on 30 January and 2 February 2017 we rated the service 'requires improvement' and found them in breach of legal requirements relating to safe care and treatment, safeguarding and good governance. We undertook a focused inspection on 19 July 2017 to check what action the provider had taken in response to the breaches. Whilst the service remained rated 'requires improvement', we found appropriate action had been taken to improve the service and they were no longer in breach of the regulations. At this inspection on 27 March 2018 we rated the service 'good' overall and for each key question.

A registered manager was in post. 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.

People received personalised care that met their needs. Detailed care plans were in place which detailed people's support needs as well as information about their life histories and preferences. Staff respected people's end of life choices. Staff ensured people's dietary requirements were met and supported them to access healthcare services. Staff adhered to the principles of the Mental Capacity Act 2005. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. Staff adjusted their communication methods to ensure people understood them and they empowered people to make decisions about their care.

Staff treated people with kindness and compassion. They respected people's dignity and privacy. People's families were welcome to visit the service and there were unrestricted visiting arrangements. A pastor visited the service regularly to support people's religious preferences. The service had also arranged a befriending service for people that did not have regular visitors.

People were supported by staff that had the knowledge, skills and experiences to meet their needs. Staff received regular training, supervision and appraisals. There were sufficient numbers of staff to keep people safe. Staff mitigated risks to people's safety and followed safeguarding adults' procedures. Staff adhered to procedures to minimise the risk of infections and safe medicines management processes were in place.

The leadership team had been strengthened with the addition of a lead nurse. The service's quality

assurance processes were more robust and enabled 'live' tracking of key performance data. The staff had built close working relationships with the clinical commissioning group, the local authority and staff from other care services. Staff welcomed feedback from people using the service and their relatives. A complaints process remained in place, although no complaints had been received since our last inspection.

The registered manager adhered to the requirements of their CQC registration.

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. There were sufficient numbers of staff to keep people safe. Staff mitigated risks to people's safety and followed safeguarding adults' procedures. Staff adhered to procedures to minimise the risk of infections and safe medicines management processes were in place.

Is the service effective?

Good

The service was effective. People were supported by staff that had the knowledge, skills and experiences to meet their needs. Staff received regular training, supervision and appraisals. Staff adhered to the principles of the Mental Capacity Act 2005. Staff ensured people's dietary requirements were met and supported them to access healthcare services.

Is the service caring?

Good

The service was caring. Staff treated people with kindness and compassion. They respected people's dignity and privacy. People's families were welcome to visit the service and there were unrestricted visiting arrangements. Staff adjusted their communication methods to ensure people understood them and they empowered people to make decisions about their care.

Is the service responsive?

Good

The service was responsive. People received personalised care that met their needs. Detailed care plans were in place which detailed people's support needs as well as information about their life histories and preferences. Staff respected people's end of life choices. A complaints process remained in place, although no complaints had been received since our last inspection.

Is the service well-led?

Good

The service was well-led. The leadership team had been strengthened with the addition of a lead nurse. The service's quality assurance processes were more robust and enabled 'live' tracking of key performance data. The staff had built close working relationships with the clinical commissioning group, the local authority and staff from other care services. Staff welcomed feedback from people using the service and their relatives.

The registered manager adhered to the requirements of their CQC registration.	

Orchard House Nursing 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.

This inspection took place on 27 March 2018 and was unannounced. The inspection was undertaken by an inspector, a specialist professional advisor with a specialism in nursing and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service, including statutory notifications submitted about key events that occurred at the service. We also reviewed the information included in the provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We received feedback from two representatives from a local authority and a clinical commissioning group who funded people's care at the service.

During the inspection we spoke with 10 people, seven relatives and seven staff, including members of the management team, nursing team, care staff and the chef. We also spoke with the visiting GP. We reviewed five people's care records, medicines management records, two staff recruitment records, the staff rota, training, supervision and appraisal matrices and records relating to the management of the service. We undertook general observations throughout the day and at mealtimes.

Good

Is the service safe?

Our findings

People and their visitors told us Orchard House was a safe place, and that staff knew how to keep them safe.

Staff followed procedures to safeguard people from harm. Staff were knowledgeable in recognising signs of abuse and reported any concerns to their management team. Staff confirmed there were whistleblowing procedures in place should they need to use them. Staff liaised with the local safeguarding team when they had concerns about people's safety. This included raising safeguarding alerts when people returned from hospital with significant pressure ulcers. From discussions with the management team and checking records we saw no safeguarding concerns had been raised about people's care whilst at the service since our previous inspection.

Staff assessed risks to people's safety and developed plans to manage and mitigate those risks. Risk assessments were regularly reviewed and in line with changes in people's health and/or support needs. Assessments included in regards to falls, pressure ulcers, dehydration, nutrition and any behaviour that challenged staff. We saw ABC charts were used to record when people displayed physical or verbal aggression to help identify patterns and triggers to this behaviour. We saw appropriate processes were followed in regards to the prevention of pressure ulcers, catheter care and PEG tube care so any signs of blockages or infection were quickly identified.

Since our previous inspection the registered manager had improved their process for recording incidents to enable them to more easily identify trends about when incidents occurred, the type of incident and how they occurred. From this process the staff team were able to implement improvements to reduce the risk of incidents recurring. For example, staff had identified that one person was at risk of falls. They were being regularly supervised by staff, however, their most recent fall occurred during staff handover so they were re-reviewing arrangements to further protect the person's safety.

There were sufficient staff to keep people safe and meet their needs. One person said, "Oh yes, yes…. there's enough staff." Another person told us, "You only have to ring the bell if you want someone." A relative said, "Yes, there's always enough staff on duty." The management team were able to explain to us how they ensured there were sufficient numbers of staff deployed. Staff numbers were based on the number of people using the service as well as taking into account people's dependency levels. For example, if any needed one to one support, those who were nearing the end of their life and needed additional support and other clinical needs. The registered manager also told us they would take into account other people's needs before accepting any new admissions to ensure they had adequate staff available to meet their needs. From our observations we saw staff were available, regularly checked on people's welfare and were prompt in responding to requests for assistance.

Safe recruitment practices continued to be followed, including checking staff's eligibility to work in the UK, obtaining references from previous employers and undertaking criminal record checks.

The home was clean and free from malodour. We observed two domestic staff on duty following the home's

cleaning schedule and adhering to infection control procedures. We saw cleaning products were kept secure and domestic staff were aware of the risks to people's safety when undertaking their duties, for example, that the vacuum cleaners lead could be a trip hazard. Posters were displayed in all toilets and bathrooms explaining good hand hygiene and we observed hand washing facilities were available. During January 2018 there was an outbreak of diarrhoea and vomiting at the service. The management team followed guidance from the health protection agency and it was quickly contained and managed. The staff followed good practice in regards to food safety and was awarded with a five star food hygiene rating in February 2018.

Safe medicines management processes were in place and people received their medicines as prescribed. One person said, "We get our medication on time." Medicines were stored securely and at the correct temperature. Accurate records were maintained of medicines administered, including controlled medicines and application of topical creams. Processes were in place to support people with medicines prescribed to be taken 'as and when required'. Staff securely and appropriately disposed of medicines.

Good

Is the service effective?

Our findings

Staff were knowledgeable and had the skills and experience to undertake their roles. A full induction was undertaken with staff new to their role, which included completion of the Care Certificate. The Care Certificate is a nationally recognised tool which gives staff the knowledge and skills to undertake their duties. Many of the staff we spoke with had been working at the service for ten or more years and they said they received regular training to ensure they stayed up to date with good practice guidance. One staff member said, "We do get a lot of training… you get a lot of support and everyone wants to do their best." We saw good practice guidance was made available for staff to refer to. Staff were up to date with their mandatory training and completed competency knowledge checks to ensure they understood what was delivered during the training. In addition to the mandatory training, staff attended training delivered by the local authority and the clinical commissioning group. This included training on end of life care and syringe drivers. Staff also received regular supervision and annual appraisals to discuss their roles and responsibilities, and to identify any additional support or training they required.

Staff supported people in line with the Mental Capacity Act (MCA) 2005. Staff were aware of what decisions people had the capacity to make and respected those decisions. Staff looked at people's body language to assess whether they were consenting to the care and support delivered when they were unable to verbalise this. For example, we observed a staff member gaining consent through eye contact and a smile when explaining how they wanted to support the person.

Where people did not have capacity, best interests' decisions were made on their behalf in liaison with relevant professionals involved in their care and their relatives. Information was included in people's records about what decisions they had the capacity to make and what decisions needed to be made on their behalf. Staff were aware of who had power of attorney to make decisions on people's behalf. We spoke with people's relatives who had power of attorney and they stated they were involved in every aspect regarding their family member's care. One visitor told us, "We have power of Attorney, and yes we are very involved in all aspects of our friend's care".

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff supported people in line with the conditions in their DoLS authorisation. Where people had capacity and did not have a DoLS authorisation in place, people were not unduly restricted. A risk assessment was carried out prior to people leaving to review the risks to their safety and ensure they knew what to do in a medical emergency when out in the community.

Staff supported people with their dietary requirements and had regular meals to ensure their nutritional needs were met. People told us they were happy with the meals available and were aware there were other options if they did not like what was on the menu. One person said, "The food here is excellent…. I love it." The chef told us nursing and care staff kept them updated about people's dietary needs. This included discussing who required fortified meals to help support them put weight on and who required a diabetic

diet. This included one person who through tests had been identified as at high risk of developing diabetes and the chef was supporting them to have a low sugar diet as a preventative measure.

We observed that drinks were in plentiful supply, and staff constantly asked people if they would like a drink. We observed staff assisting people with their drinks. Drinks were provided in adapted cups to help people drink independently and we saw drinks were located within reaching distance.

Staff worked with other healthcare professionals to ensure people's health needs were met. People confirmed they were able to access the GP and specialist healthcare professionals when they needed them. The GP confirmed there was good communication between them and the staff. They said staff appropriately referred people when they had concerns about a person's health and followed any advice provided. People told us the podiatrist and audiologist came to visit them at the service. Staff also confirmed that if people needed to see a dentist, speech and language therapist, physiotherapist, occupational therapist, dietician or any other specialist professional this was provided. Staff also supported them to attend hospital appointments as and when required.

The team had worked with members from the clinical commissioning group to implement the vanguard initiative to streamline people's experiences when requiring hospital admission. This included implementation of the 'red bag' and associated documents so all healthcare professionals involved in a person's journey to hospital had relevant information about them and their care needs.

A homely environment was provided. There were a variety of communal areas for people to access and the home was accessible for wheelchair uses and people with additional mobility needs. People were able to join in with the main activities in the larger lounge or choose to spend time in one of the smaller quieter communal areas. Staff told us one of the dining areas could be used for family occasions and to celebrate key events and birthdays.

Good

Is the service caring?

Our findings

A relative told us, "The care that she gets here…. she is so, so lucky it is really good". Staff appeared very relaxed and happy to be working at Orchard House. They were constantly smiling and talking with people and their visitors. They showed genuine care by the way that they interacted with people. At every opportunity staff were inclusive and involved people in their care and the service. One person said, "They're very good carers…they look after you". Another person told us, "They are very nice, very kind…. it's not an easy job but they're happy doing it."

Staff treated people with dignity and respect. Comments from people included, "I'm treated with dignity and respect…. very much so" and "Oh yes, they're very good that way…they do everything". Staff spoke to people politely and treated people with kindness and compassion.

During our inspection there were many visitors to the service. There were no restrictions to people's friends and family visiting. People told us when we asked about visiting arrangements, "[They can come] everyday…. whenever they want to come", "Staff are very friendly…they recognise me and know who I'll be visiting" and "I have regular visitors and they can come any time". People's families were also welcome to have meals at the service. One person said, "My nephew was offered a meal and he had lunch here with me, it was lovely to have his company." The service organised for a befriending service to visit people who did not have many visitors.

Staff encouraged people to voice their opinions and gave them time to make their own decisions. Staff made arrangements for people with visual and hearing impairments to be supported to aid communication, inclusion and decision making. This included links with the Royal Association for the Deaf to send a support worker to communicate using sign language, supporting people to wear hearing aids and try different hearing enhancement equipment. We saw that some information, including the menu was only available in written language which may impact on the accessibility of this information to some people. Nevertheless, we observed staff taking time with each person explaining the menu options, so that they could choose their meals.

Staff supported people with kindness and compassion taking account of their individual needs. We observed whilst staff were helping to mobilise a person, one staff member pushed the person's wheelchair, a second staff member gently supported the person's head and hands and made sure that their legs did not get caught in the doorway. The two staff that were supporting this person conversed with them all the time explaining what was happening and why, they ensured the person could see their lips, as they were deaf but were able to lip read. They were patient and mindful of the person's dignity.

Staff used touch in a subtle way to calm and reassure people. The touch of a hand and the tone of voice and smiles were used much of the time when interacting with people, which people appeared to appreciate and positively react to.

A weekly pastor service was held at the service to support people to practice their faith. There were also

arrangements for holy communion to be held at the service for those that wished to participate in it. The registered manager told us the people currently using the service were of Christian faith, but they were able to support people that practiced other faiths.

Good

Is the service responsive?

Our findings

People received person-centred care which met their needs. Relative's we spoke with were complimentary about the level of care and support their family member received and felt this reflected positively on their family member's health. A relative said, "I've been here at different times even 10 o'clock at night and I'm pleased with what I see. Since being here my [family member] instead of spending every couple of weeks in hospital, in three years it's only been once." Another relative said, "I will say that [their family member] wouldn't be here today if it wasn't for the care that she's getting here".

Staff undertook a comprehensive assessment prior to people coming to the service to identify their needs and dependency levels. This information was passed to the nursing and care team so they could have information about how to support the person upon arrival. During people's time with the service the staff undertook a comprehensive assessment, in discussion with the person and their relatives, in order to develop detailed care records. One person told us, "Yes, I've been involved in all of my care plans. I'm looked after how I like to be looked after…. if I want a bath/shower I get it when and how I like it." People's care records detailed information about the person, including their backgrounds, families, likes, interests, life histories as well as their clinical care needs. Staff also took into account other services people were accessing and liaised with other agencies as appropriate to ensure consistent and coordinated care.

We observed staff handover during our inspection. During this staff spoke about each person using the service. They commented on their clinical and social welfare. For example, we heard one person had started to decline food and staff were encouraged to ask the person what they wanted to eat even if it was not available at the service and staff would go and buy it specifically for them to encourage them to eat something. Care staff also notified the nurses if they had concerns people were starting to show signs of any infection so this could be closely monitored. Staff also commented on people's progress including socialising more and developing more independence. Staff had identified a local club for people who were deaf and were hoping to support people using the service who were deaf to access this resource to help them feel more included and less isolated because of their hearing impairment.

The service specialised in supporting people receiving palliative care. Staff had received training from the local hospice and worked with the community palliative care team to support people to make advanced care decisions and develop end of life care plans, incorporating people's wishes and preferences. 'Coordinate my care' documents were completed which enabled all health professionals to access information about people's advanced care decisions. Staff were clear about people's decisions, including if they wanted to receive treatment and if they wanted to be resuscitated. For those that did not want to be resuscitated, staff organised with the GP to complete a 'do not attempt cardio-pulmonary resuscitation' form.

Care staff and entertainers providing a range of activities at the service. People told us they enjoyed the activities on offer. Comments included, "I like the singalongs and the entertainers that we have. At Christmas we made crackers, we did Easter cards and Easter bonnets", "I like to dance, so I dance" and "You can have what you like from the activities that they have here". Staff provided activities in the lounge as well as visiting

people in their rooms. One person said, "They will always go and sing to people in their rooms that are unable to attend the activities in the lounge".

On the day of our inspection we observed an activity being delivered in the lounge where an external entertainer was delivering bingo interlaced with songs. The entertainer was very animated and encouraged people to interact with her and each other. Where people needed additional support, staff used this as an opportunity to engage everyone on a one to one basis. The entertainer encouraged one person to sing her favourite song and when they had finished everyone applauded.

We observed another activity involving 'music and movement'. Staff encouraged people to move their arms, legs and faces. Staff were actively assisting people to do the various actions to the music. They did this very gently and with the knowledge of people's abilities.

A complaints process remained in place. People and relatives were aware of how to complain but had not felt the need to. Comments from people and/or relatives included, "Yes, I'm quite lucky that staff know me very well. I'd mention it to staff if I had a complaint, and it would be dealt with there and then", "Yes, I'd know how to complain but there are no problems here at all", "I'd ask to see the manager and she would come around. Never had to make a complaint" and "No, I wouldn't complain…I've not needed to". Since our last inspection no complaints had been received.

The service had received a number of compliments since our last inspection. Comments received included, "No words could express our deepest thanks for everything you did for our mum" and "Thank you all for the loving care you have shown my [family member] during her final days. Nothing was too much trouble and she was so very peaceful".

Good

Is the service well-led?

Our findings

People and relatives told us they found the service to have an open and inclusive culture. They were very complimentary about the service and one person commented, "As long as it carries on the way it is then I'm happy with it". Staff described the registered manager as "supportive", "approachable", "wonderful" and "brilliant".

Since our previous inspection a nurse lead had been introduced this had enabled stronger leadership within the clinical aspects of the service and enabled the registered manager to spend more time focusing on their role and the leadership and management of the service. In addition to the registered manager, the operations manager was also present at the service most days. People, their relatives and staff felt the service was well managed. One person said, "It's well managed. I see the managers most days." Another person told us, "I see the manager often and we have a chat".

This restructure within the management of the service had enabled the registered manager more time to focus on their quality assurance systems and develop more robust systems to review and analyse key service data. A structured quality assurance planner had been developed with a range of audits and 'live' trackers for incidents, falls, infection rates, pressure ulcers and deaths. Audits included review of care records, infection control, kitchen and medicines management. There were also regular checks in place regarding the quality, cleanliness and safety of equipment and checks relating to the health and safety of the service, including fire, gas, electrical and water safety. The registered manager had structured their care records to mimic the format of the clinical commissioning group (CCG) assessments so information could be sought quickly and in a logical order. The quality checks in place ensured complete, contemporaneous care records were maintained and kept up to date.

The staff had built strong working relationships with other agencies, in particular the local CCG and community healthcare professionals. The service used these relationships to upskill their staff team and get additional advice when supporting people with complex needs. It also included strong links with the hospital discharge team and palliative care team which enabled smoother transitions for people. A representative from this service or the provider's sister service attended training and meetings held by the CCG and the local authority. This also gave them the opportunity to meet staff from other local care services and the registered manager told us they had built good working relationships with other local managers that enabled them to share ideas and learning. The service last received a quality visit from the local authority in September 2017 and fully met the reviewing criteria.

There were regular 'resident and relative' meetings. Comments from people and their relatives included, "Yes, I've attended the residents and relatives meetings. I get all the information that everyone gets", "Oh yes they do have them, we have been to them. They have discussions, informal chats…. if there are any problems there's someone on hand to answer questions" and "All things have been taken on board and the suggestions about quizzes and bingo are a couple of the changes that were made to the activities". We reviewed the minutes from the meeting held in January 2018. This meeting was used to discuss general service related information, introduce new staff and also discuss the learning from the recent diarrhoea and

vomiting outbreak.

The registered manager was aware of their regulatory responsibilities and submitted statutory notifications about key events that occurred at the service as required. The service also displayed their CQC ratings on their website and at the service.