Orchid House Residential Care Home

Orchid House

Inspection report

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Ratings

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

Overall summary

The inspection took place on 17 and 18 August 2015 and was unannounced on the first day. At the last inspection in May 2014 the service was judged compliant with the regulations we looked at.

Orchid House is a care home providing accommodation for up to four younger adults. It is situated close to Rotherham town centre and has limited restricted parking. It provides accommodation on both the ground and first floor and has small gardens to the front and rear of the building.

The service has 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 and associated Regulations about how the service is run.

People we spoke with told us they felt safe while staying at the home. We spoke with three people who used the service and they said that staff helped to ensure they were safe. One person said, "I like to know staff are there to help me with my money." Another said they liked staff to be with them when they were out in the community. This gave them reassurance.

Summary of findings

There were enough staff to ensure people could take part in activities of their choice. There was a programme of training, supervision and appraisals to support staff to meet people's needs. However, we identified that four staff required moving and handling training to ensure they could move people safely. We found several falls had occurred in the home which were recorded, however the provider told us that there was no equipment to safely assist people that had fallen. This meant people and staff were at risk of sustaining an injury by manually lifting people following falls in the home. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Procedures in relation to recruitment and retention of staff were robust and ensured only suitable people were employed in the service.

Care plans were person centred and most contained information needed to ensure staff could deliver care safely. However, we identified that one person's care needs required a formal review to ensure staff could continue to meet their needs. The provider had identified this and was liaising with the other health agencies to arrange this review.

The provider was aware of the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS). At the time of this inspection the registered manager told us they had made one application to the local authority who were the supervisory body for dealing with DoLS.

People were encouraged to make decisions about meals, and were supported to go shopping and be involved in menu planning. We saw people were involved and consulted about all aspects of their care and support, where they were able, including suggestions for activities and holidays. Two people told us about their recent holiday to Egypt, while another person preferred to have holidays in England.

Medications procedures were in place including protocols for the use of 'as and when required' (PRN) medications. Staff had received training in medication management and medication was audited in line with the provider's procedures. However, there were a number of records used to record medications in and out of the home which made it difficult to monitor. Some improvements were needed to ensure medications discharged to day centres and for overnight stays to relatives were clearly recorded. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

People had access to a wide range of activities that were provided both in-house and in the community. One person told us they liked going to the drama group while others enjoyed 'Gateway' which is a social group held in the evenings.

We observed good interactions between staff and people who used the service. People were happy to discuss the day's events and they showed us the small allotment in the back garden where they had grown their own vegetables and herbs.

People told us they were aware of the complaints procedure and said staff would assist them if they needed to use it. People could also access 'Speak up' if they needed any assistance to raise concerns. 'Speak up' is an advocacy organisation which mainly aims to ensure that people with learning disabilities are valued and included within society. People's views were gained using a survey and by attending regular meetings.

Quality monitoring systems needed improvements to ensure the service learnt from events that occurred in the home. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff knew how to recognise and respond to abuse correctly. They had a clear understanding of the procedures in place to safeguard people from abuse.

There were enough staff to meet people's needs. However some staff required moving and handling training to ensure they were competent to move people safely. This meant people were sometimes moved in an unsafe way.

Care plans were person centred and most contained information needed to ensure staff could deliver care safely. However, we identified that one person's care needs required a formal review to ensure staff could continue to meet their needs.

There were robust recruitment systems in place to ensure the right staff were employed.

Medicines were stored and administered safely. However auditing systems needed to be improved to make them safe.

Is the service effective?

Good

The service was effective.

The provider demonstrated a good awareness of their role in protecting people's rights and recording decisions made in their best interest. Deprivation of Liberty Safeguards had been followed to ensure the service acted within the law.

People's nutritional needs were met. The food we saw, provided variety and choice and ensured a well-balanced diet for people staying in the home. We observed people being given choices of what to eat and what time to eat.

Staff received regular supervision to ensure they were given the opportunity to discuss their development and training needs.

Is the service caring?

Good

The service was caring.

People told us they were happy with the support they received. We saw staff had a warm rapport with the people they cared for.

People had been involved in deciding how they wanted their care to be given and they told us they discussed this regularly at their reviews.

Is the service responsive?

Good

The service was responsive.

Summary of findings

We found that peoples' needs were thoroughly assessed prior to them staying at the service. A relative told us they had been consulted about the care of their relative before and during their stay at the home.

Communication with relatives was very good. One family member we spoke with told us that staff always notified them about any changes to their relatives care.

Relatives told us the registered manager was approachable and would respond to any questions they had about their relatives care and treatment.

People were encouraged to retain as much of their independence as possible and those we spoke with appreciated this.

The service had a complaints procedure that was accessible to people who used the service and their relatives. People told us they had no reason to complain as the service was very good.

Is the service well-led?

Requires Improvement

The service requires improvement to make it well led.

Quality monitoring systems needed improvements to ensure the service learnt from events that occurred in the home. People's views were gained using a survey and by attending regular house meetings.

People were regularly asked for their views. Regular meetings were used to ensure continued involvement by people living at the home.

Accidents and incidents were monitored by the registered manager to ensure any triggers or trends were identified.

Orchid House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 18 and 19 August 2015 and was unannounced on the first day. The inspection was undertaken by an adult social care inspector. At the time of the visit there were four people using the service. We spoke with three of them. We also spoke with the relative of one person who used the service. We spoke with one senior care worker, a care staff member and the provider. We also observed how staff interacted and gave support to people throughout this visit.

Before our inspection, we reviewed all the information we held about the home including notifications that had been sent to us from the home. We also spoke with the local council contract monitoring officer who also undertakes periodic visits to the home.

We looked at documentation relating to people who used the service, staff and the management of the service. We looked at three people's written records, including the plans of their care. We also looked at the systems used to manage people's medication, including the storage and records kept. We also looked at the quality assurance systems to check if they were robust and identified areas for improvement.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe and supported at the home. One person said, "Staff supports me to stay safe when I am out and about and also with my money." Another person said, "I feel safe we get on, it's great, and I would tell staff if I was worried about anything."

We looked at the care plans for three of the people who used the service. We found the care plans were person centred and contained detailed information about how people communicated. We saw on one care plan that there were several incidents where the person had fallen, and was displaying behaviours which may challenge others. We discussed this with the provider who told us that steps had been put in place to re-assess their needs. We saw evidence of this on communication records. We also spoke with the community psychiatric nurse (CPN) who told us they would be visiting the service the next day.

We found risk assessments were in place for people. Staff understood the importance of balancing safety while supporting people to make choices, so that they had control of their lives. For example, we saw risk assessment to manage behaviours which may challenge others and assessment to support people while they were out in the community were in place. However, we noted from staff rotas that there was no waking night staff on duty, although one staff member slept on the premises in case of emergency. When we looked at the falls log we found that on a number of occasions during the night the sleep-in staff member had been alerted to a person who had fallen. The sleep-in staff telephoned the on-call staff member for assistance. As a result of this the person that had fallen had to wait for some time before being assisted back to bed. We also found the service did not have any moving and handling equipment which meant the person may be put at significant risk of injury when two staff were assisting the person who had fallen. We saw from the training matrix that four staff had not received any moving and handling training. This meant the provider had not appropriately assessed the risk to both staff and people who used the service. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We discussed our concerns about the night staffing arrangements. The provider told us that they had identified that the staff on sleep-in duty had to support one person several times during the night on a regular basis. The provider told us they were working with the local authority to have the persons needs reassessed. The senior care worker showed us the rotas which were consistent with the staff on duty. She told us the staffing levels where flexible to support people who used the service. More staff were available during the evenings to enable people to attend social events.

Staff had access to policies and procedures about keeping people safe from abuse and reporting any incidents appropriately. The registered manager had a copy of the local authority's safeguarding adult procedures which helped to make sure incidents were reported appropriately. The provider told us no safeguarding concerns had been reported to the council since our last inspection. However, from the incidents logs and from what staff told us we felt that a safeguarding referral should have been made regarding the number of falls which had occurred for one person. We contacted the local authority safeguarding team after the inspection to make them aware of our concerns.

The staff we spoke with demonstrated a good knowledge of safeguarding people and could identify the types and signs of abuse, as well as knowing what to do if they had any concerns of this kind. Records and staff comments confirmed they had received periodic training in this subject and the provider told us all staff had attended the local authority safeguarding training. There was also a whistleblowing policy available which told staff how they could raise concerns. Staff we spoke with were aware of the policy and their role in reporting concerns.

There were emergency plans in place to ensure people's safety in the event of a fire. We saw there was an up to date fire risk assessment and people had an emergency evacuation plan in place in their records.

We found that the recruitment of staff was robust and thorough. This ensured only suitable people with the right skills were employed by this service. The provider told us that they had recently employed a new member of staff who was on induction. We spoke to this member of staff and they confirmed how they had been recruited following an interview which included questions from people who used the service. They told us that they had been registered to complete the 'Care Certificate' as part of their induction.

Requires Improvement

Is the service safe?

The 'Care Certificate' looks to improve the consistency and portability of the fundamental skills, knowledge, values and behaviours of staff, and to help raise the status and profile of staff working in care settings.

We checked six staff files and found appropriate checks had been undertaken before staff began working for the service. These included two written references, (one being from their previous employer), and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

The service had a medication policy to ensure medicines were stored and administered appropriately. We observed staffs approach when administering medication and we saw people were asked if they were ready to take their medications. This was carried out discreetly and in a way which preserved their dignity.

Where people were prescribed PRN (as required) medicines we saw care plans and protocols were in place to inform and guide staff on what these medicines were for and when they should give them. All staff were responsible for administering medications. Records showed they had received medication training with periodic updates. This was confirmed by the staff we spoke with.

There was an audit system in place to make sure staff had followed the home's medication procedure. The senior care worker showed us how medication was booked in and out when people had overnight stays with their relatives. There were also records which showed when medications were sent to social care centres for them to administer. We found it very difficult to establish if all medications were accounted for. We discussed this at length with the provider and senior care worker as we felt the auditing of medications needed to be improved to ensure they were accurately recorded. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Good

Is the service effective?

Our findings

The provider told us that people living at the home were encouraged to maintain their lifestyles with the support and encouragement of staff. People told us that staff helped them to develop their person centred plans which detailed the support they would need to undertake certain tasks. For example, assistance with personal care and things that were important to them. One person told us how they had been encouraged to develop a small allotment in the garden of the home. They told us they were proud to grow food that they were able to eat. Another person told us how they had developed their healthy eating plan with the support of staff.

People's nutritional needs were assessed during the care and support planning process and people's needs in relation to nutrition were clearly seen documented in the plans of care that we looked at. We saw people's likes, dislikes and any allergies had also been recorded. We spoke with people who used the service about how menus were devised. One person told us that they liked to go shopping for the food and they were involved in choosing the menus. They told us which meals they had suggested that were included on the menus. People also told us that they enjoyed meals out with staff and the occasional take-away meal. We observed people having lunch and they were given a choice and helped to prepare their meal. People were also encouraged to have a piece of fruit after their meal.

People's care records showed that their day to day health needs were being met. People had access to their own GP and additionally community psychiatric nurses. Records showed that people were supported to also access other specialist services such as chiropody and dental services.

Each person also had a separate health action plan which included things medical staff should know if the person became ill and needed hospital attention. The plan was set out using a traffic light system. The red section recorded the 'things you must know about me'. The amber section recorded 'things that are important to me like family and friends'. And the green section included 'likes and dislikes'.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and to report on what we find. This legislation is used to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in their best interests and protect their rights. The Deprivation of Liberty Safeguards (DoLS) is aimed at making sure people are looked after in a way that does not inappropriately restrict their freedom.

The provider had a good working knowledge of the Mental Capacity Act in protecting people and the importance of involving people in making decisions. They told us they had training in the principles of the Act. The provider told us that staff would attend the local authority training when places became available.

At the time of our inspection no-one living at the home was subject to a DoLS authorisation, however the provider told us that they had applied to the local authority supervisory body for a standard authorisation but this had not been considered yet. They were able to provide evidence that they had applied for the DoLS.

The registered manager told us staff were undertaking training and development in line with the 'Care Certificate'. The 'Care Certificate' looks to improve the consistency and portability of the fundamental skills, knowledge, values and behaviours of staff, and to help raise the status and profile of staff working in care settings. We looked at the file of one newly appointed member of staff who had begun to complete workbooks in relation to the 'Care Certificate' and we saw these were completed thoroughly. This showed new staff were being encouraged to develop their skills and knowledge. We also saw evidence that observations were made to ensure that correct practices were being followed. For example, we saw evidence that the provider had observed a staff member while they administered medication. The report confirmed the staff member's competency.

We saw that most training was up to date and the senior carer provided us with a training matrix, which demonstrated that training in areas such as first aid, health and safety, food hygiene, medication, fire safety, infection control, safeguarding, challenging behaviour had been undertaken. We did however note that four staff had not undertaken any moving and handling training. We discussed this with the provider who was able to confirm the dates when the training was scheduled to take place.

Systems to support and develop staff were in place through regular supervision meetings with the registered manager.

Good

Is the service effective?

These meetings gave staff the opportunity to discuss their own personal and professional development as well as any concerns they may have. Annual appraisals were planned for October.

Staff confirmed to us that they received regular supervision on an individual and group basis, which they felt supported them in their roles. Staff told us the provider and senior care worker was always approachable if they required some advice or needed to discuss something.

Good

Is the service caring?

Our findings

People who used the service told us they were involved in developing their person centred plans and all four people agreed to show us their records, which were written in a way they could understand. The support plans described how people wanted to receive their support and told us who were important to them and things they liked to do. For example, spending time with family and friends. They also told us how they needed support with hospital and other health appointments. We spoke with one relative who told us, "Staff know my family member so well. They are always kind and caring. I would not want my family member to live anywhere else." They said they were very satisfied with the care provided and felt involved in the care of their family member. Home visits were encouraged and relatives were invited into the home when their family member was returning from overnight stays.

People told us that staff were respectful and spoke to them in a way that made them feel at home. One person we spoke with said, "Staff are great we all get on very well, staff are like family to me." Another person said, "Sometimes I like peace and quiet so I go to my room, but it's nice to know I can do this."

People told us they were able to decide how they wanted to decorate their bedrooms. One person said, "I have all my things that I like in my room, I enjoy shopping for clothes and nice things to make my room feel special to me." Another person told us they liked video games. They told us they had a pet guinea pig which was kept in the garden and they had responsibility for its care.

We observed staff interacting with people in a positive encouraging way. People were asked what they wanted to do during their spare time and there was lots of encouragement given to people to undertake household tasks. For example, one person cleaned their bedroom, others helped prepare lunch and make drinks for everyone.

We heard a staff member encouraging one person to change their clothing before going out for the day. The staff member was very patient and considerate. They supported the person throughout and we heard them offering a choice of different clothing and footwear. The staff member gave the person lots of praise when they had completed the task.

The provider told us that people did not currently need to use advocacy services as they were able to make important decisions about their care. The provider told us that 'Speak up' had been used when the service used questionnaires to ask people about the quality of the service. People who used the service told us they had attended 'Speak up' centres which organised various educational courses including healthy eating. 'Speak up' is one of the leading advocacy Charities in the UK for people with a learning disability.

Good

Is the service responsive?

Our findings

We found people who used the service received personalised care and support. They were involved in planning the support they needed. We looked at three person centred plans for people who used the service. The plans told us about the activities that people were involved in, what was working well and things that may have changed. Staff told us that people were encouraged to maintain life skills like helping with cooking and cleaning. One person showed us the small allotment created in the back garden. They showed us a variety of vegetables grown and said that they enjoyed eating them. They also told us about how they volunteered to help an organisation which walks dogs. They said they enjoyed the job very much and showed us photographs of the dogs. Another person told us about a recent holiday to Egypt which they enjoyed. They had also had a short break in London where they went to the theatre.

Staff we spoke with told us that they worked flexibly to ensure people who used the service could take part in activities of their choice. They said activities such as attending social events and going for meals were arranged around people who used the service.

The senior care worker showed us a copy of the complaints' policy and procedure. This was explained to everyone who received a service. It was written in plain English, but an easy read version was not available for those people who needed it in that format. We discussed this with the senior care worker and they have told us they contacted 'Speak up' to try to obtain the alternative format. We looked at the complaints log and found one person had complained about their sleep being disturbed by another person who used the service. We discussed this with the provider and they had investigated the persons concern and were working with health agencies to resolve the problem.

People we spoke with did not raise any complaints or concerns about the care and support they received. The relatives we spoke with told us they had no concerns but would discuss things with the staff or the provider if they needed to raise any issues. One relative said, "My family member has lived at the home for a lot of years and the staff always communicate with me if they thought there were any issues. The staff are very good and I would not want my family member to live anywhere else."

Staff told us if they received any concerns about the service they would share the information with the provider. They told us they had regular contact with the provider and senior care worker, both formally at staff meeting and informally when the provider carried out observations of practice at the home.

Requires Improvement

Is the service well-led?

Our findings

On the day of our inspection, we found the provider and senior care worker to be open and approachable towards the staff and people who lived at the home. Interactions between the provider, staff and people who used the service were respectful and appropriate. People who used the service and their relatives were actively encouraged to give feedback about the quality of the service. People told us they had regular meetings and they were encouraged to raise concerns and to talk about things like outings, holidays and activities.

Observations of interactions between the provider and staff showed they were inclusive and positive. Staff spoke of a strong commitment to providing a good quality service for people living in the home. Staff were able to attend regular meetings to ensure they were provided with an opportunity to give their views on how the service was run. Daily handovers were also used to pass on important information about the people who lived at the home. Staff told us that it was important to communicate information to each other, especially if they had been away from work for a few days.

Outcomes from quality assurance surveys were used to improve the service for people who used the service. Questions asked how well the service was doing, for example, did staff encourage people to make their own decisions, if they felt safe, did they know how to raise concerns, were activities appropriate and about the meals. We saw from the results of January 2015 that people regarded the service as very good.

We found systems or processes to monitor the quality of the service were ineffective. The provider was unable to demonstrate how they monitored health and safety within the home. For example, we found there were no audits to look at the action they took when a person had fallen. Some staff had not received the appropriate training to move and handle people safely.

We were unable to monitor how the service managed one person's medications safely. Three systems were used to book in and out medications. There was no clear audit trails to confirm the amount of medication that was stored in the home. We found one person's care plan still referred to them as being able to self-medicate but it was clear from the records that they were no-longer able to carry out this task safely. On the first day of the inspection protocols for administering 'as required' medications were not in place. However when we returned the senior care worker had addressed this. This meant that the care plan audit was ineffective as it had not identified the change to the person's wishes regarding their medication.

Prior to this inspection we looked at the notifications sent to us by the provider we had not received notification of any significant events since 2014. However, we found evidence in care records we looked at which should have been reported to the Commission. After the inspection we reported the events to the local authority safeguarding team for them to consider. We spoke with the provider about their understanding of the legal requirement to notify the Commission of any significant events. These are events which may have an impact on the care and welfare of people who used the service. The provider told us they did not have copies of the notifications but would obtain them for future use.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users. Some staff had not received appropriate training in moving and handling service users Regulation 12 (1) (2)(a)-(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not effective when monitoring and improving the quality and safety of the service. Regulation 17 (1) (2)(a)(b)(c)