Stillness 929 Limited

Orchard House

Inspection report

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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

This inspection took place on the 20 June 2016 and was an unannounced inspection. At our last inspection in July 2015 we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the safety of the premises, safe and proper management of medicines and infection control. The service was not doing everything reasonably practicable to make sure people who used the service received person-centred care to meet their needs and reflect their personal preferences. The service had not carried out regular audits, risks had not been identified and records in respect of consent were not accurate. There was no reference in the records about discussions with people or their carers. Staff had not received the relevant training to carry out their roles and responsibilities.

We told the provider to take action and they sent an action plan detailing the actions they would take to improve. During this inspection we found improvements had been made.

Orchard House is registered to provide accommodation and personal care for up to nine adults with acquired brain injury, stroke and other neurological conditions. They provide rehabilitation services within a community setting. At the time of our inspection the service had seven residents.

There was a registered manager 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 told us they felt safe. Staff had received regular training to make sure they maintained their knowledge in relation to recognising and reporting safety concerns. People received their medicines as prescribed. Staff carried out appropriate checks before administering medicines. Records were accurately maintained and all medicines were stored safely and securely. Where risks to people had been identified risk assessments were in place and action had been taken to reduce the risks. Staff were aware of people's needs and followed guidance to keep them safe.

People were supported by staff that had the knowledge and skills to effectively care for them. Staff had received the training and support they required to ensure people received good care. The registered manager and staff were aware of their responsibilities under the Mental Capacity Act 2005 (MCA) which governs decision-making on behalf of adults who may not be able to make particular decisions themselves. People's capacity to make decisions was regularly assessed.
People were provided with food and drink that was freshly prepared and presented nicely. People we spoke with told us they enjoyed the food and had choices about what they ate.

People spoke highly of the care they received. Staff understood the needs of people and provided care with kindness and compassion. Staff spent time with people and treated people with dignity and respect.

People's care was planned ensuring that people were treated as individuals. People had been involved in developing their care plans and reviewing these. People were encouraged to be involved in activities and to take part in activities that assisted their rehabilitation, such as swimming and physiotherapy.

People in the service knew the registered manager and spoke to them openly and with confidence. The service had systems to assess the quality of the service provided in the home. These systems ensured people were protected against the risks of unsafe or inappropriate care. All staff spoke positively about the support they received from the registered manager. Staff told us they were approachable and supportive. The service worked with other professionals to ensure people in the service received the optimal input in their rehabilitation.

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. People told us they felt safe. Staff knew how to identify and raise concerns.

There were sufficient staff on duty to meet people's needs.

Risks to people had been assessed so they could be managed safely.

People received their medicines as prescribed. Staff carried out appropriate checks before administering medicines.

Is the service effective?

Good

The service was effective. Staff had the training, skills and support to care for people. Staff spoke positively of the support they received.

People enjoyed the food provided and had sufficient amounts to eat and drink. People received support with eating and drinking where needed.

The service worked with health professionals to ensure people's physical and mental health needs were maintained.

Is the service caring?

Good

The service was caring. Staff were kind and respectful and treated people and their relatives with dignity and respect.

People's preferences regarding their daily care and support were respected.

Staff gave people the time to express their wishes and respected the decisions they made.

Is the service responsive?

Good

People were confident they would be listened to and action taken.

Meetings were conducted with people to discuss changes in the home and to seek their feedback and suggestions were acted upon

Activities had been arranged to meet people's needs and to reflect their preferences.

Community links were developed and maintained.

Is the service well-led?

Good

The service was well led. People and staff spoke highly of the registered manager.

Regular audits were carried out to monitor the quality of service. Learning from these audits was used to make improvements.

There was a whistle blowing policy in place that was available to staff around the home. Staff knew how to raise concerns.

Management and staff had a culture of openness and desire to deliver high quality care.

Orchard House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 the 20 June 2016. It was an unannounced inspection. This inspection was carried out by two inspectors 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.

We spoke with five people, a relative, six staff, the deputy manager and the registered manager. We also spoke with a visiting healthcare professional. We looked at a sample of records, including four people's care records, medicine and administration records. We also looked at a range of records relating to the management of the home and four staff files. We also looked at training records.

The methods we used to gather information included pathway tracking, which captures the experiences of a sample of people by following a person's route through the service and getting their views on it. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We asked the provider to complete a 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. The form was completed and returned so we were able to take the information into account when we planned our inspection. We reviewed the information we held about the service. Providers are required by law to notify us about events and incidents that occur; we refer to these as 'notifications'. We looked at the notifications the provider had sent to us.

Good

Is the service safe?

Our findings

At our last inspection in July 2015, we found that there were not enough staff to meet all people's needs. We also found people were not being kept safe due to medication errors, lack of infection control and measures to protect people in the event of fire were not safe. At this inspection we found improvements had been made to increase people's safety.

There were sufficient staff on duty to meet people's needs. We saw the registered manager had strategies to ensure staffing levels were safe. She told us people's dependency levels were taken into account when planning staffing levels. During the day we observed staff were not rushed in their duties. Staff had time to chat with people and engage with them in activities.

People we spoke with told us they were happy with the support they received with their medicines. We observed people receiving their medication. People were given choices about where they received their medication. An explanation was given about what the medicines were for and independence was encouraged and appropriate praise given. We spoke with a person who had started managing their own medication to prepare for their discharge. They said "I am working with them as part of my discharge arrangements". Medicine administration records (MAR's) were completed correctly. We saw one person received their medication covertly, which means that it is placed in their food or drink. This decision had been made in the best interests of the person and had an authorisation from the GP for the medicines to be given that way. Where people had been prescribed pain medication 'as required' we saw them being offered this as detailed on their MAR's.

We found that all medicines including controlled drugs were stored securely and stock balances were being recorded correctly. Staff checked a person's identity and explained the process before giving people their medicine. This ensured people received the right medicine at the right time. Only trained staff carried out medication administration. All staff that were involved with administering medication had undergone training with a chemist and had competency assessments before they were allowed to administer medication.

All staff went through infection control training during their induction and received extra training by the infection control champion. There were hand washing guidelines in all bathrooms/toilets and an extra hand cleansing facility in the corridor near to bedrooms.

People we spoke with confirmed they felt safe and comfortable when they were supported by the staff team. One person told us, "I feel safe here but not smothered". Another person said, ""Always felt safe and secure here, without a doubt".

Staff we spoke with could clearly explain how they would recognise and report abuse. Staff told us, and training records confirmed that staff received regular training to make sure they were able to identify abuse. They told us they would report concerns immediately to their manager or senior person on duty. They were also aware they could report externally if needed. One member of staff said if they had concerns they

"Would go straight to the deputy manager or the registered manager, or higher up if needed". Another said "I had safeguarding training a couple of weeks ago. I understand how to report up the chain and outside if necessary". Records confirmed the service notified the appropriate authorities with any concerns. There was information about safeguarding procedures available to staff.

People had risk assessments in place which identified any risks due to their specific health and support needs, such as mobility, falls, and nutrition. These assessments included information for staff to follow to minimise the chance of harm occurring. For example, a person was at risk of pressure damage to their skin. The risk assessment was complete and gave guidance to staff on how to safely support this person. This included ensuring the person was in their chair for no longer than four hours and they were repositioned every two hours to reduce pressure. We saw this guidance was been followed and regularly reviewed.

Another person was at risk of seizures due to epilepsy. Guidelines were in place which included hourly observations, use of a sensor mat and when to call for medical assistance. We saw in records that this person had a seizure lasting for eight minutes. We saw the paramedics had been called in line with the guidance.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the home. These checks included requesting and checking references of the staff member's character and Disclosure and Barring Service (DBS) check. The DBS is a check undertaken to ensure staff are suitable to work with people.

People had personal emergency evacuation plans in place to protect people from untoward events. These plans were kept in the service's 'grab bag' that was easily accessible to staff in the event of an emergency. We noted that the service had undergone a fire inspection in June 2016.

Good

Is the service effective?

Our findings

At our last inspection in July 2015, we found that people's consent was not being sought appropriately. There were concerns the principles of the Mental Capacity Act 2005 were not being followed to ensure people were not being deprived of their liberty unnecessarily. We did not see all records confirming training the staff had received. Staff had not received regular supervision and felt unsupported. At this inspection we found improvements had been made to improve the effectiveness of the service.

We found during this inspection that staff had received all training needed to ensure they carried out their roles effectively. Staff confirmed they had received the training they required and that if they needed advice or extra training management arranged this. One staff member said, "Management are keen for us to do any training". Staff had recently had safeguarding training from the local safeguarding team and some face to face training about the Mental Capacity Act 2005 (MCA). A staff member said, "I had MCA training last week and it was quite useful". We saw that further training had been identified and would be ongoing as needed.

Staff had the skills and knowledge to carry out their roles and responsibilities. A relative told us "Staff are knowledgeable. [Relative] has made amazing progress". Staff told us they received an induction and completed training when they started working at the service. Induction training included fire, moving and handling, infection control and dementia care. We saw that staff had received specialist training in areas such as epilepsy and Percutaneous Endoscopic Gastrostomy (PEG) feeding. A PEG is a feeding tube which passes through the abdominal wall into the stomach so that food, water and medicines can be given without swallowing. A person we spoke with said, "I like it here, the staff helped me lose the PEG – I am having it removed for good". They were clearly delighted to not have to receive their food via this method in the future.

Staff told us, and records confirmed they had effective support. Staff had received a recent supervision from the registered manager and there was a supervision matrix on the wall stating when the next supervision's were due. Records showed staff had access to development opportunities. For example, a member of staff had a certificate in dementia care and three senior staff members were being trained to carry out supervision sessions with staff. Staff told us they found the supervision meetings useful and supportive. One member of staff said "I feel listened to".

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.

We discussed the Mental Capacity Act (MCA) 2005 with the registered manager. They were knowledgeable about how to ensure the rights of people who lacked capacity were protected. Care records showed the principles of the Mental Capacity Act 2005 code of practice had been followed when assessing an individual's ability to make a specific decision. We observed and heard staff asking people's consent before

providing support. We saw that where people lacked capacity, assessments were specific to each decision and best interest decisions were recorded in their files. For example, a person had been assessed as not having capacity around receiving care and treatment, taking medication, alcohol consumption and where to live. In view of this a referral had been made to an Independent Mental Capacity Advocate (IMCA) to ensure the person's views were considered. An advocate helps people who may have difficulty speaking out, or who need support to make their own, informed, independent choices about decisions that affect their lives.

All the staff had received recent training in the MCA and had a good understanding of the principles of the act. Staff adhered to these principles in their day to day work. For example one staff member described how a person they supported chose what they wanted to wear and what they wanted to eat. This staff member told us that capacity should always be assumed. We spoke with another staff member who confirmed that the person had capacity in most areas, but lacked capacity in respect of managing their medication and finances.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that DoLS authorisations were in place for some people. Staff we spoke with had an understanding of the requirements of the DoLS. For example, an application was made as a person had stated they wanted to leave but were too unwell and their safety would have been compromised if they left. We saw this person improved with support and the DoLS application was withdrawn as they were no longer at risk if they left the premises. There was guidance on the person's records about occasions when an urgent DoLS should be considered, such as the person may lose capacity when very distressed. Staff had received training on DoLS and knew which people in the service had these in place and what this meant for the person and actions needed if they tried to leave.

People told us they had enough to eat and drink and enjoyed the food. A person said, "This place far exceeds any other place I've been for food". Another said "I am given special fish dishes to tempt me. The only fish I didn't like when I arrived was salmon but I like that now too". The menu operated on a four week cycle with a 'specials board'. We saw the chef speak to each person individually to see what food they wanted. If they did not want anything that was advertised, he would suggest an alternative which he knew he was able to provide from the kitchen. The chef was aware of people's likes and dislikes and took pride in ordering, cooking and serving fresh, home cooked food.

We observed the lunchtime meal and saw it was a relaxed and enjoyable experience. There was a drinks machine in the dining room and a large bowl of fruit on the side. Each table had a small bowl of fresh fruit and were laid out with napkins and cutlery. The meals were served hot from the kitchen and looked wholesome and appetising. Where people needed assistance with eating and drinking they were supported appropriately. For example, we observed a member of staff assisting a person to eat their lunch. They offered the person a choice of puddings and spoke calmly and gave them time to decide and their choice was respected. We saw that staff sat and ate with people in the dining room at lunchtime.

One person in the service did not like eating lunch. We saw the chef encouraging them to have some lunch but respected the person's choice not to eat. A staff member explained that the person was assisted to cook their own evening meal of their choice.

Malnutrition Universal Screening Tool (MUST) assessments were completed. However, one person had lost weight and no action had been noted. We discussed this with the registered manager who said they would investigate immediately and take action. The registered manager explained that new care records were

being put in place with measures to ensure any changes in a person's health were noted more easily.

People at Orchard House had a variety of needs and were at different stages of their rehabilitation. They were supported by in-house professional support such as physiotherapists, occupational therapists, speech and language specialists (SALT) and psychology and psychiatry professionals. People were also supported to access local GP's and visits by healthcare professionals, assessments and referrals were all recorded in people's care plans. We saw one person had been referred for tests due to symptoms they were experiencing and records showed this had been arranged.

Good

Is the service caring?

Our findings

People told us they were happy and felt cared for by all staff in the service. Comments included; "All the staff are caring, without a doubt" and "I like it here they are very kind", and "They always ask me what I want to wear in a morning". One person said "The staff do not wear a uniform and that makes me feel more at home".

A relative said there was a "Personal approach to care" and "Everyone's kind and understanding, they're like friends. There's no restrictions to visit, I just turn up". Staff told us they enjoyed working at the home. Comments included; "I enjoy coming to work" and "It's all about the people who are here. We make a difference". Another staff member said "I love working here. I would be happy if my mum was here".

Staff were knowledgeable about the care people required and the things that were important to them in their lives. We saw they conversed with people about their family and where they had lived. The chef acknowledged each person's birthdays by baking a cake for them. A relative told us they were always offered a meal when they visited. We heard about how staff arranged a special Valentine's meal for a couple who had never been separated before. When the person's spouse turned up they had set the manager's office up as a private dining area and decorated the table and they had a special meal. Staff understood the importance of their relationship and allowing them time alone.

We also saw that the staff had organised themed days and we saw examples of this in photographs around the service. On these occasions the chef prepared a special meal and people and staff dressed up for the theme, for example, Mexican clothes.

We saw staff had a positive approach towards people; involving them in regaining their own skills and independence. . One person was walking with the aid of two sticks and needed time to get up and steady themselves. Staff respectfully supported the person and gave them time without rushing them. Staff were patient, attentive and caring towards this person whilst promoting their independence.

Throughout our visit we saw people were treated in a caring and kind way. The staff were friendly, polite and respectful when providing support to people. Staff took time to speak with people as they supported them. For example, a staff member involved three people in the dining room in a memory game and each took terms to name items. They were laughing and enjoying it. We saw people being asked by staff what their wishes were in relation to what they ate, where they sat and what they wanted to do.

People's dignity and privacy were respected. All personal care tasks were provided in people's own rooms. Curtains and doors were closed prior to any tasks taking place. We saw staff sought permission from a person before we looked in their room. Staff knocked on doors that were closed before entering people's rooms. We saw how staff spoke to people with respect using the person's preferred name. When staff spoke about people to us or amongst themselves they were respectful. Staff had received diversity and equality training and were being encouraged to become Dignity Champions. There was a designated therapy room where people were seen by visiting professionals such as the OT or psychologist. This was so people could

focus and have privacy during their sessions.

We observed many positive interactions. For example, the registered manager had a chat with a person, getting down to their level and using relevant humour. It was clear they had a good relationship from this interaction. Relationships between people in the service were positive. One person said "I look on everyone here as my brothers and sisters"

Staff gave people the time to express their wishes and respected the decisions they made. We observed a person during their lunch and the staff member had a good understanding of the person's needs. They engaged with person and discussed what channel on TV they would like. The staff member knew the person liked the food channel and the person smiled and indicated her agreement of this.

Good

Is the service responsive?

Our findings

At our last inspection in July 2015, we found that people were not being involved in planning their care. People were not given many opportunities to be involved in activities they chose or be part of the local community. At this inspection we found improvements had been made to ensure the service was more responsive to people's needs.

People's needs were assessed prior to admission to the service to ensure their support needs were clear and care plans could be developed from this. Care records contained details of people's physical health needs and also emotional support needs. The records were detailed, personalised, and were reviewed on a fortnightly basis by the multi-disciplinary team (MDT). Therapists carried out assessments for people and provided guidelines on how to manage behaviours and support them in the community. People had key workers allocated to them who they could discuss any issues with.

All support needs were recorded in care plans that were discussed with the person. Staff were asked to adopt a person centred 'Do with, not for' approach. People were encouraged to approach management to discuss anything and staff were reminded of this on a regular basis. Therapists had made adjustments to guidelines to ensure that each care or support task was being carried out to a high standard. Therapists attended handovers and staff meetings when they were present to gain extra feedback from the staff. A staff member attended the fortnightly MDT meeting to give feed-back to the therapy team. The care records contained communication guidelines. For example, one person needed one instruction at a time and given time to respond. There were also plans for the speech and language therapist to screen the person's taste and smell to check this had not been affected.

New care records had been developed by the registered manager. We looked at these with the registered manager and they were clearly laid out and would contain all the information in one file so that all people involved in people's care could record information in one place. This would ensure the information was easy to access and ensured important information was clearly filed.

People were protected from the risk of social isolation. Information in care records was used to arrange activities suited to people's preferences. Hobbies and interests were explored and facilitated accordingly. People had been on daily outings such as walks and tea at the garden centre. One person had been going home weekly, so they could enjoy the company of their family. A 'Pet as Therapy' dog visited the service regularly with its owner.
A person who was struggling to understand the effects of their brain injury had been encouraged to find out more information about their condition using the computer. It was hoped this would help the person to come to terms with the changes they had experienced.

Activities to help with rehabilitation such as swimming and going to a gym were recorded and we saw that people were accessing these activities. A person that liked to cook their own food had records from the occupational therapist (OT) stating the person had prepared their own breakfast, taken part in weekly food shop and menu planning. The person had visited the supermarket and selected pizza toppings. They had

also been to a café and ordered coffee and paid. These activities were an important part of the person regaining as much independence as possible as part of recovery. It helped to increase their confidence and gain some control back. Staff understood how important it was for the person to regain as much independence as possible for when they returned home.

The home had a large, well maintained garden area for people to enjoy. Access to the garden was unrestricted and we saw people using the garden which was accessible for people who used wheelchairs. A person, who enjoyed gardening, had planted and weeded the baskets, tubs and raised beds in the garden. We saw staff take a person out for a cigarette when they requested. Staff regularly visited the garden to make sure people were safe and to provide support if it was needed.

The service had received compliments and we saw a recent email stating "I just want to say how delighted and grateful I am that you and your marvellous staff have made [name] life so much more bearable".

People knew how to raise concerns and were confident action would be taken. However, we did not see many complaints. We saw one that had been responded to in line with their policy. Information on how to complain was detailed in care plans and on display in the home. Staff were aware of the complaints procedure and told us they would assist anyone needing to make a complaint. We spoke with the registered manager who said "Complaints are generally dealt with so we don't get many formal complaints".

Residents meetings were regularly held. People were encouraged to raise issues with the staff and registered manager. The registered manager had developed a 'Welcome to Orchard House' folder which would go in each person's room. This had photographs of the management team, staff and described their roles. There were descriptions of therapy provided, for example, speech and language therapy, physiotherapy, psychology. It had detailed information such as 'What should I expect when I arrive?' In the food and drink section, it said 'If you have a favourite meal talk to the catering staff and they will try and include it on the menu'. It said visitors were welcome and friendly pets.

When a person arrived at the service or was getting ready to leave, the service shared information with relevant professionals and aimed to work in partnership with all external agencies to ensure discharge plans kept people safe. A person who was getting ready to return home said, "It's been a very positive experience being here. A totally individual experience". They said they were confident they would receive ongoing support when they left and could phone the service anytime.

Good

Is the service well-led?

Our findings

At our last inspection in July 2015, there was not a registered manager in post. Staff felt unsupported and the communication between management and staff was poor. Management had not carried out effective audits of the service to ensure they were aware of any shortfalls that may affect the safe and effective running of the service. People were not given many opportunities to be involved in activities they wanted or access the local community.

At this inspection we saw that changes had been made to the management structure. The service had recruited a registered manager. They had made significant improvements to the management and running of the service. Staff felt very positive about the management of the service and supported.

Regular audits had been carried out to monitor the quality of service and learning from these audits was fed back to staff to make improvements. For example, following an audit in May 2016, paperwork had been introduced to give a clear account of best interest decisions. The audit had also identified that people needed accessible and clear guidance about safeguarding concerns. This information had been put into the newly developed Welcome Pack. Other audits included medicines and accidents and incidents. Accidents and incidents were recorded and investigated. The registered manager ensured this information was passed on to the MDT to consider at their reviews. For example, a person who had been abusive to staff needed support around their behaviour and this had been implemented into their care records.

We saw there were clear lines of accountability in the service. The registered manager was supported by a deputy manager and senior staff supported the care staff. Discussions with all the staff confirmed that communication had improved in the home and everyone now worked together. One staff member said, "It's like working with friends, a nice environment".

All of the people we spoke with told us they thought the service was managed well. One person told us, "[Registered manager], like her very much". We observed throughout the day the registered manager interacting with people in the service and with staff. The registered manager told us "I have an open door policy. Staff are getting to know that I trust them with their decisions". The registered manager had encouraged and empowered staff. Champions had been appointed for infection control and dementia. Champions are a point of contact for people and other staff in relation to their speciality. Champions had received extra training allowing them to be a point of reference for other staff and give them oversight of their area of specialism.

Staff knew their roles and responsibilities and understood what was expected of them. All of the staff we spoke with spoke highly of the registered manager. One staff member told us, "[Registered manager] is a fantastic, motivational manager". Another staff member said. "The changes since [Registered Manager] has been here are phenomenal. It is much more homely and I feel more supported in my role". Another said, "Probably the best manager I've ever had". Staff we spoke with told us they thought the service was being managed well and the registered manager provided effective leadership and direction. Staff spoke about how the culture of the service had changed and how positive and focused staff were to ensuring people's

needs were met and rehabilitation was the primary aim and focus of people's recovery.

Staff we spoke with were familiar with the provider's whistleblowing policy and they were confident to raise concerns. Whistleblowing is the process for raising concerns about poor practice.

The service had made some positive links with the local community. For example, someone in the village had brought in some fresh flowers. The chef made a batch of cupcakes to give out to people for a local village parade. The registered manager had received a complaint about staff parking and had put measures in place to reduce this inconvenience for residents in the vicinity.

The service worked in partnership with visiting agencies and had good links with GPs, the pharmacist and district nurse. One healthcare professional we spoke with said "When I walk in I always feel everything is running well"

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager of the home had informed the CQC of reportable events.