Stillness 929 Limited

Orchard House

Inspection report

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Ratings

Overall rating for this service	Outstanding ☆

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

Summary of findings

Overall summary

We undertook a comprehensive unannounced inspection of Orchard House on 23 January 2019. Orchard House is a 'care home' registered to provide accommodation and support. 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 is a neurological rehabilitation centre providing specialist community-based transitional rehabilitation for people with brain and spinal injuries, stroke, minimally conscious states and a range of progressive neurological conditions. The service could support up to nine people in one adapted building with communal areas and eight bedrooms. In addition, there is a self-contained flat for those in active rehabilitation to support their move on to more independent living. There were eight people living at Orchard House on the day of the inspection.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection we rated the service Good overall. At this inspection we found areas of the service had improved to Outstanding.

The leadership and management of Orchard House had made significant improvements since the last inspection. This was evidenced by high levels of satisfaction from people, relatives, staff and professionals. The registered manager had aspired to achieve a service that delivered exceptional care and support people in the service. The registered manager had continually thought of initiatives to make improvements to enhance people's lives and those of the staff. The vision and values of the service were reflected in day to day practice and staff demonstrated the values, clearly showing a very person-centred service. The impact of this meant people felt valued and cared for and their feedback reflected this. The registered manager had sought to improve not only their own learning but provided opportunities for staff to develop and learn as well. This was reflected by staff comments about the manager and their effectiveness and how well supported they felt by the manager.

The effectiveness of the service had improved to Outstanding. The service had received re-accreditation with three domains rated excellent from a national organisation that specialised in promoting understanding in all aspects of head injury. Staff were trained to follow best practice and training in this specialist area and specific training was developed to enhance staff's understanding of people's conditions. Staff were provided with excellent support from their manager which meant staff could go on and support people well. The importance of food and fluids had been considered to ensure these provided choice and were palatable and enjoyable. Any risks associated with eating had been assessed and were managed in line with taking positive risks.

People's needs were assessed in all areas of their life and information had been sought to inform people's ongoing care. Current national guidance and advice was used to improve people's health and social care. When people moved to the service they were well supported and at the time of discharge, arrangements were well organised to ensure the person had adequate ongoing facilities in place to meet their needs. People's health was optimised with input from relevant professionals and relevant information recorded to inform other health services to ease communication. Where necessary, technology had been considered and put into place to enhance people's outcomes. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People and their relatives repeatedly praised the kindness of staff. Everyone we spoke with praised the exceptional care that they received from the service. We were given numerous examples of times when staff had gone above and beyond people's expectations to provide truly personalised care. Staff promoted positive values when working with people using kindness and respect continually. Equality, diversity and human rights were well embedded in the service and we saw examples of the registered manager ensuring these were meaningful and respected in practice.
Relatives also felt supported by the service and were appreciative of this. People and their relatives recognised and appreciated these efforts which allowed them to receive their support in a way that made them feel individual and cared for.

The service was truly person centred. People and their relatives described how responsive staff had been to their needs. All levels of the service demonstrated a strong commitment to providing a personalised and holistic service. The registered manager and staff showed a commitment to ensure people's quality of life was optimised and provided emotional support. Staff had gone the extra mile in ensuring the people maintained and experienced interests and activities that were important to them. People were treated as individuals when considering recording any preferences or wishes at end of life. Respect was given when a decision not to discuss this was made.

People were safe. Staff understood their responsibilities in relation to safeguarding. Staff had received regular training to make sure they stayed up to date with recognising and reporting safety concerns. The service had systems in place to notify the appropriate authorities where concerns were identified. Where risks to people had been identified assessments were in place and action had been taken to manage the risks. Staff were aware of people's needs and followed guidance to keep them safe. People received their medicine as prescribed.

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 were supported by staff with a sound understanding of what was needed to keep people safe.

Risks to the health, safety and well-being of people were addressed in an enabling and proportionate way which promoted independence.

Care workers had the knowledge, skills and time to care for people safely and consistently.

There were safe and robust recruitment procedures to help ensure that people received their support from staff of suitable character.

The service had good systems in place to safely support people with the management of their medicines

Is the service effective?

Outstanding

The service was exceptionally effective.

People's needs were fully assessed in line with current best practice to achieve positive outcomes to improve quality of life.

Staff were provided with ongoing and specialist training, support and supervision to ensure they always delivered the very best care.

People's eating and drinking needs were met in a consistently effective way providing choice and managing risks.

The service worked collaboratively with other professionals to ensure that people maintained their health and wellbeing.

People were supported by staff who confidently made use of their knowledge of the Mental Capacity Act 2005, to make sure

people were involved in decisions about their care and their human and legal rights were respected.

Is the service caring?

Outstanding ☆

The service was exceptionally caring.

People and their relatives repeatedly praised the kindness of staff.

Staff promoted positive values when working with people using kindness and respect continually. Relatives also felt supported by the service and were appreciative of this.

People were supported to express their views and make decisions about their care and support.

People could have privacy and were treated with dignity and respect at all times.

Is the service responsive?

Outstanding ☆

The service was exceptionally responsive.

People's lives were improved because of the care they received. All staff recognised people as individuals and worked together to give people high quality support.

People's care was kept under continual review and the service was flexible and responsive to people's individual needs and preferences.

People were actively encouraged to give their views and raise concerns because the service viewed all feedback received as a natural part of driving improvement.

People were consulted about preferences and views to inform end of life care planning.

Is the service well-led?

Outstanding ☆

The service was exceptionally well led.

The leadership and management of Orchard House had improved evidencing high levels of satisfaction from people, relatives, staff and professionals.

The registered manager had continually thought of initiatives to make improvements to enhance people's lives and those of the staff.

The vision and values of the service were reflected in day to day practice and feedback from people, staff and relatives evidenced this.

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 23 January 2019 and was unannounced. The inspection team consisted of two adult social care inspectors.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection we reviewed information, we held about the home, including previous inspections and notifications from the service. A notification is information about important events which the service is required to send us by law. We also reviewed the local authority contract monitoring reports.

During the inspection, we spoke with the registered manager, a team leader, a therapy technician, assistant psychologist, the administrator and the chef. We also spoke with three people using the service and two visiting relatives. We looked at records including two care plans, four staff files, including information about recruitment. We also looked at a range of records relating to the safety, quality and management of the service.

Following the inspection, we contacted feedback from six professionals about their views on the service. We heard back from three.

Good

Is the service safe?

Our findings

People were protected from abuse and avoidable harm. The service had effective safeguarding systems, policies and procedures in place and records showed that safeguarding concerns were investigated, and outside agencies notified appropriately. There were information posters in the service which identified the importance of having a person-centred approach to safeguarding and raised awareness of 'making safeguarding personal'. Making safeguarding personal is about engaging with people regarding the outcomes they want in relation to the safeguarding concern. All staff had an understanding of abuse and knew what to do to make sure that people were protected. A member of staff said, "I would report any concerns and I am confident they would be dealt with". Another said, "I'd alert the manager and if necessary it would go to a safeguarding meeting".

Restrictions were minimised so that people felt safe but had as much freedom as possible. The service was proactive in encouraging positive risk taking to enhance people's autonomy and quality of life. For example, one person wished to go into the local community independently. The person's care plan detailed the risks associated with this and the steps taken to minimise the risk. The risk assessment was regularly reviewed and showed the deterioration in the person's condition. To enable the person to maintain independence in this area of their life, the service had sourced an electronic device that alerted the service immediately if the person had difficulties and enabled the person to speak with the service using the device.

We saw in people's records that all risks that had been identified, had measures in place to ensure people were kept safe. For example, we saw care plans in place to protect people's skin due to not being able to freely mobilise. This meant that all areas were considered and measures in place to protect people safely. The service also had measures in place to assess and reduce the risk of injury caused by people's living environment. We saw records to evidence that areas of risk such as fire, water, equipment and premises were regularly checked in line with guidance.

Where people behaved in a way that may challenge others, staff managed the situation in a positive way to protect people's dignity and rights. We saw that one person could have variable changes of behaviour and we saw that the person's care plan had clearly documented how to support the person, and others, at times when the behaviour was escalated. We saw the person's mood was assessed daily and details of how the person may communicate during these times. Staff were knowledgeable about how to support the person to minimise their distress. We spoke with the person's relative who said, "[Co-ordinator] has really got to know and understand [person's] behaviours and using techniques such as distraction. They've got communication right and that helps". The service did not use physical restraint and staff had received training in ways to manage behaviours that may challenge such as considering the environment and using distraction techniques.

There were enough staff to keep people safe. The registered manager had reviewed the staffing rotas and was trialling a change of shift patterns to both benefit people using the service and to enable staff to have longer periods of rest. Staff had been consulted about the new shifts and were happy to trial these. Throughout the inspection we saw staff taking time to speak with people and spending time with them

chatting.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the service. These included employment references and Disclosure and Barring Service (DBS) checks. These checks identified if prospective staff were of good character and were suitable for their role. This allowed the registered manager to make safer recruitment decisions

Medicines were managed and stored safely. There were systems in place to ensure medicines were ordered and disposed of safely. The service had introduced an electronic system for the recording of medicines administration. The system highlighted if medicine records were not completed which reduced the risk of medicine errors.

Staff responsible for the administration of medicines had completed training and their competency was assessed to ensure they had the skills and knowledge to administer medicines safely. We saw a member of staff administering medicines who took time to ensure people took their medicines as prescribed. For example, one person was at risk of choking. The member of staff ensured the person was seated correctly and placed the medicine on a spoon with some fluid as per the persons' care plan. The member of staff was patient and encouraging, ensuring the person had swallowed one medicine before administering the next.

Where people needed 'as required' (PRN) medicines there were protocols in place to guide staff as to when the person may require the medicine. Protocols also detailed the signs that may indicate the person required the medicine. Administration of topical medicines were recorded accurately. Topical medicines are medicines that are administered to body surfaces. For example, creams and lotions. Where people were prescribed medicines to be applied through a patch to the skin, records identified that they were applied to different areas of the body as per guidance.

People were supported to be as independent as possible in the management of their medicines. One person was encouraged to bring a card to the medicines room when they were due to take their medicines. This was to encourage the person to recognise when their medicines were due and take responsibility for ensuring they received them.

The service managed the control and prevention of infection well and the home was clean and well maintained. Staff followed good infection control procedures which included hand washing and use of personal protective equipment.

Staff understood and fulfilled their responsibilities to raise concerns and report incidents and accidents. We saw records which showed that risk assessments were reviewed and action taken where appropriate to minimise the risk of further incidents.

Outstanding ☆

Is the service effective?

Our findings

At the last inspection, we found that people were receiving good effective support. At this inspection, we found the service had improved further and people were receiving exceptionally effective support to promote their quality of life. People's desired outcomes were identified and care and support based on the best available evidence.

The service had received accreditation from a national organisation, Headway, in respect of people's care and support. Headway's mission is 'To promote understanding of all aspects of brain injury and provide information, support and services to survivors, their families and carers'. Orchard House was an Approved Provider for Headway. This is an accreditation scheme open to residential care settings where they are assessed against standards devised by Headway to ensure they provide appropriate specialist care for brain injury survivors with complex physical and cognitive impairment. The service had just undergone a re-accreditation process and had been judged as excellent in three domains. This meant that care and support continued to be planned and delivered in line with best evidence-based practice.

Assessments of people's needs were holistic and comprehensive. We saw that full information had been sought and recorded to identify outcomes. For example, we saw a person with extremely complex symptoms was having an extended assessment period with a referral to external professionals. This was to ensure that the most effective rehabilitation outcomes could be put in place. The internal multi-disciplinary team often discussed current guidance from The National Institute for Health and Care Excellence (NICE). NICE provides national guidance and advice to improve health and social care. This ensured they were using evidence-based techniques to support the delivery of high-quality care and support.

New staff underwent a comprehensive induction, training and shadowed shifts before working alone. A member of staff said, "My induction is on-going. I have completed break-free training and fire training and many others". The service had also devised a rehabilitation assistant therapy based competencies booklet. This was to assist staff identifying where people were in their rehabilitation pathway, and to engage with and work alongside with therapists. It was also used to demonstrate that staff could carry out therapeutic tasks safely and effectively without supervision. Once tasks were observed as being delivered safely, a therapist signed these off. Each member of staff had their own booklet.

Staff completed a range of training to ensure they had the skills and knowledge to meet people's needs. We saw that training was specific to people's needs such as acquired brain injury, care planning, challenging behaviour, cognitive behavioural therapy and communicating effectively. Where people were diagnosed with specific conditions the service arranged training to ensure staff understood how to support people. The service also included relatives of people to ensure they understood the conditions. For example, the service had arranged for a representative of the Huntingdon Disease Society to speak with staff and relatives. The relative told us, "They [staff] are learning all the time. They've got in the Huntingdon Society which was excellent".

The service had organised a session focusing on sensory impairments of the stroke. Equipment and clothing

had been ordered that would simulate sensory impairments that people may experience after a stroke, such as goggles, leg splint, gloves and heavy clothing. This helped staff to better understand the limitations and feelings of people who were experiencing the symptoms.

Staff received support on a daily informal process and with planned supervision meetings where they could discuss areas relevant to their roles. A member of staff said, "I have regular supervision, including clinical supervision". Annual appraisals took place to review staff practice and consider professional development. We saw that staff had opportunities to progress in the service and saw one person had been promoted and received a letter of appreciation for their contribution from senior management.

People's experience and input in respect of their nutrition had been incorporated into staff development days. A development day had taken place to enable people and staff to understand conditions and the impact on them. For example, the service had arranged a dysphagia day. Dysphagia is the medical term for swallowing difficulties. During the day, food of different consistencies was prepared in line with International Dysphagia Diet Standardisation Initiative Framework [IDDSI]. People then supported staff to eat the different consistencies of food which enabled staff to experience what it was like to be supported to eat and drink. We saw photographs which showed everyone enjoying the day and staff told us how the experience had made them realise how it felt to be supported to eat and drink.

People enjoyed a wide range of good quality food and drink to meet their individual needs. One person told us, "The food is brilliant". There was a new chef who was enthusiastic about improving the food people received and was spending time with each person to find their likes and dislikes. The chef was knowledgeable about people's dietary needs and understood the different consistencies of food people required. They spoke of plans to look at creative ways to make the pureed food look more attractive. People were encouraged to make healthy food choices with alternating puddings of fruit options at one meal and more traditional puddings at another. During lunch time we saw people were not rushed and were enjoying their food. We saw people been given time and encouragement to encourage those who had difficulty eating and we saw they were supported at their own pace. This was assisted by staff having a good knowledge of people and their individual needs.

People with complex needs, such as risks of swallowing problems that may affect their health were supported. For example, we saw risk assessments and consultations and guidelines from Speech and Language Therapist (SALT) to identify and manage risks such as choking. For example, one person's record showed a SALT had visited in recent months due to the person coughing quite a lot. Advice was given about monitoring at mealtimes for signs of increased swallow difficulty or aspiration.

We saw people given options of what drinks they would like during the day. For example, we observed a member of staff asking a person what drink they would like. Choice was communicated in the person's preferred way. The member of staff spoke about options of drinks such which the person selected when they were repeated by a thumb's up. The flavour options were then given and repeated so the person could select their desired option of the milkshake they had opted for. This meant people had genuine choice despite their difficulties in verbally communicating.

When people were discharged, the service ensured a timely and holistic approach in preparing service users for discharge. They ensured all the necessary arrangements such as adaptations and ensuring equipment were in place prior to the person's move.

Technology to support reablement and rehabilitation was used. This included call systems, including epilepsy monitoring equipment, so that care and support could be provided promptly but limiting intrusion.

Another person had environmental controls to promote their independence. For example, the person could control their television, radio and call bell. Another person had a communication aid to assist them in voicing their wishes. A person experiencing involuntary movement was using a computer to type weekly letters to a relative due to their handwriting becoming illegible. The technology was used so that people could maximise their rehabilitation by giving people control.

People experienced effective healthcare which led to an improved quality of life. For example, medicines were reviewed which may cause unwanted side effects. We saw a person was on a reducing dose of a medicine to limit side effects. The person's condition was being monitored for any effects of the change and staff had recorded clearly the dose required and when the dose was due to change.

Health passports had been developed and used to provide consistency in the event of any medical emergencies. The service had also developed 'emergency bags' which people kept on them when out of the service. This contained information such as an ID card explaining what the person's communication needs were and a phone number for the service. The bags also contained the health passports, any rescue medicines that may be necessary and if applicable, a 'Do not attempt resuscitation' (DNACPR) form.

We saw that people had input from an internal multi-disciplinary team consisting of psychologists, neurologists and other professionals who contributed to frequent reviews to ensure people's health needs were optimised. Records confirmed that people had access to local GP's, dentists, opticians and hearing services. Where people had complex or continued health needs, we saw that the service had identified and involved specialist services such as the Huntingdon's Society.

The home and garden had been adapted to meet people's needs and promote accessibility and independence. We saw in corridor's where people's bedrooms were, there was no signage that would make it feel institutionalised. People's rooms were differentiated by a picture chosen by the person that was meaningful to them. This meant they could recognise their room without their privacy being compromised, for example, with names on the doors.

The service was skilled in how it obtained people's consent for care and treatment, involving them in related decisions and assessing capacity when needed, and optimising input from people whose disability made this difficult. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People were supported in line with the principles of the MCA and the service took every opportunity to promote people's rights and ensure they were protected. The service took exceptional steps to ensure people's capacity was assessed and their right to make unwise decisions was safeguarded. For example, one person was at high risk of choking and a speech and language therapy (SALT) assessment identified the person required a pureed diet to reduce the risk of choking. However, this person did not enjoy pureed food and had made the decision to eat food that was not pureed. The person's capacity to make this decision had been assessed and the decision had been supported. The decision was regularly reviewed and discussed with the person to ensure they continued to understand the risks associated with their decision. The person now 'ate with risk'. We saw the person being supported by staff to eat food and was closely monitored. The chef told us they had met with the person to discuss the type of food they enjoyed and look for ways to prepare food that would help manage the risk of choking. A health professional commented, "There is evidence of complex care planning including when a [person] has chosen not to take advice, for

example, when eating at risk. They have been supported to make a capacitous decision and are monitored regularly".

One person had lived at a previous service and had been assessed as lacking capacity to make all decisions. Since moving to live at Orchard House, staff had worked closely with the person to improve communication and as a result had completed capacity assessments in relation to decisions relating to their care. This had resulted in the person making the decision to have a Percutaneous endoscopic gastrostomy (PEG) removed. A PEG tube is a method of feeding people when taking food through the mouth is either not possible or unsafe. The person was now enjoying food and drink orally and was enjoying ordering a take away once a week.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). Where people were assessed as lacking capacity the service considered whether any elements of their care were considered a deprivation of their liberty. A DoLS application was then made to the supervisory body to ensure any deprivation was legally authorised. Where conditions were placed on the DoLS authorisation these were clearly detailed in people's care records and were met. The service had a nominated champion for mental capacity, restraint and consent and the registered manager had developed a flow chart to enable staff to better support service users in the decision-making process when lacking capacity. A health professional provided feedback stating, I am confident. The team follow the MCA and DOLs process. They provide evidence of any issues (when positively risk taking in rehab this is to be expected) and I have seen notices for training. Staff talk about the residents in a respectful way and the culture is one of support. A relative commented, "They (staff) are very good on consent". A member of staff told us, "Everybody has capacity unless it is deemed otherwise". This ensured staff were fully educated and trained to have a comprehensive understanding of the MCA and DoLS.

Outstanding ☆

Is the service caring?

Our findings

People were cared for and supported in a visibly person-centred environment from staff that were highly motivated to offer exceptional care and support in a kind and compassionate way. We asked people and their relatives if they felt staff treated them with kindness and respect and feedback reflected that care and kindness towards their loved ones exceeded their expectations. A person in the service said, "I feel I am safe and in a good place. I am respected. I have been moved from home to home for [number of] years. They [people and staff] are like a second family. I love it here. I was very down and they made me a better man who respects myself and other people". A relative commented, "I am absolutely amazed at the care [person] gets. Girl's [staff] are really good. Always there. Anything you want you get". A professional commented, "I have always seen all members of staff, carers speaking with the residents with lots of care and attention".

Before people moved to the service, there was thorough planning to ensure any anxiety could be reduced. We heard that the service had implemented a designated person to welcome people on the day of their admission to the service by having one member of staff to support the person. We had feedback following the first trial of this as a person had moved to the service a few days after the inspection. The registered manager said the person experienced high levels of anxiety when meeting new people. They found that having one member of staff helped reduce their anxiety levels as they had the constant reassurance from their 'buddy'. It also helped the person to become quickly more orientated to their new surroundings. Another benefit was that having conversations about what the person liked and didn't like from day one, meant delivery of care could be developed in an individualised way. The person told the registered manager, "I've become more myself since I'm here, I can be really me here!" The registered manager said this process had been very successful and they planned to continue incorporating this into their admissions process into the future.

Staff displayed caring qualities and went the extra mile to ensure people felt respected and cared for. People with changing needs had staff that responded in an understanding manner. For example, we saw that people's mood was assessed daily and activities offered in line with how they were feeling that day. A person was celebrating their birthday on the day of the inspection. When they arrived in the dining room, everyone sang Happy Birthday and the person was given a gift and card. Staff tactfully offered support to unwrap the present. The person was smiling and was visually pleased with the welcome and present. Staff comments included, "The staff work together, it is a genuinely caring team", "There is a real family feel to the home", "The job is rewarding more than anything else. I enjoy coming to work because I can really make a difference to people's lives" and "We have a brilliant team here. All very respectful. Everyone goes above and beyond".

Staff received training in equality and diversity and were monitored to ensure the key values of kindness, respect, compassion, dignity in care and empowerment were present in people's day to day care. This ensured people's human rights were well embedded in practice. The registered manager had developed a handbook for equality and diversity called 'Different people, equal care'. Each member of staff was given a protected characteristic to research and collect relevant information and then produced the booklet. The booklet contained detailed information regarding protected characteristics such as sexual orientation for people using the service and staff. There was also information about neurodiversity in employment covering

areas such as autism, dyslexia and attention deficit disorders. This information helped to ensure staff were knowledgeable and supported in order that they, and people they supported, received equality and respect in all areas of their lives. Staff evidenced that they had embedded a human rights approach into their roles encouraging respect for each other and the people they supported. A member of staff gave an example of how this culture had improved relationships between people. For example, one person used to shout at another person when they coughed, now encouraged the person to take a breath after coughing. A relative commented, "They have managed to foster good relationships between residents, even though the residents span a wide range of ability/disability and temperament". Staff commented on the ethos of the service. One said, "It has a wonderful family environment. I would put one of my relatives here if they needed care, definitely". A health professional commented, "I found Orchard House very professional, and caring towards the residents and service providers like me".

Staff created a family environment which ensured the inclusion of people, relatives and staff. We observed staff and people chatting and laughing together which created a relaxed and comfortable atmosphere. For example, during lunchtime, people and staff enjoyed their meal together. A member of staff was encouraging everyone to take part in a quiz which created a lot of banter and gentle competition. It was clear people were thoroughly enjoying the engagement. Staff made sure they took account of people's communication needs and encouraged everyone to take part.

Staff were particularly sensitive to people's emotional needs and we observed staff spending time with people reassuring and comforting them. One member of staff took time to speak with a person about their family and offering reassurance about the next time they would be seeing them.

People's privacy was respected if they chose spent time in their rooms. People were supported to maintain and develop their relationships with those that mattered to them. When family members visited staff respected that people wanted to spend time alone with their relatives. We were given examples of ways that people maintained relationships and how this had impacted on people's emotional stability and wellbeing. Staff were respectful of people's relationships and supported people to keep in contact with relatives supporting visits within the service and at relative's homes. Regular social events were held which families were invited to such as afternoon teas, birthday parties and seasonal celebrations. A local information leaflet was produced to enable family and friends to organise activities/days out with the service user in the surrounding community. This was helpful to those who may not know the local area well.

People were supported to express their views so that staff and managers understood their views, preferences, wishes and choices. For example, where necessary, people had communication aids such as equipment that could type with the use of eye gaze and could then be read by staff.

People could source advice or support from other organisations such as advocacy organisations. This made sure people got the support they needed, to resolve any conflicts and tensions involved with the help of someone impartial. We saw that a person had been supported to consider consulting with an advocate to deal with some family conflict.

People's records reflected a culture of respect. For example, we saw that the term 'vulnerable adult' had been removed from care plan as current guidance no longer saw this as appropriate terminology to describe people. There were emotional and physical wellbeing care plans which detailed how these needs could be met. For example, one to one interaction such as reading poetry.

Relatives of people in the service were also provided with support from the registered manager and care staff. A relative told us, "Very supported. I couldn't come in for a while due to a personal situation and I had

great faith in them during this time and was kept up to date". We saw that consultation had taken place to see if relatives wanted to have regular meetings to support each other. The feedback had been that relatives felt their loved ones had different needs and the issues and impact were very variable. Therefore, it was not taken up but the registered manager said her 'door was always open' and she had moved her office to be near the front door of the home so that she was accessible for people to pop in and chat if they wanted to. Relatives could also access individual sessions with the psychologist.

Staff had a clear understanding of the boundaries of confidentiality and worked within these. Information about staff was also kept in a confidential manner. For example, supervision notes were kept in sealed envelopes to restrict those viewing them.

Outstanding ☆

Is the service responsive?

Our findings

Care plans were extremely person-centred and focused on the person's whole life. They detailed people's life history and the people and things that were important to them, both now and in their earlier lives such as pets and holidays enjoyed. One person's care plan detailed the impact of their condition on their life and their family in a compassionate and understanding way. The care plan also detailed the importance of supporting the person to keep contact with family through letter writing and telephone calls.

Care planning was considered both to people who had an active rehabilitation pathway and for people with long term complex care management where quality of life was paramount. People's needs were respected regardless of their condition, presentation and complexity of their specific condition. For example, delivery of care and support respected a person's right to privacy to express their sexual needs.

The registered manager's approach to person-centred care was evidenced in her drive to provide people with support that would result in an improved sense of well-being. For example, the registered manager told us about a person who could present with behaviour that may be seen as challenging. The registered manager stated that the person was supported through management plans rather than medication and was working with professionals to reduce the person's medication. The registered manager said, "We need to be treating the symptoms. Staff know [person] well and they adjust their interaction daily to respond to their needs". Staff likewise had a person-centred approach to their work and put people at the centre of all they did. Staff comments included, "There is an extremely holistic approach here. We get to know [people] well and that helps us support them as individuals" and "It's a lovely place. It is very client focused. All the carers know every one of them [people] individually".

Care plans were regularly reviewed and when there were any changes in people's conditions. Where people's condition was progressive, care plans recognised the changes in people's abilities and how they could be supported to maintain their independence. For example, one person had enjoyed swimming and was encouraged to continue to attend. Recent changes in their abilities had meant that swimming had become more difficult. Staff had spoken with the person to find alternative ways to help them maintain their fitness. The person had identified that they would like to attend a gym. Staff had supported the person to attend and the person was getting great enjoyment from the sessions.

People were protected from the risk of social isolation. The service used the local community to build links and we heard that people used facilities such as the local pub and shops. Staff encouraged people to engage in interests and social activities with each other and in the community. One member of staff told us how two people who had little verbal communication enjoyed sitting with each other and going out. Joint outings had been arranged to enable the people to enjoy their friendship away from the service.

People enjoyed a range of activities which included reading, trips out, quizzes and watching TV. Care plans recognised the benefit of people being actively engaged and identified the changes in people since moving to live at Orchard House. For example, one-person had displayed behaviours that may be seen as challenging prior to coming to the service. By working with the person to identify how they wished to spend

their time there had been no episodes of this behaviour since the admission.

Staff had gone the extra mile to find out what people had done in the past and did all they could to make it happen again. A 'bucket list' had been implemented into all key worker sessions. Care staff asked people if there was anything that they would like to do. These included going sailing, going on a plane and baking a proper birthday cake for their relative. The benefits were to bring some purpose in life but also some fun and normality which increased their quality of life. We saw that staff had gone to significant lengths to ensure people were able to pursue these. One person had enjoyed sailing. When this was identified staff found a sailing facility that supported people with disabilities. Staff told us there were many issues to overcome but had succeeded in taking the person to the facility six times to try and enable them to enjoy the sailing experience. Unfortunately, the boat had not sailed on those occasions but staff were planning to try again when the weather improves. The staff member told us, "There is huge promotion of independence here. We are given the time to promote that".

We were told that a person was supported to access university to complete their exams during their period of rehabilitation which was one of the person's goals. Another person's career had been as an [name of sport] teacher. The service recognised the importance the contact with the sport had been. However, there were risks associated due to the person's condition deteriorating. The service therefore assessed the risks and presented an alternative facility that presented minimal risk alongside providing the person with a sense of well-being, enjoyment and health benefits.

Reasonable adjustments were made and action taken to remove barriers to communication. The provider complied with the Accessible Information Standard by identifying, recording, flagging, sharing and meeting the information and communication needs of people with a disability or sensory loss. Each person had information in their rooms detailing what to expect from the service alongside information on safeguarding with contact details, decision making, mental capacity and deprivation of liberty process and the right to appeal. This information was adapted to people's cognitive impairments and could be adapted in different formats and/or languages if required, to facilitate understanding. Some people used technology which promoted effective and timely communication.

People and their relatives were aware of how to raise any concerns and that these were dealt with in an open and transparent way, with no repercussions. A relative told us how much they appreciated being able to raise issues without fearing a negative outcome. This was important as in previous services, they had been seen as a 'trouble maker' and felt this impacted upon the person in the service. The attitude of the registered manager and staff when raising issues had been "Refreshing". A relative told us, "We are a team. A small, personalised, well run community service with a positive culture and excellent staff which they retain".

The service demonstrated what improvements had been made as a result of learning from reviews. Feedback had been received as well on things that worked well. For example, a professional had praised the service for the quality of their notes. We saw many expressions of appreciation that had been received from relatives. Examples of this stated, 'Delighted and grateful that you and your marvellous staff have made his life so much more bearable'.

No-one was receiving end of life care. However, we heard that one person had moved to the service with a 'Do not attempt resuscitation' (DNACPR) authorisation. The person had been very depressed when they arrived. The registered manager said they were proud to report that after some time the person requested that the DNACPR be removed as they were enjoying their life and felt their quality of life was such that they wished to receive active assistance to live in the event of a serious health event occurring.

If they wished, people were supported to make decisions about their preferences for end of life care. Details included whether the person had any religious beliefs or wanted active treatment for illnesses that could compromise their life. They also considered people's prior values, beliefs and feelings from relatives who knew the person before the injury. Some people had chosen not to discuss any end of life plans and this wish was respected and documented.

Outstanding ☆

Is the service well-led?

Our findings

Since the last inspection, we found the registered manager had introduced many initiatives and developed the service which meant people were achieving exceptional care and support to enhance their quality of life. This was evidenced by the feedback we received from people, their relatives, staff and professionals who commented on the service at the time of the inspection.

The registered manager had created a positive culture of engaging with people who used the service, their families and with staff. We saw the registered manager led by example by being visible around the service. It was clear she knew people, relatives and staff well and took time to speak with them. The service had a clear vision and strong values which were integrated into day to day practice providing people with exceptionally effective, responsive care delivered with kindness. Staff interviews incorporated applicant's values. We saw questions were asked about how they would work as part of a team and gave examples of their values and qualities with answers such as caring, empathic, respectful, good communicator.

People and their families told us that they felt the service offered care and support over and above what they expected. A relative told us, "[Person] is supported better than they have ever been before and now have an improved quality of life. They've given [person] a quality of life here. Their pain has improved and is managed and this was achieved with correct positioning and they rarely experience any pain now. There is a great sense of community here. It is such a relief to have found somewhere like this which exceeds previous settings. Management have been outstanding and have stood up for [person's] rights".

The registered manager had excellent leadership skills and a desire to offer a high quality, effective and caring service. Staff were motivated by and proud of the service and the manager was available and provided consistent advice. This meant staff felt respected and valued and felt their opinions were listed to and acted upon. All the staff we spoke with were positive about the registered manager. Comments included, "[Registered manager] is very, very down to earth. Everything is two-way. She puts herself below the team and always asks our opinions about any ideas before implementing them", "This is a good place to work and [name] is a good manager", "[Registered manager] is very fair. She has an open-door policy. I would be comfortable to raise any concerns and I know I would be listened to".

The registered manager had developed their own knowledge by pursuing refresher training in brain injury studies and healthcare leadership with the Edward Jenner Programme as part of the NHS leadership academy. This programme was designed with health and care staff to help staff working in a health and care context to understand the purpose, challenges and culture of the NHS. They were also a member of the Skills for Care. This provided the manager with up to date best practice guidelines and legislation which could be shared with the staff team. Staff were also provided with development opportunities. A champion scheme had been developed whereby each member of staff chose an area of care to be responsible for and to lead, develop and implement improvements. For example, the dysphagia champion had been involved in the implementation of the new international descriptors. Another member of staff was being encouraged to pursue a mindfulness course to support the therapies provided in the service.

The registered manager showed a commitment and effective action towards ensuring that there was equality and inclusion in the staff team. For example, the registered manager told us a member of staff felt they had been discriminated against. We saw that the registered manager had taken action to address this and the staff member had been written to with reassurance and offering ways to ensure their rights were respected.

There was a range of quality monitoring systems in place to enable the registered manager and provider to identify and manage risks and to monitor and improve the service. An example of this was a system in place to monitor medicines and ensure they were safely managed. This included counts of all medicines each time they were administered, weekly audits and regular audits from a pharmacist. Where any areas for improvement were identified, action was taken. We saw that the provider undertook quality monitoring visits which identified the service did not identify any areas of improvement. There were regular audits of care plans and behavioural incidents were reviewed monthly by the multi-disciplinary teams and looked at all aspects of care to ensure where support could be improved. The registered manager had an overview of these. Legal requirements, including about conditions of registration and managers, were understood and met.

There was consistent engagement with people who used the service, their families and staff. There was an annual survey for people, relatives and staff. The registered manager had used the outcomes from the survey to develop a 'Together we flourish' poster that identified the excellent work that had been acknowledged through the survey and where the service wished to improve. The registered manager had also developed an electronic feedback system that was in the entrance of the service which enabled people and visitors to provide feedback at any time.

The service had a track record of being an excellent role model for other services as evidenced by the re-accreditation by Headway achieving a rating of excellent in three areas of the service. The registered manager strived to constantly improve the service for people, relatives and staff. Staff had been encouraged to participate in a research project relating to the impact on staff working in rehabilitation services. The registered manager planned to review the outcome of the research and look for ways to make improvements.

The service worked in partnership with other specialist services. These included regular visits from bladder and bowel management nurses, specialist Huntingdon's nurses (specialist neurology practitioners). This meant staff could learn from these specialists about what to expect and so they could report signs of deterioration for early intervention. The service had worked with the Oxford Centre for Enablement and this had provided an improved moving and handling process and positioning for a person which led to huge improvements in managing their pain. We saw in-depth guidelines in place to ensure staff followed these at all times. A health professional commented, "Orchard House have a good understanding of rehabilitation and are willing to be flexible in their approach to ensure they are person centred". Another health care professional commented, "I have looked after three patients with complex care needs at home in the community who have now become residents at Orchard House. All three report they are happy at Orchard House. They all appear less anxious and their care needs are being well met. I would say Orchard House have been highly effective in supporting these patients care needs".