Home from Home Care Limited

Orchard Lodge

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

The inspection took place on 26 July 2016 and was announced.

Orchard Lodge is registered to provide accommodation and personal care for up to six people who have a learning disability.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect them. The management and staff understood their responsibility and made appropriate referrals for assessment. Five people living at the service had their freedom lawfully restricted under a DoLS authorisation.

People felt safe and were cared for by kind, caring and compassionate staff. People were kept safe because staff undertook appropriate risk assessments for all aspects of their care inside and outside of the service. Care plans were developed to support people's individual needs. Staff knew what action to take and who to report to if they were concerned about the safety and welfare of the people in their care. People received their prescribed medicine safely from staff that were competent to do so. The registered provider ensured that there were always sufficient numbers of staff on duty to keep people safe.

People were given a nutritious and balanced diet and hot and cold drinks and snacks were available between meals. People had their healthcare needs identified and were able to access healthcare professionals such as their GP. Staff knew how to access specialist professional help when needed.

People were at the centre of service and staff acknowledged them as unique individuals. Relatives told us that staff were kind and caring and we saw examples of good care practice. People were always treated with dignity and respect. People were cared for by staff that were supported to undertake training to improve their knowledge and skills to perform their roles and responsibilities.

People lived busy and active lives and were encouraged to take part in hobbies and interests of their choice. Some people were supported in education, sporting activities and all enjoyed being part of a strong social network. Relatives commented that their loved ones were well looked after and their wellbeing had improved since moving into the service.

People were supported to make decisions about their care and treatment and maintain their independence.

People had access to information about how to make a complaint.

The registered provider had robust systems in place to monitor the quality of the service and make improvements. Staff had access to professional development, supervision and feedback on their performance. People, their relatives and staff found the registered manager approachable.

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 had their risk of harm assessed to keep them safe.

Staff were aware of safeguarding issues and knew how to raise concerns.

Medicines were stored and administered safely.

Is the service effective?

Good

The service was effective.

Staff had received appropriate training, and understood the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were cared for by staff that had the knowledge and skills to carry out their roles and responsibilities.

People were supported to have a healthy lifestyle.

Is the service caring?

Good

The service was caring.

Staff formed a strong relationship with people and people felt that they mattered.

Staff communicated with people in a way that helped them to understand their care.

People were treated with dignity and staff respected their choices, needs and preferences.

Is the service responsive?

Good

The service was responsive.

People were at the heart of the service. They were enabled to take part in a range of innovative activities of their choosing that

met their social needs and enhanced their wellbeing.

A complaints policy and procedure were in place in that was accessible to people.

Is the service well-led?

Good

The service was well-led.

There were systems and processes in place to check the quality of care and improve the service.

Staff felt able to raise concerns.

The registered manager created an open culture and supported staff.

Orchard Lodge

Detailed findings

Background to this inspection

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

The inspection took place on 26 July 2016 and was announced. The inspection team was made up of one inspector.

We gave 24 hours notice of our inspection because people who live at the service are often out of the service taking part in recreational activities. We needed to be sure that they would be in so as we could speak with them.

Before the inspection, the provider completed 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 what improvements they plan to make. We used this information to help plan our inspection.

We also looked at information we held about the provider. This included notifications which are events which happened in the service that the registered provider is required to tell us about.

During our inspection we spoke with the registered manager, the locality manager, two members of care staff, a member of care staff from the provider's own agency and five people who lived at the service. Following our inspection we spoke with three relatives by telephone. We also observed staff interacting with people in communal areas, providing care and support.

We looked at a range of records related to the running of and the quality of the service. These included two staff recruitment and induction files, staff training information, meeting minutes and arrangements for managing complaints. We looked at the quality assurance audits that the registered manager and the provider completed. We also looked at care plans for five people and medicine administration records for six people.

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 were unable talk with us.

Good

Is the service safe?

Our findings

Most people who used the service had limited verbal communication skills and were unable to tell us if they felt safe living there. However, we watched people interact with staff and saw that they were at ease with staff and did not hesitate to approach staff if they needed something such as a drink or wanted to listen to their music. We observed that people trusted the staff that looked after them to keep them safe.

We spoke with relatives of three people who lived at the service who told us that staff made people as safe as they could. One relative told us that their loved one had lacked road sense and added, "He went to college to learn road safety." We found that their key worker had attended college with them so as they were fully aware of what the person had been advised to do and could continue to support them to keep them safe away from the service.

The provider had policies and procedures in place to support staff to prevent people from avoidable harm, potential abuse and help keep them safe. Staff told us that they had received training on how to keep people safe and how to recognise signs of harm and abuse and who to report any concerns to.

There were systems in place to support staff when the registered manager was not on duty, such as access to on-call senior staff out of hours for support and guidance. There was a business continuity plan to guide and support staff in an emergency situation such as a power failure. If the service needed to be evacuated in an emergency, procedures were in place to relocate people to a neighbouring service. In addition, staff told us that if they needed urgent assistance they had a radio alert system and could summon immediate assistance from a neighbouring service.

People had their risk of harm assessed. We found that a range of risk assessments had been completed for each person for different aspects of their care such as road safety and having the key to their bedroom door. Care plans were in place to enable staff to reduce risks and maintain a person's safety.

We looked at two staff files and saw that there were robust recruitment processes in place that ensured all necessary safety checks were completed to ensure that a prospective staff member was suitable before they were appointed to post. We spoke with an agency care worker who was employed by the provider's own agency. We found that they had undergone the same recruitment and induction processes as permanent members of staff. Furthermore, it was their first time working at this service and they were given a full tour of the premises, introduced to the people who lived there and given time to read care plans and other important information before they were acknowledged as responsible to deliver care and participate in overseeing activities with people.

We found that the provider employed sufficient numbers of staff to keep people safe and each person had a support worker allocated to them to assist with assessing, planning and delivering their care and social needs. The registered manager explained that the service used a "layering system" of staffing to ensure people had the right support to undertake hobbies and interests and keep them safe inside and outside of the service. Having a layering system meant that staffing levels were increased to cover periods of high

activity. For example, we saw that one person had support from one member of staff when they were in the service. However, if they went on a trip out this was increased to two staff members. Staff told us that there was enough staff to meet people's care needs as people received a minimum of one to one support. Relatives told us that their loved one had the right level of support to meet all of their needs.

People received their medicine from staff who had received training in medicines management and had been assessed as competent to administer them. We were unable to observe medicines being administered as most people were only prescribed medicine at breakfast time and bed time. We looked at medicine administration records (MAR) for six people and found that medicines had been given consistently and there were no gaps in the MAR charts. Each MAR chart had a recent photograph of the person for identification purposes and any allergies and special instructions for taking medicines were recorded. Where a person did not receive their medicine a standard code was used to identify the reason, such as when a person was on a visit to their family home or an external activity. We saw that there was a separate sheet that went with the person on leave and a responsible person, such as their relative had signed to say that they had received their medicine and recorded the balance left.

All medicines were stored accordance with legal requirements, such as locked cupboards, medicines trolleys and fridges. There were processes in place for the ordering and supply of people's medicines to ensure they were received in a timely manner and out of date and unwanted medicines were returned promptly. Staff had access to guidance on the safe use of medicines, the medicines policy and a system that identified when medicines needed to be reordered.

Good

Is the service effective?

Our findings

Relatives told us that staff has the skills to care for their loved one. One relative said, "They staff know everything about him. We have spoken with the providers and they have given us confidence in the care he receives" People were unable to tell us if staff had the knowledge and skills to look after them. Therefore we observed staff deliver care to people and saw that they acted in a responsible and confident manner. All staff undertook mandatory training in key areas such as safeguarding, deprivation of liberty safeguards and health and safety. In addition, staff were provided with training in areas relevant to the care needs of people who lived in the service such the care of a person living with epilepsy and autistic spectrum disorder and supporting a person with communication difficulties in everyday activities. The provider had their own training facility that staff attended for most of their training needs. Staff spoke positively about the training they received. One staff member said, "Training is very good, it's consistent and planned to 2017. My induction was full on, it was very good. I have refreshers every year."

The provider had their own staff agency to cover for sickness and holidays. We found that agency staff received the same high standard of induction and training as permanent staff. We spoke with a member of agency staff who told us about their induction and training. They said, "I was trained in everything before I was allowed on the "shop floor" even although I had worked in care before. It was very thorough and I also received extra training in safe hold and breakaway techniques to use the least restrictive moves, unique to that person."

Staff received regular supervision sessions every two months and an annual appraisal. We looked at supervision records for two members of staff and saw that their feedback was positive and their professional development needs had been identified and required action recorded. For example, a new care plan format had recently been introduced and one member of staff had identified this as a training need that required support to be achieved. The registered manager also received regular supervision and an annual appraisal from their line manager. Agency staff received supervision and appraisal from a member of the head office staff. A recently appointed member of staff told us, "I had my monthly supervision yesterday. It was really good one to one time. I was asked if I was happy in my work and we talked about the guys [people who lived at the service]."

The people who lived in the service were not always able to give consent to their care and treatment and we saw that staff followed the guidance in the Mental Capacity Act 2005 (MCA). The 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. For example, we saw that people had their mental capacity assessed and best interest decisions were made so as they could receive their medicines safely.

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 procedures for this in care homes and hospitals are

called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had followed the requirements in the DoLS and six applications had been submitted to the relevant local authority and five were approved. Furthermore, we saw that the provider had complied with the conditions of the DoLS.

The provider had properly trained and prepared their staff in understanding the requirements of the MCA and staff knew how to support people subject to a DoLS authorisation. Relatives we spoke with were aware of the DoLS authorisations and had been involved in the process.

Relatives told us that their loved ones were well fed and where they had not shown an interest in food in the past, they now did. One person's relative said, "There is always lots of it. He will only eat beige food, not greens. He enjoys computers, they are functional, so he helps [food] shop on-line." Another relative told us, "He can watch meals being made and can have snacks. Gaining access to the kitchen is good for him. They have revolutionised his approach to food,"

Although food and drink was stored in locked cupboards and fridges for people's own safety, people could have a drink or snack at any time. We observed when a person lacked the ability to verbalise that they wanted a drink or a snack they stood at the snack cupboard or took a member of staff to the cupboard. The staff recognised this as a sign that the person wanted something to eat and drink and helped them make their choice.

Mealtimes were flexible and were planned around the times that people were coming and going from their different activities and trips out. At lunchtime there was no set menu and people choose what they wanted to eat and drink. We saw one person who was assessed as able to assist with meal preparation make their own sandwich.

Photographs of the evening meal were displayed on the kitchen cupboards to help people who lived at the service to understand what their main meal of the day was. Two people did not like fresh food and ate what their relatives and staff called "grey food". We found this was mainly finger food such as chicken nuggets and other breaded foods. Staff told us that they worked with the people to gradually introduce new foods that were more nutritious, but this was a long slow process.

People were supported to maintain good health. We saw that people had access to healthcare services such as their GP, dietician and psychologist. Furthermore, people had a weekly health check from staff and an annual health check from their GP. One person's relative told us that their loved one had had a seizure and now they had a monitor on their bed to alert staff.

Staff supported people to take regular exercise to maintain their physical fitness. We saw that a wide range of activities were enjoyed, such as swimming, rock climbing and trampolining.

We saw staff had worked in partnership with health professionals and relatives so that different relaxation approaches were taken with people to help them stay calm and reduce their anxieties. For example, one person could not tolerate heat and had an air conditioning system in their bedroom; another person liked water therapy and enjoyed sessions in their paddling pool and another person relaxed to water music when they went to bed at night. Some people regularly accessed the sensory room in the adjoining day care centre. Staff told us that these approaches had led to improvements in a person's overall wellbeing and people had made progress with improving their independent living skills. One staff member said, "We adapt as we need to." Another staff member told us," [person's name] has come on leaps and bounds since he

used the sensory room."

Good

Is the service caring?

Our findings

We observed staff interacting with people who lived at the service. People and staff had a good relationship and there was evidence of mutual respect and trust. For example, one person with limited verbal communication skills frequently approached members of staff and raised their hand to "high five" them. The person's facial expression demonstrated that they were happy that the staff member reciprocated their gesture.

We spoke with relatives who were positive about the care their loved one received. One relative said, "Definitely improved with lots of prompts. Much more confident, really happy." Another relative said, "It's the tops, it's brilliant. Staff have the skills to care and they have a good relationship with him." The relative went on to tell us that their loved one trusted staff and followed their lead. They gave an example, "He now washes up his plate after a meal." Their relative saw this as a significant improvement in their ability.

We found that a person centred approach was taken with people who were unable to communicate their needs verbally. For example, one person used picture cards to inform staff when they wanted to make a snack or a drink. We spoke with their relative who said. "He uses PECS [picture cards]. He's really trained to use them. It's a good thing." In addition, people had a communication passport that they took with them on visits to their GP or to attend an outpatient appointment. We noted that one person's passport translated what different sounds meant to them.

People were provided with information on how to access an advocate to support them through complex decision making, such as moving into the service. Advocacy services are independent of the service and local authority and can support people to make and communicate their wishes. We saw where one person had complex family issues and an advocate had been appointed to act on their behalf so as they could continue to live at Orchard Lodge.

People were enabled to maintain contact with family and friends and could receive visitors at any time. We saw that in addition to visits to the family home and being involved in family holidays that people were supported to communicate with their relatives through social media. For example, Skype, emails and telephone calls. A relative told us, "He comes home every other weekend. There are no barriers to visits."

We observed how staff enabled people to develop and maintain their skills to live an independent life. The service did not employ ancillary staff such as a cook or housekeeper. People who lived at the service were supported to undertake a range of general housekeeping duties. For example, one person assisted with on-line food shopping twice a week, others helped with meal preparation and all were supported to keep their bedroom and lounge area clean and tidy and do their laundry. We observed people and staff working together in the kitchen, making lunch and preparing their evening meal.

We saw that people's right to their privacy and personal space was respected. For example, we noted that a person who had moved into the service three years ago still had "welcome to your new home" cards on display in their lounge area. Staff told us that they would never move a person's personal possessions

without their permission. Another person had a special film put on their window so as they could sleep with their curtains open at night without anyone looking in.

We saw that one person had the key to their bedroom door. This provided a sense of security and ensured that other people could not enter their bedroom without their permission. A staff member told us that they were very aware of the need not to walk into a person's rooms uninvited and said, "We all respect each other [people who lived at the service and staff]. Staff know to knock on the door; we don't barge in. It's their home, not mine."

Good

Is the service responsive?

Our findings

The service was purpose built and adaptations were made when necessary to meet the individual needs of the people who lived there. Each person had their own self-contained living area with a bedroom, lounge/craft room and an en-suite bathroom or shower room. All bedrooms had access to the garden and some people had a front door with a porch to hang their coats and store their shoes. Five people were happy to show us their rooms. We saw that their decoration, furniture and personal items were relevant to their needs and preferences and people had chosen them themselves and most were very homely. For example, one person had posters of their favourite cartoon film characters and photographs of places they had visited with their family. Another person who was at risk of destroying their personal possessions and furniture had their belongings securely locked away. However, staff assisted the person to access their personal belongings when needed. People communicated to us that they liked their accommodation. In addition there were two open plan kitchen/lounge/dining areas where people met to take their meals and socialise. Staff told us that the design of the building was most suitable for the people who lived there. One staff member said, "It has open space and the clients are happy. A closed space would raise their anxieties and they would feel cooped in. It is well designed" These comments were echoed by relatives. One relative told us, "We looked at several homes, he's got space here." Another relative said, "I'm very impressed with the space. He has his own lounge, never had that before. It has a good shared space."

We found that before a person moved into the service there was a period where a key member of staff got to know the person and their relatives and supported the transition from one care environment to another. A relative told us that they came to see the service before their loved one moved in and were shown his room. They told us, "I like the approach of the provider. They tend not to make it institutional."

The provider had a discussion group called "our voices" for people who lived in their services. One person who lived at the service was the nominated vice chairman of the group and represented their peers and people who lived in a neighbouring service. We saw that the person kept a record of their regular monthly meetings. We saw that the meeting minutes were accessible to all and were recorded in word and picture format. Furthermore, there was a photograph of all the people who attended the meetings.

The registered manager told us that each day was different and structured around the people who lived in the service and was influenced by their planned activities and individual moods and behaviours. We observed and care records recorded that people lived busy and active lives and were encouraged to take part in hobbies and interests of their choice. Some people were supported in education, others in work placements, sporting activities and all enjoyed being part of a strong social network. We found that people's sporting, life skills and academic achievements were recognised. For example, we saw one person had a nationally recognised certificate of achievement for "skills for independence" and other person had received an award from The Prince's Trust for gardening. The Prince's Trust supports young people to unlock their potential and learn new skills. Relatives told us that there was so much for their loved one to do. One relative said, "We got the right place for him in the middle of the country. He loves countryside walks."

We saw that staff exchanged information about a person's care needs and wellbeing at shift handover to

maintain continuity of care throughout the day. The handover was face to face and also an electronic record was maintained and staff could consult this at any time during their shift.

People had their care needs assessed and personalised care plans were introduced to outline the care they received. Care was person centred and people and their relatives were involved in planning their care. One person's relative told us, "If I need to, I have a look at the care plans. And I like to see what he's spent his money on." We looked at the care plans for six people. We saw that individual care plans focussed on supporting a person to live well and maintain their independence. A new care plan system had been introduced across the provider organisation following feedback from CQC inspections undertaken in the last year. We found that the new care plans were straightforward and we readily found the information we needed.

The vice chairperson of "our voices" discussion group had been involved in creating a "resident" satisfaction survey. The survey used pictures and words to help people understand the questions asked and people gave their response through "yes, no and don't know" smiling faces.

We looked at the minutes of the "our voice" meeting held in July 2016 and saw that topics for discussion included the success of the May Ball where people and staff had dressed as super heroes. Overall the minutes were person centred and about what was important to people who lived at the service. In addition people were invited to attend regular house meetings to discuss day to day issues. However, most people did not want to attend.

People and their relatives had access to information on how to make a complaint. One person's relative said, "If I have any concerns I will talk with the staff. I am never made to feel like a nuisance." Staff told us that if they received a complaint they would escalate the concern to the registered manager or the locality manager. The registered manager had not received any complaints about the service. However, we saw that relatives had given positive feedback through the annual quality assurance questionnaires.

Good

Is the service well-led?

Our findings

Staff told us that they found the registered manager approachable and supportive. And said they could go to them at any time. The registered manager was supported by the locality manager, who was also the registered manager at a neighbouring service. The locality manager acted as a mentor to the registered manager.

Monthly staff team meetings were held with the registered manager and a member of the human resources department. Human resources attended so as any employment issues could be addressed straightaway. Staff were expected to attend a minimum of ten meetings a year. Team leaders had an additional monthly meeting with the registered manager. The locality manager led group meetings with staff and staff from the neighbouring service. We found that the "our voice" representative also attended these meeting on behalf of their peers. A member of staff spoke of the strong camaraderie between colleagues and said, "I love it. We have a strong team; we all get on really well and do lots of outside activities together."

We found that the registered manager was a visible leader, knew their staff and the people in their care. Relatives told us that they could speak with the registered manager at any time.

Staff had access to policies and procedures on a range of topics relevant to their roles. For example, we saw policies on safeguarding and infection control and guidance on safely managing violence and aggression. Staff were aware of the whistle blowing policy, knew where to find it and knew how to raise concerns about the care people received with the registered manager. A member of staff told us, "I'm aware of whistleblowing. I would not hesitate. It could be one of my family."

A programme of regular audit was in place that covered key areas such as health and safety, medicines and infection control. Action plans with realistic time scales were produced to address any areas in need of improvement. The audit outcomes and required actions were shared with staff. In addition, some areas were subject to external audit such as the safe management of medicines by the dispensing pharmacist. In addition, the service had an unannounced quality audit once a month that is structured on the Health and Social Care Act 2008 regulations. The registered manager also undertook regular health and safety walkabouts of the service.

The provider had a system were the registered manager reported their staffing levels and skill mix, and accident and incidents to their head office once a week. In addition, the provider had informed us of notifications as required by law. Notifications are events which have happened in the service that the provider is required to tell us about.

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