Friends of the Elderly

Orford House Residential Care Home

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 4 and 6 December 2018.At our last inspection of the service in November 2017 we rated the service 'Requires Improvement' overall. This was because staff were insufficiently prepared to respond to a fire emergency, they did not receive supervision or appraisal and quality assurance processes were not robust. We rated the service 'Requires Improvement' in the domains of 'Safe', 'Effective' and 'Well-led'.

At this inspection we found the service had improved in relation to each key question and as a result the service's overall rating has risen to 'Good'.

Orford House Residential Home is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Orford House Residential Home accommodates up to 29 people in one adapted building. The service specialises in supporting older people some of whom maybe living with dementia. At the time of our inspection there were 22 people using the service.

The service did not have 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. The manager of the service had submitted an application to register with CQC shortly before our inspection.

People's safety was enhanced by the preparedness of staff to respond to emergencies. Staff received on-going training to ensure they were clear about their roles and responsibilities in safeguarding people from improper treatment and the provider took prompt and decisive action where safeguarding concerns arose. Risk assessments were in place to reduce people's risks of experiencing avoidable harm. The provider ensured that staff were safe and suitable to deliver care and support. The environment of the care home was clean.

People's assessed needs were met by trained, supervised and appraised staff. People's mental capacity was assessed and supported. People ate well and staff supported them to access healthcare services whenever required. People, their relatives and healthcare professionals were actively involved in successful transitioning into the service.

People and relatives told us the staff were caring and kind. Staff respected people's privacy and dignity and promoted their independence. People and staff shared positive relationships and visitors were made to feel welcome at the service.

Staff were responsive to people's changing needs. People's needs were detailed in their care plans which

people participated in developing. People engaged in a range of activities made available at the service. The provider managed complaints appropriately. Staff ensured that people were cared for compassionately at the end of their lives and in line with their preferences.

The service had improved the robustness of its quality assurance processes so that action was taken where shortfalls were identified. Staff felt supported by the manager and encouraged to share their views regarding improvements to the service. The provider sought and responded to feedback from people and relatives and made information available to them. People benefitted from the provider's partnership working with external organisations.

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. Assessments and clear procedures were in place and understood by staff to respond to fire emergencies.

Staff were trained and understood their role to safeguard people from abuse.

People had their risks assessed and plans were in place to reduce them.

People were supported by safe and suitable staff.

Staff administered medicines in line with the prescriber's instructions.

Is the service effective?

Good

The service was effective. Staff were supervised and appraised.

Staff received on-going training to meet people's needs.

People were supported to eat and drink well.

Healthcare professionals visited the service to support people when required

People were treated in line with mental capacity legislation.

Is the service caring?

Good

The service remains caring.

Is the service responsive?

Good

The service continued to be responsive.

Is the service well-led?

Good

The service was well-led. Robust quality assurance processes were in place.

Staff felt supported by the manager and the provider organisation.

Staff were encouraged to share their views about improving the care and support people received.

The provider responded to feedback from people and their relatives.

The service worked collaboratively with external organisations to achieve positive outcomes for people.

Orford House Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 4 and 6 December 2018. The first day was unannounced. This inspection was carried out my one inspector and one 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.

Prior to the inspection we reviewed the information we held about Orford House Residential Home including notifications we had received. Notifications are information about important events the provider is required to tell us about by law. We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to share with us some key information about the service, what the service does well and improvements they plan to make. Following our last inspection the provider also sent an action plan detailing the improvements they intended to make. We used this information in the planning of the inspection.

During the inspection we spoke with10 people, one relative, one visiting food safety officer, three staff, the activities coordinator, office manager, house manager, regional director and the director who was also the provider's nominated individual. We reviewed nine people's care records which included needs and risk assessments, care plans, health information and support plans and medicines administration records. We reviewed eight staff files which included pre-employment checks, training records and supervision notes. We read team meeting minutes, compliments and complaints and the provider's quality assurance records.

Following the inspection we contacted three health and social care professionals to gather their views about the service people were receiving.

Good

Is the service safe?

Our findings

At our last inspection in November 2017 we rated the service requires improvement. This was because people were not protected by the readiness of staff to respond as planned in the event of an emergency. The service had not complied with its policy to undertake building evacuation drills and staff were not clear what the provider's evacuation plans were.

At this inspection we found that the provider carried out fire drills which enabled staff to rehearse building evacuations. The details of each drill were recorded. People had Personal Emergency Evacuation Plans (PEEPs) which provided staff with detailed information about people's individual support needs during a building evacuation. All staff undertook fire safety training and the service's fire alarm systems were tested each week. Checks were also undertaken of the automatic closing fire doors which were located throughout the building to ensure they closed when the fire alarm activated to keep people safe. In addition, a fire safety risk assessment was carried out by external fire safety specialists. This assessment reviewed the home environment along with fire detection and alarm systems. The provider took action where required in response to fire safety checks and assessments. This meant people's safety was enhanced by the service's preparedness to respond appropriately to a fire emergency.

People were protected from abuse and improper treatment. The service had safeguarding procedures in place and staff received on-going training around identifying signs of abuse and the immediate actions they should take. Staff we spoke with understood their role in protecting people from abuse and their duty to report any suspicions of abuse. Where safeguarding concerns were raised the provider acted promptly and decisively to protect people. This included making safeguarding referrals to the local authority, notifying CQC and taking action through its disciplinary procedures to ensure people's safety.

The risk of people experiencing avoidable harm were reduced because of the assessments and plans staff put into place. People's risks were assessed and where risks were identified action was taken. People were supported with regular assessments of their falls risks. These assessments looked at a number of factors which could contribute to increasing the risk of falls such as people's medicines, health issues, mobility, continence and falls history. Where people were identified to be at risk of falling, referrals were made to healthcare professionals who undertook assessments. Staff implemented the recommendations of healthcare professionals to ensure people continued to mobilise safely.

People were protected from the risk of malnutrition. Staff used nutritional assessment tools to assess if people were at risk of eating too little. With their consent staff weighing people and took action where unplanned weight loss was identified. This action included referring people to the GP and dietician and following the guidance healthcare professionals provided. People with poor appetites who were at risk of weight loss were supported with fortified meals and calorie dense drinks.

Where people presented with health-related risks these were assessed and people were supported to see a health professional regularly. Care records noted people's physical health needs and their associated risks and provided staff with detailed information to identify if people were becoming unwell. Care records also

provided staff with guidance on the actions to take if they observed any symptoms of deterioration.

There were enough suitable staff available at all times to ensure people received their care safely. People told us there were enough staff to support them. One person told us, "They are good at coming when I buzz – you don't have to wait and worry." The manager ensured there were sufficient numbers of staff available by completing a dependency tool and the provider ensured staff were suitable by using robust recruitment processes. The provider's recruitment process included interviews, criminal records checks, proof of identity and taking up two references. This meant people were supported by staff whom the provider assessed to be safe to deliver care and support.

People received their medicines safely. Staff were trained to administer medicines and completed people's medicines administration records appropriately. Medicines with significant risks associated with them are called 'controlled drugs'. The provider had additional security and checking measures in place for controlled drugs including a separate locked cabinet and increased monitoring with daily stock checks and double staff signing. Where people were prescribed 'when required' medicines there were clear protocols in place for staff to follow which included the number doses people could receive during a 24 hour period.

People were protected by the hygiene practices used at the service. Staff wore personal protection equipment (PPE) when providing personal care. PPE included gloves and aprons which were used once and then disposed of to reduce the risk or spread of infection. Each bathroom and toilet had hand wash and paper towels and posters demonstrated correct techniques for handwashing. Hand sanitiser dispensers were located around the building. There was limited food preparation at the service as main meals were cooked and delivered from another location. Staff tested the temperature of food when it arrived at the service to ensure it was safe and records were maintained of the serving temperatures of food. Staff received food safety training as part of their induction and regular refresher training. There were regular checks of foods stored in the fridge and staff followed a kitchen cleaning programme which was reviewed by the service manager. The service scored a four out of five food hygiene rating when inspected by the local authority. This score equates to 'Good'.

The service used identified shortfalls and incidents as a learning opportunity. The manager was supported by senior managers from the provider organisation to review issues when things had gone wrong. Lessons learnt from these reviews were shared with the team and used to drive change.

Good

Is the service effective?

Our findings

People's needs were assessed and met. The provider undertook comprehensive assessments of people's needs and made referrals to healthcare professionals where specialist assessments were required. People participated in their assessments which covered areas including physical health and mobility, risk assessments, emotional well-being and mental health. Where people's needs changed they were supported with reassessments.

Staff received training to meet people's needs effectively. The manager monitored the training staff undertook to ensure they maintained their skills and knowledge. Training undertaken by staff included moving and handling, fire safety and mental capacity. Training also covered areas specific to people's needs such as dementia awareness and challenging behaviour. Refresher courses were provided regularly to keep staff skills up to date. New staff joining the service received an induction which included core training and shadowing experienced colleagues as they delivered care and support. One member of staff told us, "The manual handling and dementia training were particularly good for me because I came from outside of the care industry and I needed to learn things quickly."

The new manager had started to implement a programme of planned supervision meetings and appraisals. These meetings were used to discuss people's changing needs as well as the support and training needs of staff. Goals were set for staff during appraisal which were reviewed during supervision. Staff told us they found the supervision and appraisal processes beneficial. One member of staff told us, "It is a good opportunity to find out how you're getting on and what will happen in the future." Another member of staff said, "I was really pleased when I got positive feedback."

People received the support they required to eat. Staff assessed people's nutritional needs and met people's preferences. Where people required support to eat and drink staff did this in line with the guidelines developed by healthcare professionals. People's dining experience was relaxed and social and we observed people and staff conversing and enjoying each other's company.

People were supported with effective transfer arrangements. The service had undergone significant changes since our last inspection. A second service delivered by the provider and located across the road from it had closed. The majority of people living in the other service resettled to Orford House and a number of staff redeployed to Orford House too. As part of the transition arrangements the provider hosted multiple meetings for people and their relatives. Healthcare professionals assessed people's needs and where necessary people were supported with the involvement of advocates. People moving to Orford House chose their new bedrooms and were allocated a member of staff from their previous service to provide continuity during the transition. This meant people were supported with effective transfer arrangements. To improve team cohesion the provider arranged for staff to participate in a series of team building exercises following the amalgamation.

People had access to healthcare services when required. A GP and practice nurse regularly visited the service. Where people received ongoing support from healthcare professionals this was stated in care

records. For example, where people received input from physiotherapists staff maintained records of the appointments and any guidelines to be followed by staff.

The service was homely. Living plants were visible on window sills and people's artwork was displayed around the building. The redecoration and refurbishment that was underway at our last inspection had been completed. The result was a bright and clean service. The service was wheelchair accessible throughout including the courtyard garden where astro turf had been laid. Shaded areas had been created in the courtyard to provide people with respite from the sun on hot days.

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 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).

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 had the appropriate legal authority and were being met. We found that the manager had submitted a number of DoLS applications to the local authority to place restrictions upon people to keep them safe. Care records detailed the assessment and decision-making processes along with the restrictions to be put in place. Where the responsibility for people's finances and property lay with relatives or solicitors this was stated in care records along with copies of the supporting legal documentation.

Good

Is the service caring?

Our findings

At our last inspection in 2017 people and their relatives told us staff were kind and caring. At this inspection we found this continued to be the case. One person, referring to the staff told us, "They are all good people." Another person said, "I like them. I think they are nice."

People and staff knew each other well and care records contained personal information that enabled staff to learn about people's backgrounds. People's care records included the recollections they shared with staff about their lives. These reflections included people's early childhoods, teenage years, working lives and significant relationships. Some people's care records contained their family trees with the name and dates of birth of their parents, siblings, children, grandchildren and great grandchildren. Staff told us this information enabled for meaningful conversations to occur and positive relationships to develop. One member of staff told us, "Nothing is better than knowing about people because you can chat about stuff they like with them and you both get to enjoy it." Another member of staff said, "Listening to people is so important. Find out about what interests people and you're half way there."

People's care records were written in a way which promoted respect towards them. For example, within one person's care records, in a section entitled, "What people appreciate about me", one person stated, "I've had an interesting life." Another person's care records said, "My friends appreciate my company". Care records noted people's legal names but their preferred names were used throughout. We also heard staff address people by their preferred names.

Staff encouraged people to make choices about how they received their care. One person told us, 'It's entirely up to me when I get up or go to bed." Another person said, "I like to have a quiet snooze after lunch. The staff are good, they don't wake me. They know I don't go back into my room until night time." People chose the activities they engaged in and how they received their care and support. People's preferences were noted in their care records and known to staff.

People's cultural and spiritual needs were identified, assessed and met. People, and where appropriate their relatives, shared information they considered relevant which was staff noted in care records. This information included faith related activities, diets and practices. A local vicar regularly attended Orford House to deliver a service to people. The vicar also visited people who chose to remain in their rooms to lead individual prayer and administer communion.

People were supported to experience mealtimes as relaxed and social events. We observed the care and support people received during their lunchtime dining experience on both days of our inspection. People dined in naturally brightly lit area. Tables were well dressed with tablecloths and flowers. Where people required tabards, these were placed on them with their consent. Where people required support to eat staff did so in an unhurried manner whilst talking with people. Conversation was free-flowing around dining tables and we saw the chef asking people how their meals were.

People's privacy was protected. People received their personal care behind closed doors and staff knocked

people's doors before entering. One member of staff told us, "Some people have failing vision. So you always tell them who you are and kind of give a running commentary on what you're doing. It's always important to say when you are leaving their room and when you'll be back." People's information privacy was also maintained by staff who kept people's care records in locked areas where they could not be viewed by visitors or other people.

Staff promoted people's dignity. People's care records contained their preferences for how their personal care should be delivered. For example, one person's care records stated, "[Person's name] likes to have a bath run by staff and then left to enjoy it." A member of staff said, "I always ask people if they want some alone time in the bath to have some privacy and a soak and relax." Another member of staff told us, "I talk to people when I am giving them assistance so they feel don't uncomfortable and I use a towel when giving person care so that people aren't completely exposed." Staff protected people's dignity around issues of continence. Where people required prompting to use the toilet staff did this discreetly. Care records reflected people's needs and preferences around continence support. One person's care records stated, "[Person's name] likes to empty their commode themselves" Another person's care records noted that whilst they could meet their own personal care needs and dress independently, staff support in the form or reminders and suggestions were required to avoid the person wearing the same clothes on multiple days.

The service did not place any restrictions on visitors. People and relatives told us that staff made visitors welcome when they visited the service. Visitors were able to spend time with people in communal areas, quiet areas and in people's bedrooms. Snacks and drinks were made available to friends and relatives when they visited.

Good

Is the service responsive?

Our findings

At our last inspection in November 2017 we found the service was 'Good' when we asked the key question 'Is the service responsive?' At this inspection we found the service continued to be good.

People continued to have care plans in place which detailed how staff should meet their assessed needs and preferences. People's care plans were regularly reviewed and updated to reflect their changing needs. People's care records continued to state what was important to them. We read in one person's care records that what was important to them was, "Peace and quiet" and "listening to classical music." In another person's care records, we read, "Artwork." Care records also noted information of day-to-day importance to people such as where people who wore glasses kept them when not being worn was noted. Staff used this information to reassure people who may have forgotten where their glasses had been left and were worried they were lost.

The renovation and redecoration that was under way at the time of our last inspection had been completed before we started this inspection. The service had developed a dementia friendly environment. Signage around the service was in large text and clear. Pictures were used to illustrate what rooms such as the kitchen and bathroom where contrasting colours supported people's ability to differentiate between surfaces. For example, toilet seats were blue, making them easier for people to see. Similarly, doors were a different colour to the walls they were set in. People's photographs were on their bedroom doors to enable them to recognise their rooms and the provider was advancing plans to introduce personalised memory boxes for people.

A range of activities was available at the service for people to participate in. The service had an activities coordinator who planned and led activities with people. These included arts and crafts, music, quizzes, bingo, board games and chair exercises in group settings. Activities were also provided on an individual one to one basis. These activities included hand and head massages, aromatherapy sessions, and facials. The service received visiting entertainers and had recently hosted performances from a local choir and a ballet school.

We received mixed feedback people who spent most of their time in their bedrooms about their experience of social isolation and the provider's actions to counter it. One person told us, "I don't like crowds so choose not to go downstairs but that means that there's nothing for me to do except watch television. That can get me down." Another person said, "You can be on your own for a long time and I get anxious then." A third person "I stay in my room and they are good at checking in on me but it would be lovely if someone could stop for a chat." However, other people who chose to remain in their bedroom said they liked that their choice and privacy were respected. One person commented that they liked when staff brought them hot chocolate and stayed for a while to chat. Another person told us they liked when staff read to them in their bedroom. A member of staff told us, "We always offer to take people to group activities. Even if they say no every time it helps them to know what is going on within the community of the home every day." Whilst one to one activities were delivered to people in their bedrooms by the activities coordinator and staff regularly check people, the new manager recognised the need to increase the quality of support people received to

prevent social isolation and was making plans to achieve this. We will be checking to confirm this has happened.

A clear complaints procedure was in place. We reviewed complaints made by people and found they were addressed in line with the provider's policy. This included recording the complaint in detail, investigating them, arriving at an outcome and stating any further action to be taken. This information was shared with the complainant in a timely manner.

People were supported with compassion when they required end of life care. People identified to be on the end of life pathway were supported in line with their end of life care plans. These reflected people's preferences and the involvement of relatives with people's consent. Where people did not want to discuss end of life care this was stated in care records and respected by staff. The service liaised with healthcare professionals to ensure that people were comfortable and good practice was followed in supporting people receiving end of life care.

Good

Is the service well-led?

Our findings

At our last inspection we rated Orford House 'Requires Improvement' when we reviewed how well-led the service was. This was because quality audits did not always result in shortfalls being addressed and because the registered manager at the time was managing two services which reduced their oversight of each service.

At this inspection we found the service did not have a registered manager. However, a new manager had been in post for two months and they were in the process of registering with CQC. The new manager did not manage any additional services. They were supported by an office manager who was also new to their role, having been in post for one month when we visited. People and staff spoke positively about the new manager. One person told us, "She is so friendly and interacts right with people and the staff. She has settled in really well." Staff were positive about the new home manager too. One member of staff told us, "We had three managers in one year and that's hard. But the new manager is good. She's nice. She likes the people and they like her."

The quality of care people received was the subject of regular auditing. The management team carried out checks which included medicines, infection control, fire safety, care records the physical environment. Where shortfalls were identified action was taken. For example, when one audit identified that a fire door was warped and not closing properly a new one was ordered. Regional managers carried out additional audits which included confirming the satisfactory completion of tasks set out in the service's action plans. This meant that quality checks led to improvements in care quality.

The new manager planned to improve the quality of care planning and delivery and shared their plans for developing the service with us. The provider's plans included introducing electronic care records to replace paper documents. To enable this provider had arranged for fibre optics cables to be laid to the building which provided people with access to broadband and for the introduction of electronic care records in January 2019. The provider told us that software packages had been confirmed and training in the use of electronic care records was planned. The provider also planned to improve staff knowledge to meet people's needs. For example, two staff had been selected to become 'dementia champions' for the service. The service planned for these staff to receive specialist training which they will share with colleagues. Dementia champions will act as role models and demonstrate best practice.

An open culture was promoted at the service. Staff were encouraged to share their views about improving care and support. The new manager arranged team meetings for staff to receive and share information. We read the minutes of two team meetings. These showed the manager leading discussions around a number of issues including safeguarding, training, maintenance, communication. Staff told us they felt comfortable sharing opinions with the manager and colleagues in meetings as well as informally on an on-going basis.

People and their relatives shared their views about the service they received with the provider. The service conducted surveys of people and relatives and acted on the findings. For example, in response to feedback from relatives who said they wanted to be better informed about what was happening in the service, the

provider had produced a monthly newsletter. This provided updates about events at the service including staffing changes, social events and activities arranged for people to participate in.

The service continued to work in partnership with other organisations including other providers, local authorities and multidisciplinary teams. The provider also partnered organisations engaged in research. For example, the provider was collaborating with catering specialists who were researching and developing 'hydration sweets'. These would be made available to people to maximise their fluid intake each day and reduce their risk of dehydration. The manager ensured that timely notifications were submitted to the CQC keeping us informed of all significant events taking place at the service.