directors of adass Adult Social Services

Eastern Region

The Eastern Region Monitoring Tool & Report for Adult Social Care Accommodation based Services

Release 2.0 March 2015

This workbook forms part of the Regional Quality Monitoring Framework (QMF) and has been designed to support local authorities in monitoring and assessing the overall outcomes experienced by service users. It measures the delivery against the regional standards by gathering evidence across a wide range of sources.

CQC ID: 1-	0118135549
LA Name:	Cambridgeshire
Provider:	**Orchard House**
Address	**107 Money Bank** **Wisbech Cambs** **PE13 2JF**
Parent Company	**RCH**
Officer	**Katrina Dix CCC & Fran Goodwin CCG**
Date:	**27/04/2021**

This Document has been approved by the Directors of Adult Social Services - Eastern Branch. Please email any queries to guy.pettengell@hertfordshire.gov.uk

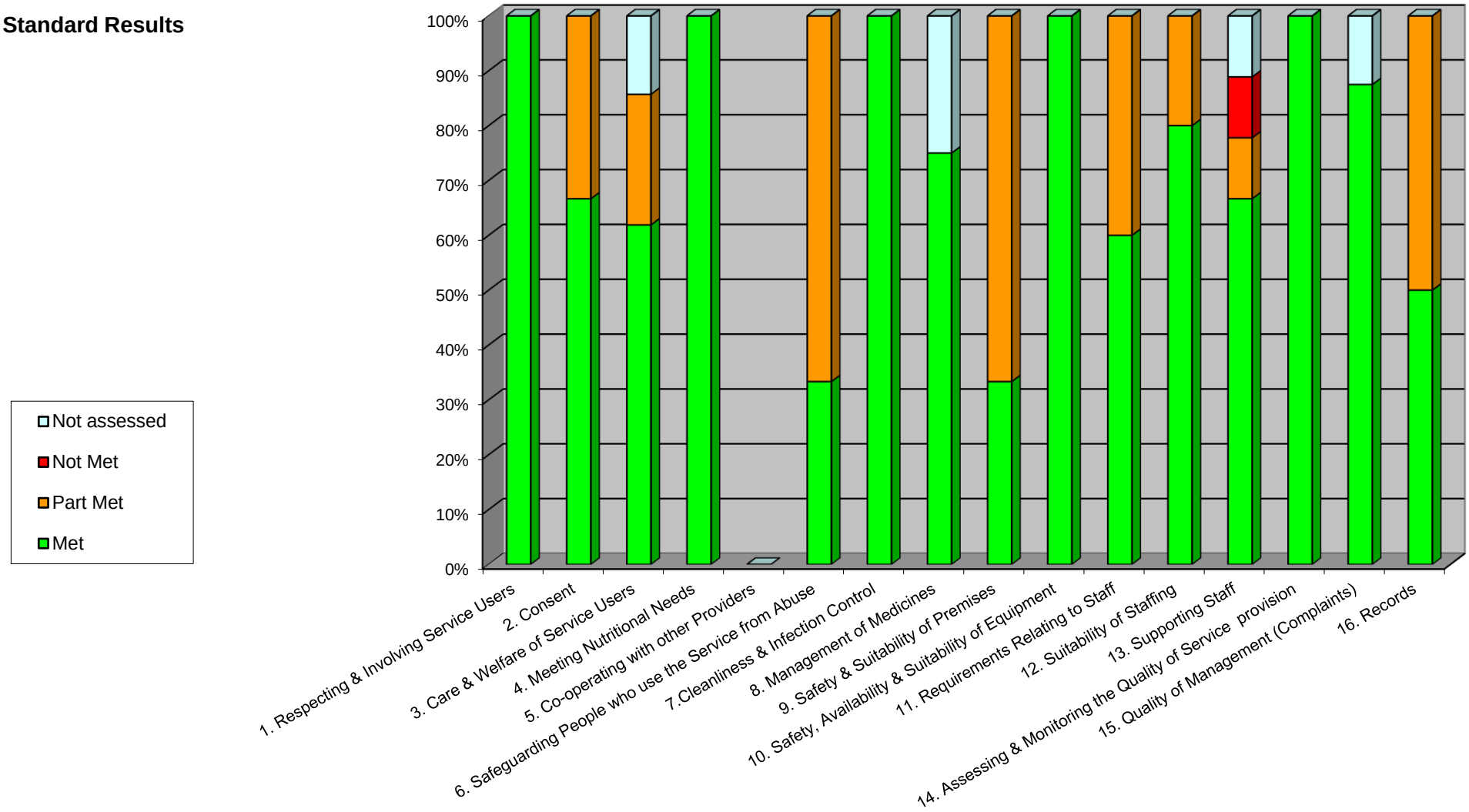
Provider: **Orchard House**
Officer **Katrina Dix CCC & Fran Goodwin CCG**
Date: **27 April 2021**

		% score
1	Respecting & Involving Service Users	**100.0%**
2	Consent	**79.2%**
3	Care & Welfare of Service Users	**91.0%**
4	Meeting Nutritional Needs	**100.0%**
5	Co-operating with other Providers (currently not assessed)	**0.0%**
6	Safeguarding People who use the Service from Abuse	**75.0%**
7	Cleanliness & Infection Control	**100.0%**
8	Management of Medicines	**100.0%**
9	Safety & Suitability of Premises	**66.7%**
10	Safety, Availability & Suitability of Equipment	**100.0%**
11	Requirements Relating to Staff	**80.0%**
12	Suitability of Staffing	**90.0%**
13	Supporting Staff	**81.3%**
14	Assessing & Monitoring the Quality of Service provision	**100.0%**
15	Quality of Management (Complaints)	**100.0%**
16	Records	**62.5%**
	Overall % score	**88.4%**

East of England Rating

Excellent (95%)	**Overall rating**	**88.4%**
Good (78%)		
Requires Improvement (65%)		
Poor (<65%)		

Standard Results



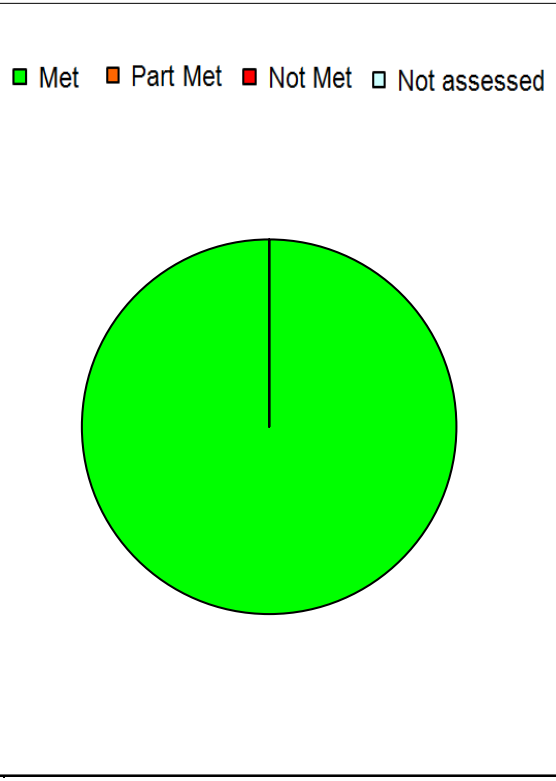
Provider: **Orchard House**
Officer **Katrina Dix CCC & Fran Goodwin CCG**
Date: **27 April 2021**

Summary by Standard

1. Respecting & Involving Service Users

Score **100.0%**

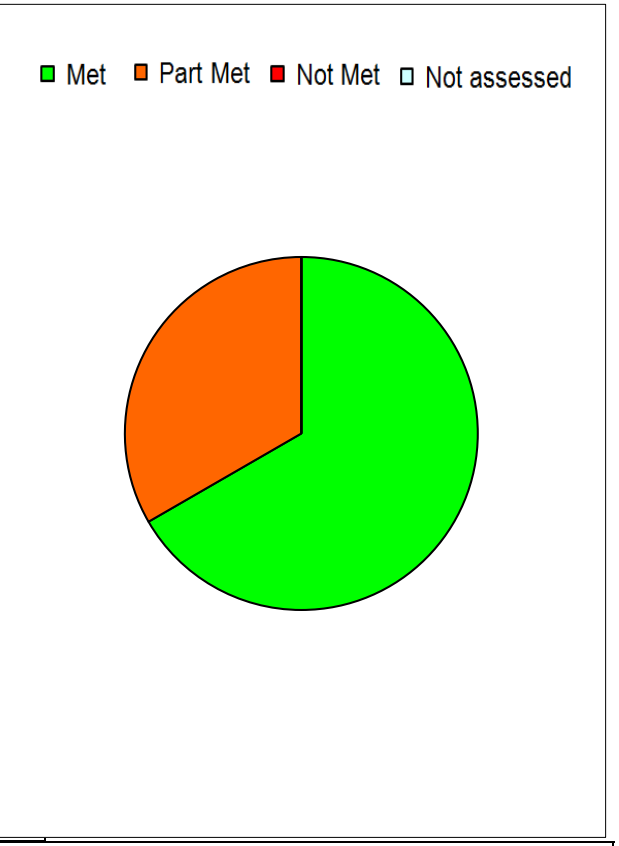
Section A Standard 1	Of the four care plans that were monitored by CCC, no evidence of discriminatory language recorded. Evidence of policy for Equal Opportunities/Equality & Diversity review date 01/01/22. Evidence of choices and preferences being offered such as types of cake and puddings. One Service User chooses not to socialise with others. Evidence of information provided on entering the home and on noticeboards such as sending messages to the Queen re the death of Prince Philip. Observed staff explaining and listening to Service Users regarding choices such as where to sit.
Section B Standard 1	Respondents stated that they did not think their relative was discriminated against because of their age, disability, gender. The Service User Guide and Employee handbook relating to how Service Users should be treated. Respondents al said that their relative's privacy and dignity was maintained. Two relatives said that the Service User was not able to express choices due to poor cognition, however, one said a the time regarding preferences.. Evidence of information being provided in an appropriate way such as the Service User Guide and in the entrance foyer. Relative feedback said that they were encouraged to provide feedback or speak to the Manager who has an open door policy.
Section C Standard 1	Observed no discriminatory behaviour towards Service Users. All staff receive an Employee handbook on starting employment. Equality & Diversity policy review date 01/01/22. Staff said "they cover them up with towels and close the door and pull the curtains when completing personal care" and to involve them in all conversations and decisions where possible. Staff responses said they would "ask the resident what they would like to wear and show them". Also look at the care plan re choices.



2. Consent

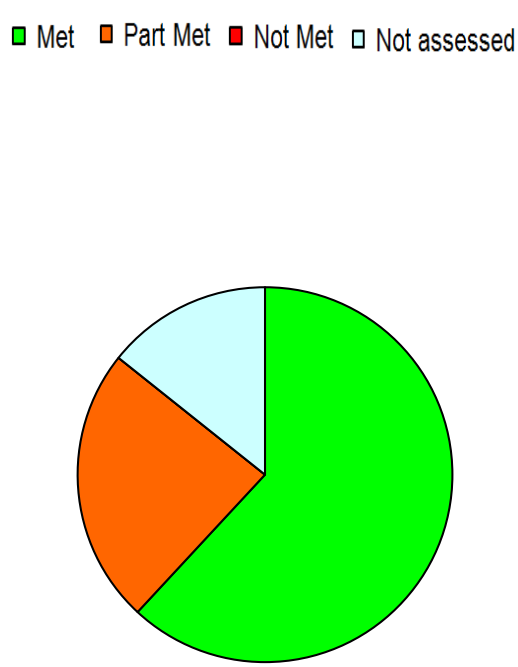
Score **79.2%**

Section A Standard 2	Unclear understanding of informed consent. See additional notes below. MCA documents copied and pasted with incorrect documentation. Person centred documentation regarding End of Life wishes although not Advanced Decisions. Use of RESPECT document at the front of the care plan. Evidence of DOLS in care plan and in separa folder. Log of which have been authorised.
Section B Standard 2	Observed staff asking permission to move a resident to go for lunch. Staff are aware that they need to record cons in the daily notes.
Section C Standard 2	Staff said to ask for consent, "allow time to respond", document in care notes. Information from staff questionnaires indicated that many of them thought DOLS related to MCA, some thought it related to taking away someone's freedom, but not clear.



3. Care & Welfare of Service Users

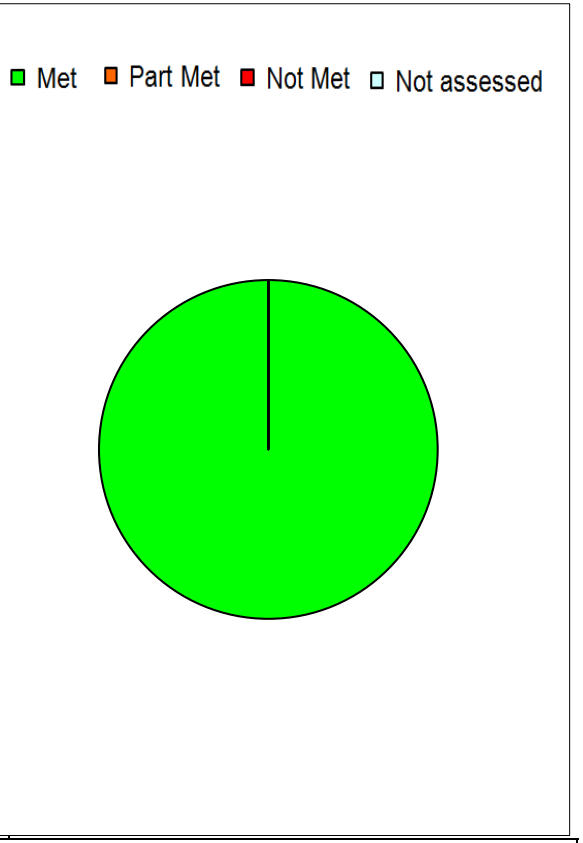
Score **91.0%**

Section A Standard 3	Evidence of Service Users being involved in their care -such as not consenting to activities, having a key to their room. Evidence of key worker recorded in the care plan at the front of the folder and the room folder (daily records, fluid and food charts). The care plans monitored, evidenced strengths and interests. One care plan showed how important her family was to her. Evidence of Risk assessments in place, but information regarding body maps unclear and not recorded clearly. In one set of body maps, inventory and property on the back of the sleeve. Robust risk assessments in place such as waterlow, choking, MUST, visiting throughout covid. PEEPS stored in the middle of the care plan -this would have been better placed at the front of the care plan with DNACPR & or RESPECT. Evidence of care plans being reviewed on a monthly basis or if the level of need changes. Observation of surrounding garden area out the back of property appear untidy and full of weeds -unattractive for Service Users and potentially a risk.	
Section B Standard 3	Feedback from the questionnaires indicated that Service Users are involved in their care planning. One relative said no due to covid restrictions, however, is encouraged to point and make gestures re choice. Two of the respondents were not aware who their relative's key worker was or their role. Evidence n the care plans and room folder both clearly indicated the name of the key worker. Relatives were unsure if care plans were reviewed yearly, one relative said that covid had prevented access to the plans. However, evidence in the care plans indicates they have been reviewed.	
Section C Standard 3	Evidence from the staff responses that they are aware how to involve Service Users in decisions around their care, explaining processes. Staff said completing risk assessments and reviewing them as and when necessary. Staff said they would review care plans monthly or if the need changes. Different responses were recorded, such as opportunities to have more physiotherapy, encouragement to take part in activities, interaction with other residents. Staff said to ask the person what would mazimise their quality of life.	

4. Meeting Nutritional Needs

Score **100.0%**

Section A Standard 4	Evidence of Service Users encouraged to choose healthy options. Menu evident in the dining room. Service Users offered choice of meals. Evidence of MUST being recorded on all of the care plans. Evidence of weekly weights on some care plans where MUST was high. Observed one care plan whereby a referral to the dietician had been sent on 16/09/20.
Section B Standard 4	Evidence from the respondents that they think their relative is provided with enough food and drink. One relative sa their resident had a PEG feed inserted but was managed well. Service Users have access to snacks and drinks 24 hours a day. There is information in the dining rooms with menus. Service Users are able to identify preferences, this was observed on the days of monitoring. Service Users are provided with choice of whether they wish to eat in the dining room, lounge or in their individual rooms.
Section C Standard 4	Staff said that the residents have access to snacks and drinks in the communal areas. Any dietary requirements are catered for routinely. Staff said that Service Users have 24 hour access to food and drinks. Staff said that they receive Food Safety training via e-learning yearly. Evidence from the training matrix confirmed this.



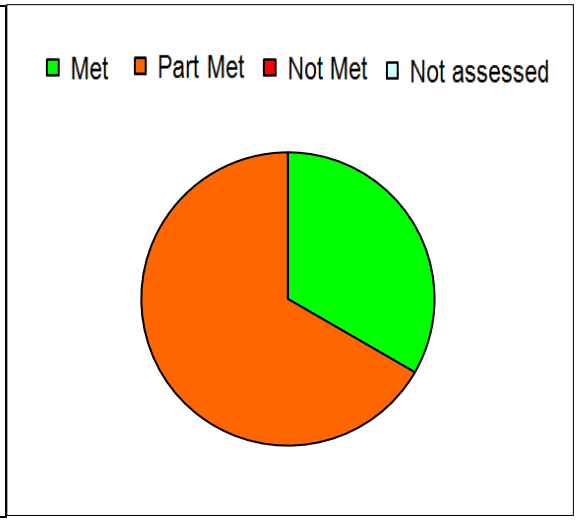
5. Co-operating with other Providers

Score **0.0%**

6. Safeguarding People who use the Service from Abuse

Score **75.0%**

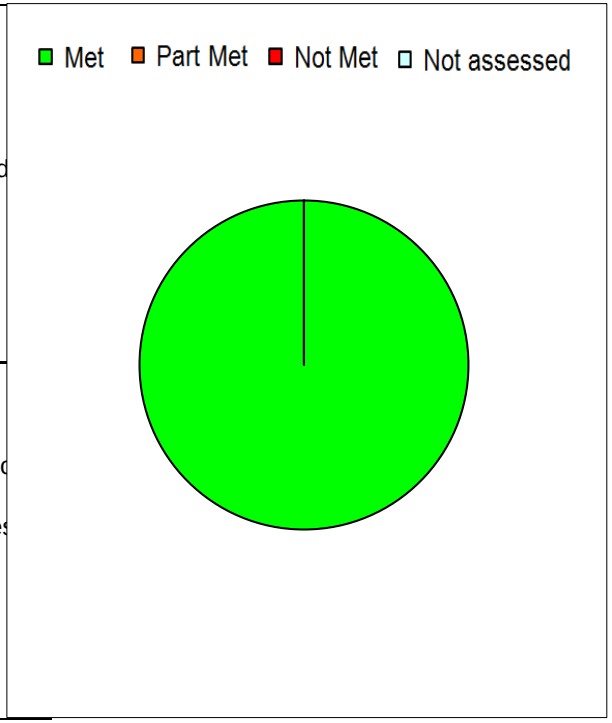
Section C Standard 6	Staff who responded to the questionnaire were able to describe how to respond if abuse was suspected. Staff explained they would report to the Team leader/Manager. Although the provider has a safeguarding policy review date 01/01/22, they have responded by saying it does not follow the Local Authority's Safeguarding and Whistleblowing policy. Information from the training matrix shows that 90% of staff have received safeguarding training. However, staff were unable to explain when their last training took place. Evidence from the responses in the questionnaires indicated that staff do not have a robust understanding of DOLS.



7. Cleanliness & Infection Control

Score **100.0%**

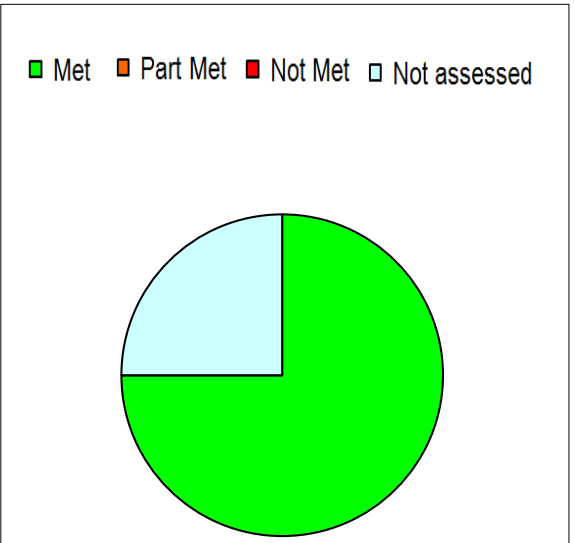
Section C Standard 7	Observed staff using appropriate Infection Prevention & Control measures such as use of PPE, hand washing, monitoring visitors entering the home. Information from the training matrix identifies that 92% of staff have received training in Infection Prevention & Control and COSHH via e-learning and work practice.
Section E Standard 7	Evidence of robust Infection Prevention & Control measures in place. Temperature, evidence of LFT testing, correc use of PPE. Evidence of Health & Safety, COSHH & Infection Control policy review date 01/01/22. Obsereved information in the entrance re Covid and correct use of PPE, wahsing hands, and hand washing notices the toilets. Information from the training matrix evidences that 92% of staff have received their Infection Prevention & Control training.



8. Management of Medicines

Score **100.0%**

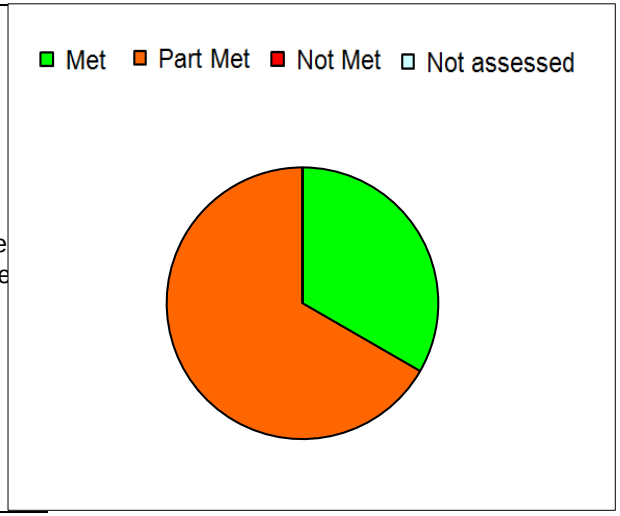
Section A Standard 8	Evidence of one Service User completing a Self medication assessment enabling them to self administer.
Section B Standard 8	Two of the respondents did not answer this question and one responded by saying they were not able to be involved due to cognition.
Section E Standard 8	Medication was reviewed by CCG collegue. All medication appeared to be stored correctly. Controlled drugs monitored and all correct.The provider maintains records around administration, monitoring and review of medication.



9. Safety & Suitability of Premises

Score **66.7%**

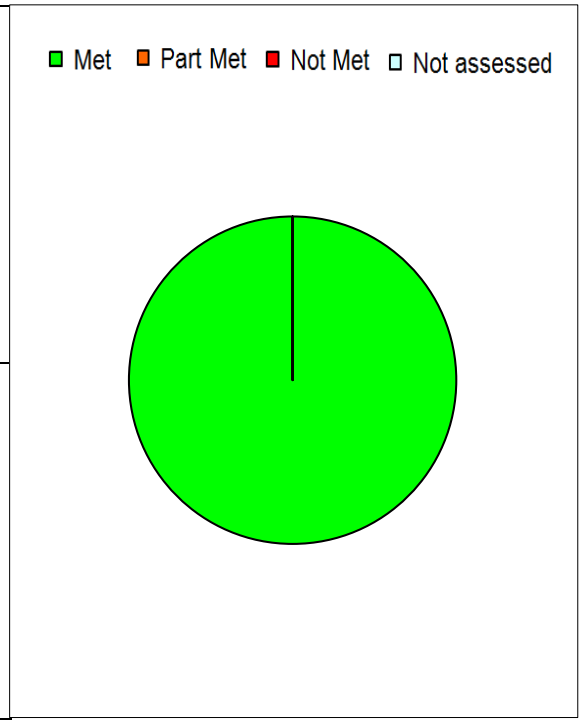
Section E Standard 9	Evidence of Legionella Certificate -due May 21, PAT testing, Local Fire plan 11/03/21, Cambs Fire Service Risk Assessment 05/02/21. Potential risk of trip hazard out the back of building near the POD. Oxygen being used in the care home, however, no notice on the front entrance -fire hazard. Notice on Service User's door. Key safes in place ensure Service Users are safe. Staff maintain security when checking re Covid (LFT test).



10. Safety, Availability & Suitability of Equipment

Score **100.0%**

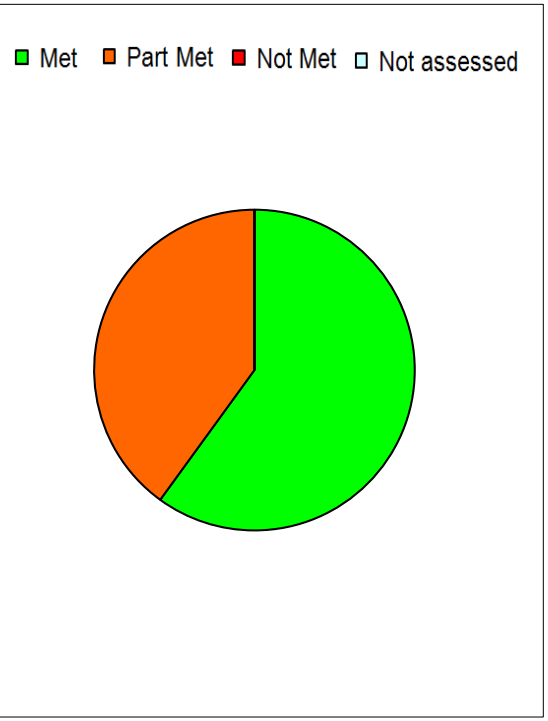
Section C Standard 10	Observed staff using correct equipment when moving Service Users. Equipment is maintained and serviced correctly. (Bath 03/21). Staff responded by saying they had received Moving & Handling e-learning theory and practical training. Staff felt competent to use equipment.
Section E Standard 10	Equipment is suitable for purpose, properly serviced and records kept which can be cross referenced with dates on equipment. Information from the training matrix evidences that 94% staff have received Moving & Handling training and 86.49% staff have received Moving & Handling Practical training.



11. Requirements Relating to Staff

Score **80.0%**

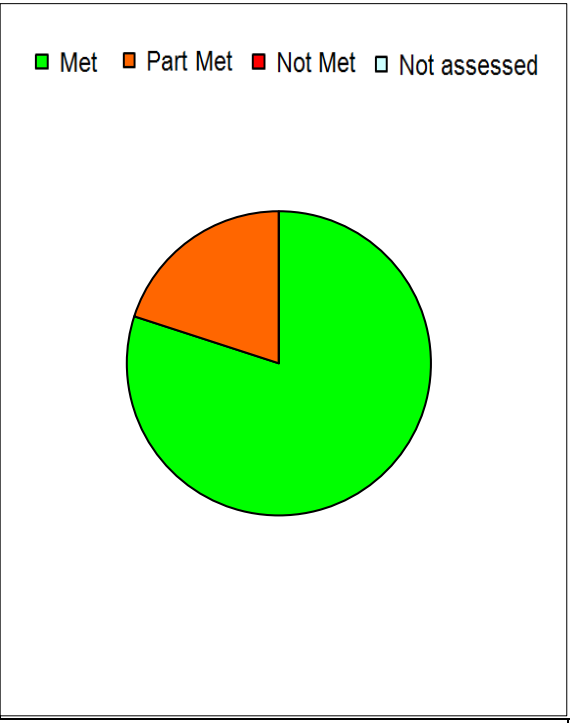
Section B Standard 11	Feedback from the questionnaires indicated that the relatives felt staff behaved appropriately. Staff are all provided with an Employee Handbook on starting employment re conduct.
Section D Standard 11	Three recruitment folders monitored. Evidence of application form, references, DBS, Interview sheets, some had scoring some didn't. (See Additional notes below). Some of the folders had no job offer present. Evidence that the provider uses agency staff when required. They will block book them to maintian continuity and safety.They complete an Induction and shadow shifts Evercare). Persons who provide additional services are either covered by their own professional registration such as chiropodist, District Nurse or have to provide evidence of DBS, Indemnity Insurance. Limited evidence of Job Description on file.



12. Suitability of Staffing

Score **90.0%**

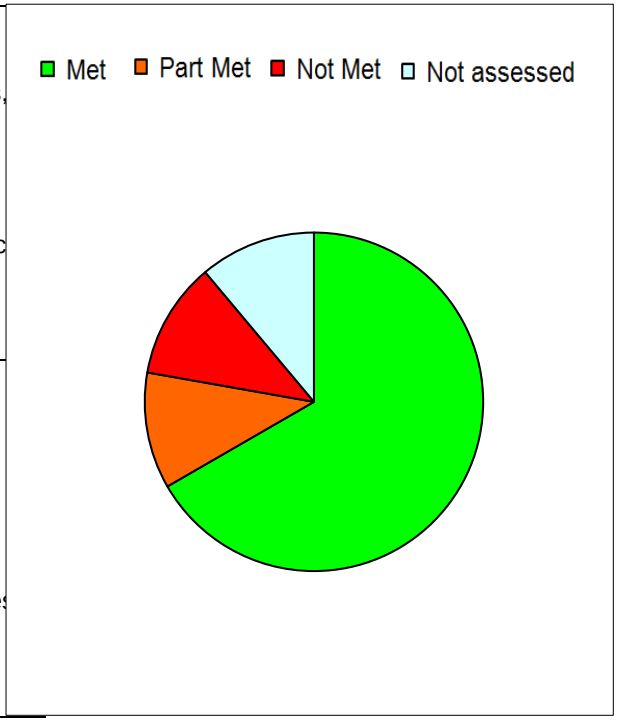
Section B Standard 12	Relatives said that they felt there were sufficient staff on duty with the correct knowledge and experience to care and support the Service Users.
Section C Standard 12	From the questionnaires, 14 staff felt there were sufficent staffing levels, 5 did not. One said that "the dependency tool does not always reflect the complex and diverse needs for the residents". All the 19 staff who responded said that shifts would be offered to other staff members or agency staff would be contacted.
Section F Standard 12	Information from the pre-monitoring tool, the staff rota and signing in sheet on the dates of 16/04/21 & 17/04/21 were cross referenced. Sufficient staff were on duty on nights on the 16/04/21 but not on the 17/04/21. See below. Evidence of the provider having robust mechanisms in place to cover unexpected changes to the service by offering shifts to other staff and agency staff.



13. Supporting Staff

Score **81.3%**

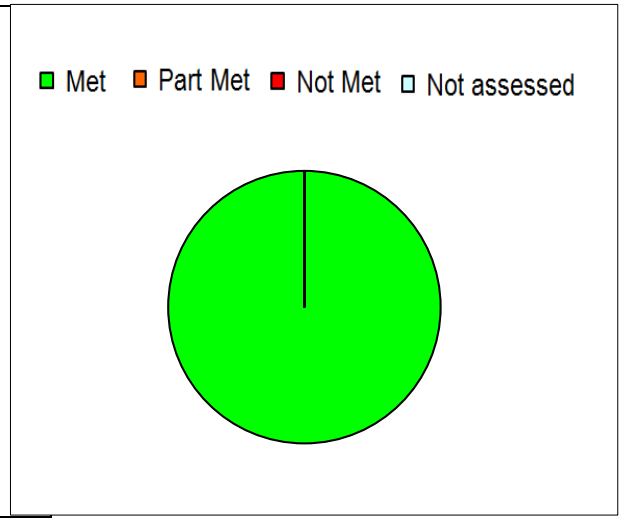
Section C Standard 13	Evidence that all staff who responded were able to describe their training on their Induction such as fire awareness, first aid, safeguarding. Of the 19 respondents 12 staff were uncertain as to regularity of supervision , 4 recorded nothing and 3 said monthly. CCC Contract stipulates bimonthly, therefore non- compliant. Staff said that their mandatory training was up to date, this could be cross referenced with the training matrix. No temporary staff employed due to the pandemic so not assessed. Evidence of staff having a robust understanding in relation to bullying and harassment . They are aware of the polic and mechanisms in place and who to report to such as their Manager.
Section D Standard 13	The provider was able to evidence a 5 day induction programme. New staff attend a 5 day corporate induction and then 1 week shadowing. Evidence form the supervision matrix show that supervisions are taking place but not in line with CCC Contractual Compliance which is bimonthly. Evidence of the appraisal process having commenced. Clear evidence from the training matrix that training is on schedule. Evidence of Medication tracker and competency checks.The provider monitors staff training and this is evident on the training matrix with those outstanding in different colour. Certificates can be printed by staff. Management keep copies in training folder.



14. Assessing & Monitoring the Quality of Service provision

Score **100.0%**

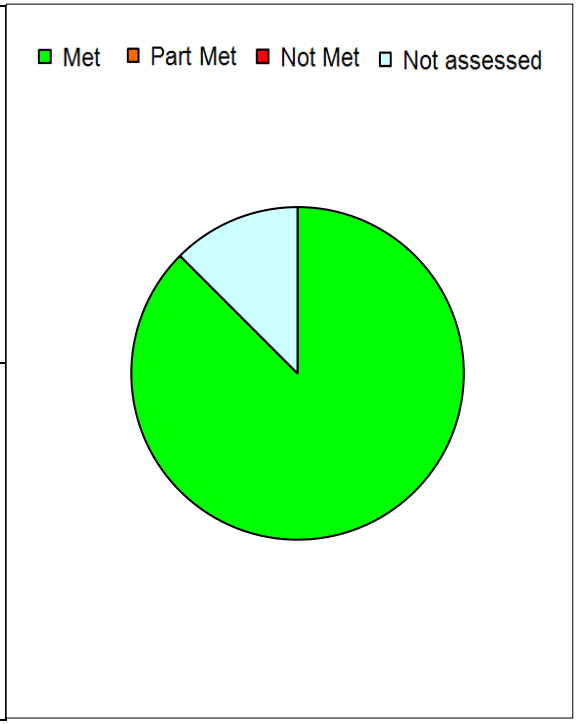
Section F Standard 14	Evidence that the provider gathers and collates feedback on the quality of service by on line questionnaires (22/04/21), resident meetings weekly as a coffee morning. Minutes are taken. The provider has information regarding complaints, whistle blowing and safeguarding in the foyer.



15. Quality of Management (Complaints)

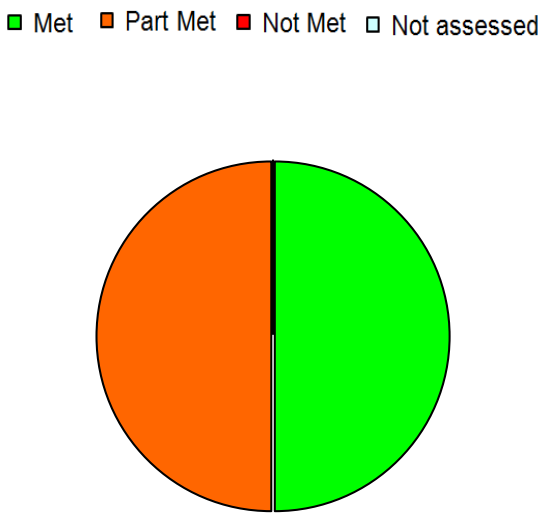
Score **100.0%**

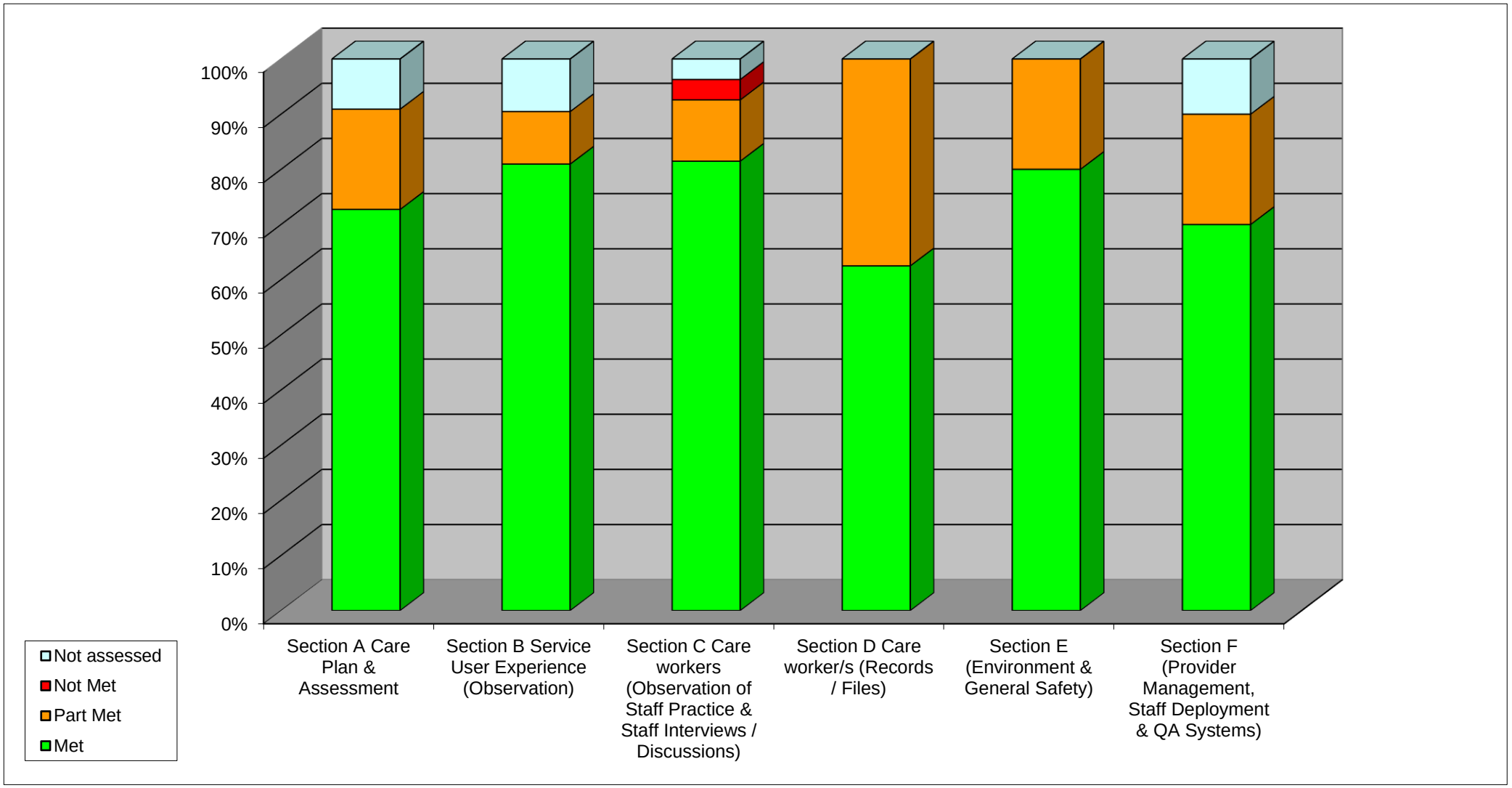
Section B Standard 15	Family members who responded to the questionnaire all felt that there is suffient information regarding complaints and how to contact the LGO, Local Authority, CQC. There have been compliments about the service, however, no complaints this year. Evidence that the provider has responded to safeguarding concerns/complaints in a time effective manner. Any complaint is followed up with a Lessons Learny scenario/staff meeting to improve services .
Section F Standard 15	There is evidence of a complaints and compliments folder. On the day of the visit there were no complaints, however, three compliments. Process of how to record a complaint, log at the front of the folder. Lessons are learnt re safeguarding concerns that are stored in the safeguarding folder. The provider was happy to share any complaints with the Local Authority.



16. Records

Score **62.5%**

Section F Standard 16	The care plans were a little disorganised. Daily records were very task orientated. Care plans personalised but grammar and use of English language requires attention. Care plans are stored securely. Evidence of medication, kitchen and care plan audits.	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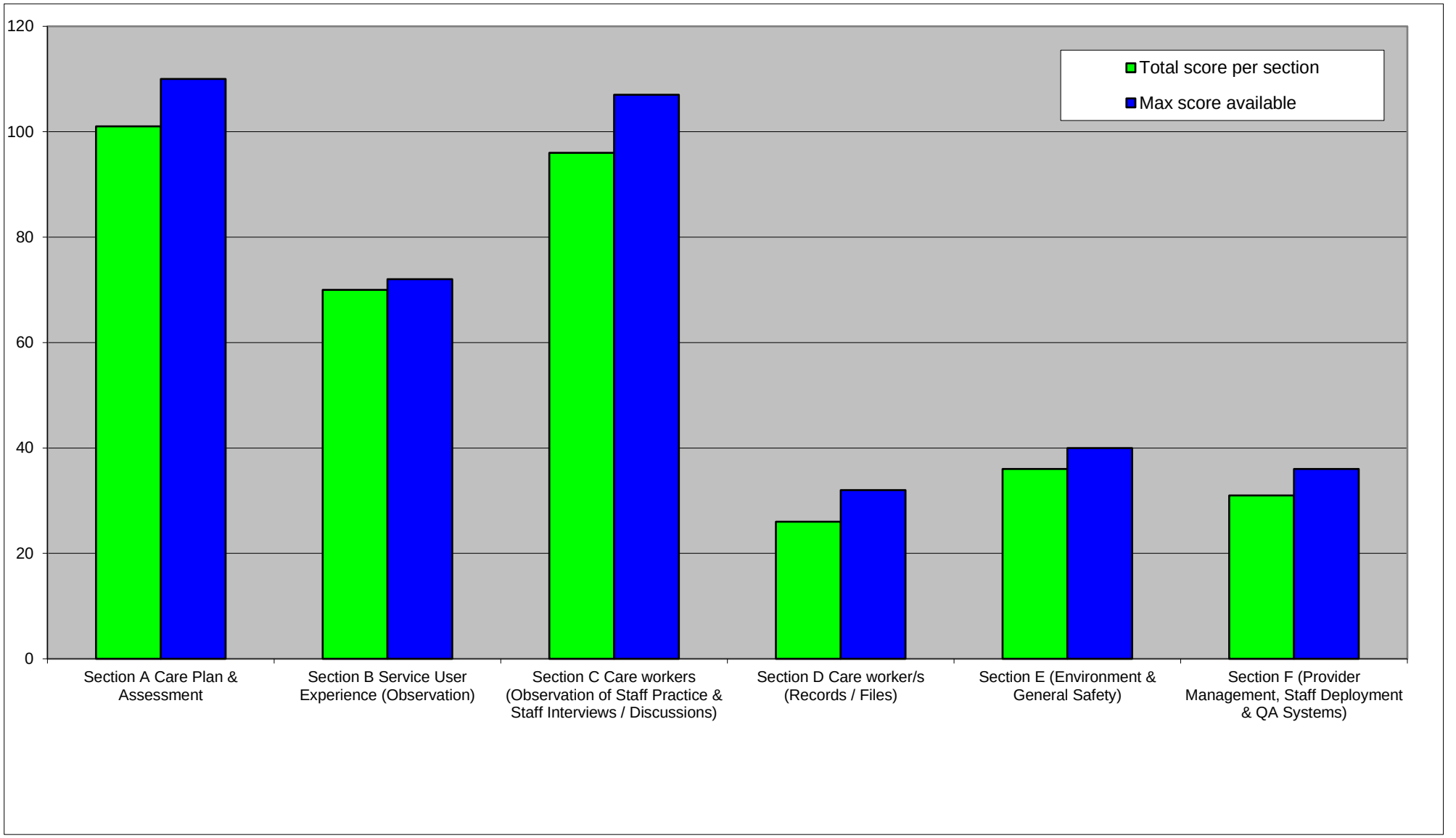
Section A Care Plan & Assessment
Section B Service User Experience (Observation)
Section C Care workers (Observation of Staff Practice & Staff Interviews / Discussions)
Section D Care worker/s (Records / Files)
Section E (Environment & General Safety)
Section F (Provider Management, Staff Deployment & QA Systems)
Not assessed
Not Met
Part Met
Met


120
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Total score per section
Max score available
Section A Care Plan & Assessment
Section B Service User Experience (Observation)
Section C Care workers (Observation of Staff Practice & Staff Interviews / Discussions)
Section D Care worker/s (Records / Files)
Section E (Environment & General Safety)
Section F (Provider Management, Staff Deployment & QA Systems)

Provider: Orchard House
Officer Katrina Dix CCC & Fran Goodwin CCG
Date: 27 April 2021

Summary by Section

Section A Additional notes for the Provider	**On the day of the visits two care plans were monitoried by K Dix -NC and TG and two were monitored by Fran Goodwin -PH (respite) and SS. On the second day K Dix monitored two more care plans -PS & DH. One Service User is clearly able to consent to decisions. It was recorded and signed that she did not wish for her photos to be used in identification for any other professionals, media. However, CCC was given this care plan to monitor. There did not appear to be a robust understanding of MCA's and Best Interest Decisions. Good practice would advise that MCA's be stored behind the care plan need and risk assessment. Manager to review these. Management assured CCC that visitors and Service Users do not use the POD out the back, however, it is not very user friendly. Quotes for providing concrete to have better access has been sought.**
Section A Standard 1	Of the four care plans that were monitored by CCC, no evidence of discriminatory language recorded. Evidence of policy for Equal Opportunities/Equality & Diversity review date 01/01/22. Evidence of choices and preferences being offered such as types of cake and puddings. One Service User chooses not to socialise with others. Evidence of information provided on entering the home and on noticeboards such as sending messages to the Queen re the death of Prince Philip. Observed staff explaining and listening to Service Users regarding choices such as where to sit.
Section A Standard 2	Unclear understanding of informed consent. See additional notes below. MCA documents copied and pasted with incorrect documentation. Person centred documentation regarding End of Life wishes although not Advanced Decisions. Use of RESPECT document at the front of the care plan. Evidence of DOLS in care plan and in separate folder. Log of which have been authorised.
Section A Standard 3	Evidence of Service Users being involved in their care -such as not consenting to activities, having a key to their room. Evidence of key worker recorded in the care plan at the front of the folder and the room folder (daily records, fluid and food charts). The care plans monitored, evidenced strengths and interests. One care plan showed how important her family was to her. Evidence of Risk assessments in place, but information regarding body maps unclear and not recorded clearly. In one set of body maps, inventory and property on the back of the sleeve. Robust risk assessments in place such as waterlow, choking, MUST, visiting throughout covid. PEEPS stored in the middle of the care plan -this would have been better placed at the front of the care plan with DNACPR & or RESPECT. Evidence of care plans being reviewed on a monthly basis or if the level of need changes. Observation of surrounding garden area out the back of property appear untidy and full of weeds -unattractive for Service Users and potentially a risk.

Section A Standard 4	Evidence of Service Users encouraged to choose healthy options. Menu evident in the dining room. Service Users are offered choice of meals. Evidence of MUST being recorded on all of the care plans. Evidence of weekly weights on some care plans where MUST was high. Observed one care plan whereby a referral to the dietician had been sent on 16/09/20.
Section A Standard 8	Evidence of one Service User completing a Self medication assessment enabling them to self administer.
A(i)	Evidence of room folders that contain "Ensuring Resident Dignity", overview of care -no signature, topical medication, hourly checks, daily oral care, repositioning, fluid and food charts -one chart calculated incorrectly on three days. Daily records, however, very task centred. Triangulation between daily notes, incident report and safeguardng referral.
A(ii)	Care needs are reviewed on a regular monthly basis or if there is a change in need.

Section B Additional notes for the Provider	**Due to Covid 19 restrictions, K Dix did not ask individual residents or relatives their opinions on the care at Orchard House. Questionnaires were provided instead. Unfortunately only three were returned. More information regarding Service User key worker scheme would be beneficial perhaps at the review. Evidence of the menu and food intollerances/allegens in each day's menu such as nuts, gluten. diary.**

Section B Standard 1	Respondents stated that they did not think their relative was discriminated against because of their age, disability, gender. The Service User Guide and Employee handbook relating to how Service Users should be treated. Respondents all said that their relative's privacy and dignity was maintained. Two relatives said that the Service User was not able to express choices due to poor cognition, however, one said all the time regarding preferences.. Evidence of information being provided in an appropriate way such as the Service User Guide and in the entrance foyer. Relative feedback said that they were encouraged to provide feedback or speak to the Manager who has an open door policy.
Section B Standard 2	Observed staff asking permission to move a resident to go for lunch. Staff are aware that they need to record consent in the daily notes.
Section B Standard 3	Feedback from the questionnaires indicated that Service Users are involved in their care planning. One relative said no due to covid restrictions, however, is encouraged to point and make gestures re choice. Two of the respondents were not aware who their relative's key worker was or their role. Evidence n the care plans and room folder both clearly indicated the name of the key worker. Relatives were unsure if care plans were reviewed yearly, one relative said that covid had prevented access to the plans. However, evidence in the care plans indicates they have been reviewed.
Section B Standard 4	Evidence from the respondents that they think their relative is provided with enough food and drink. One relative said their resident had a PEG feed inserted but was managed well. Service Users have access to snacks and drinks 24 hours a day. There is information in the dining rooms with menus. Service Users are able to identify preferences, this was observed on the days of monitoring.
Section B Standard 8	Two of the respondents did not answer this question and one responded by saying they were not able to be involved due to cognition.
Section B Standard 11	Feedback from the questionnaires indicated that the relatives felt staff behaved appropriately. Staff are all provided with an Employee Handbook on starting employment re conduct.
Section B Standard 12	Relatives said that they felt there were sufficient staff on duty with the correct knowledge and experience to care and support the Service Users.
Section B Standard 15	Family members who responded to the questionnaire all felt that there is suffient information regarding complaints and how to contact the LGO, Local Authority, CQC. There have been compliments about the service, however, no complaints this year. Evidence that the provider has responded to safeguarding concerns/complaints in a time effective manner. Any complaint is followed up with a Lessons Learny scenario/staff meeting to improve services .

Section C Additional notes for the Provider	**19 Staff questionnare were returned for the purposes of monitoring.** **If Service User refuses, responses included, document and let the senior carer know.** **Some staff had a better understanding of MCA ,BI and DOLS than others. Would benefit some extra support regarding this area.** **In response to safeguarding quite a number of staff responded by saying "Told/Seeit -Document it-Report it".** **Some staff felt regarding staffing levels that there are enough supporting 40 residents, however, would need more if at full occupancy.**
Section C Standard 1	Observed no discriminatory behaviour towards Service Users. All staff receive an Employee handbook on starting employment. Equality & Diversity policy review date 01/01/22. Staff said "they cover them up with towels and close the door and pull the curtains when completing personal care" and to involve them in all conversations and decisions where possible. Staff responses said they would "ask the resident what they would like to wear and show them". Also look at the care plan re choices.
Section C Standard 2	Staff said to ask for consent, "allow time to respond", document in care notes. Information from staff questionnaires indicated that many of them thought DOLS related to MCA, some thought it related to taking away someone's freedom, but not clear.
Section C Standard 3	Evidence from the staff responses that they are aware how to involve Service Users in decisions around their care, explaining processes. Staff said completing risk assessments and reviewing them as and when necessary. Staff said they would review care plans monthly or if the need changes. Different responses were recorded, such as opportunities to have more physiotherapy, encouragement to take part in activities, interaction with other residents. Staff said to ask the person what would mazimise their quality of life.
Section C Standard 4	Staff said that the residents have access to snacks and drinks in the communal areas. Any dietary requirements are catered for routinely. Staff said that Service Users have 24 hour access to food and drinks. Staff said that they receive Food Safety training via e-learning yearly. Evidence from the training matrix confirmed this.
Section C Standard 6	Staff who responded to the questionnaire were able to describe how to respond if abuse was suspected. Staff explained they would report to the Team leader/Manager. Although the provider has a safeguarding policy review date 01/01/22, they have responded by saying it does not follow the Local Authority's Safeguarding and Whistleblowing policy. Information from the training matrix shows that 90% of staff have received safeguarding training. However, staff were unable to explain when their last training took place. Evidence from the responses in the questionnaires indicated that staff do not have a robust understanding of DOLS.

Section C Standard 7	Observed staff using appropriate Infection Prevention & Control measures such as use of PPE, hand washing, monitoring visitors entering the home. Information from the training matrix identifies that 92% of staff have received training in Infection Prevention & Control and COSHH via e-learning and work practice.
Section C Standard 10	Observed staff using correct equipment when moving Service Users. Equipment is maintained and serviced correctly. (Bath 03/21). Staff responded by saying they had received Moving & Handling e-learning theory and practical training. Staff felt competent to use equipment.
Section C Standard 12	From the questionnaires, 14 staff felt there were sufficent staffing levels, 5 did not. One said that "the dependency tool does not always reflect the complex and diverse needs for the residents". All the 19 staff who responded said that shifts would be offered to other staff members or agency staff would be contacted.
Section C Standard 13	Evidence that all staff who responded were able to describe their training on their Induction such as fire awareness, first aid, safeguarding. Of the 19 respondents 12 staff were uncertain as to regularity of supervision , 4 recorded nothing and 3 said monthly. CCC Contract stipulates bimonthly, therefore non- compliant. Staff said that their mandatory training was up to date, this could be cross referenced with the training matrix. No temporary staff employed due to the pandemic so not assessed. Evidence of staff having a robust understanding in relation to bullying and harassment . They are aware of the policies and mechanisms in place and who to report to such as their Manager.
Section D Additional notes for the Provider	**Three recruitment folders monitored: JC, JB & HB. Claire Sylvester explained that new recruitment documents are being brought in by RCH with model answers to specific questions that match the job role. By the end of the first day, the recruitment folders had been amended.** **Due to the pandemic, visitors have not been allowed such as the hairdresser.** **The recruitment folders would benefit from some better organisation as not all of them were the same format. Two had an index at the front, one didn't.** **Robust Induction programme for different roles of staff.** **A new trainer has been recruited in December 2020 to cover all RCH homes. Overall mandatory training statistics -92.8%. A new Hospitality Manager has been employed to manage all aspects of the dining room experience, menu planning.**
Section D Standard 11	Three recruitment folders monitored. Evidence of application form, references, DBS, Interview sheets, some had scoring some didn't. (See Additional notes below). Some of the folders had no job offer present. Evidence that the provider uses agency staff when required. They will block book them to maintian continuity and safety.They complete an Induction and shadow shifts Evercare). Persons who provide additional services are either covered by their own professional registration such as chiropodist, District Nurse or have to provide evidence of DBS, Indemnity Insurance. Limited evidence of Job Description on file.
Section D Standard 13	The provider was able to evidence a 5 day induction programme. New staff attend a 5 day corporate induction and then 1 week shadowing. Evidence form the supervision matrix show that supervisions are taking place but not in line with CCC Contractual Compliance which is bimonthly. Evidence of the appraisal process having commenced. Clear evidence from the training matrix that training is on schedule. Evidence of Medication tracker and competency checks.The provider monitors staff training and this is evident on the training matrix with those outstanding in different colour. Certificates can be printed by staff. Management keep copies in training folder.

Section E Additional notes for the Provider	**Every member of staff is a fire marshall, fire drill completed regularly.**
Section E Standard 7	Evidence of robust Infection Prevention & Control measures in place. Temperature, evidence of LFT testing, correct use of PPE. Evidence of Health & Safety, COSHH & Infection Control policy review date 01/01/22. Obsereved information in the entrance re Covid and correct use of PPE, wahsing hands, and hand washing notices in the toilets. Information from the training matrix evidences that 92% of staff have received their Infection Prevention & Control training.
Section E Standard 8	Medication was reviewed by CCG collegue. All medication appeared to be stored correctly. Controlled drugs monitored and all correct.The provider maintains records around administration, monitoring and review of medication.
Section E Standard 9	Evidence of Legionella Certificate -due May 21, PAT testing, Local Fire plan 11/03/21, Cambs Fire Service Risk Assessment 05/02/21. Potential risk of trip hazard out the back of building near the POD. Oxygen being used in the care home, however, no notice on the front entrance -fire hazard. Notice on Service User's door. Key safes in place to ensure Service Users are safe. Staff maintain security when checking re Covid (LFT test).
Section E Standard 10	Equipment is suitable for purpose, properly serviced and records kept which can be cross referenced with dates on equipment. Information from the training matrix evidences that 94% staff have received Moving & Handling training and 86.49% staff have received Moving & Handling Practical training.

Section F Additional notes for the Provider	**There appeared to be some discrepancies between which staff were supposed to be on shift, however, different staff had signed in on the signing in sheet. On the 17/04/21 there appeared to be 2 Team Leaders and I carer. There was no Nurse on shift which even with less residents is a concern. I am aware one of the Team Leaders may be CHAPS trained but I would still expect to have a Nurse on shift on Nights. The signing in sheets are incomplete with some staff not signing out, some staff not requesting a new sheet, therefore 5 columns became 4 with half of the staff not signing out. This could be potentially a fire risk. The provider uses carehome.co.uk to gain feedback (Recently scored 9.5). Limited information regarding actions being completed and followed up in the care plan audits.**
Section F Standard 12	Information from the pre-monitoring tool, the staff rota and signing in sheet on the dates of 16/04/21 & 17/04/21 were cross referenced. Sufficient staff were on duty on nights on the 16/04/21 but not on the 17/04/21. See below. Evidence of the provider having robust mechanisms in place to cover unexpected changes to the service by offering shifts to other staff and agency staff.
Section F Standard 14	Evidence that the provider gathers and collates feedback on the quality of service by on line questionnaires (22/04/21), resident meetings weekly as a coffee morning. Minutes are taken. The provider has information regarding complaints, whistle blowing and safeguarding in the foyer.
Section F Standard 15	There is evidence of a complaints and compliments folder. On the day of the visit there were no complaints, however, three compliments. Process of how to record a complaint, log at the front of the folder. Lessons are learnt re safeguarding concerns that are stored in the safeguarding folder. The provider was happy to share any complaints with the Local Authority.
Section F Standard 16	The care plans were a little disorganised. Daily records were very task orientated. Care plans personalised but grammar and use of English language requires attention. Care plans are stored securely. Evidence of medication, kitchen and care plan audits.
Additional Notes	Any other notes will be added in this box

Section A Care Plan & Assessment

Care Plan: Does it include: All assessed areas of need / An appropriate person centred approach to supporting assessed need / appropriate risk management / risk assessment?

Care Assessment: Does it include: Personal Info / Reasons for referral / Admission / Medical history / Allergies & Intolerances / Likes & Dislikes / Capacity / Assessment of Need / Consideration of risks? Is it: Signed by SU / Rep? / Life history / includes a Photo

		Select one answer from the drop down list below:	Note: To insert a new line, you press the "Alt" key plus the "enter" key
Standard 1 (CQC Outcome 1)	**Respecting & Involving Service Users (Care planning & assessment stage)**		
1.1	Evidence that Staff do not discriminate against people because of their age, disability, gender, race, religion etc. (see standard 1 for protective characteristics) and that they have policies that will incorporate respect for both their Staff and Service Users .	**Met**	Of the four care plans that were monitored by CCC, no evidence of discriminatory language recorded. Evidence of policy for Equal Opportunities/Equality & Diversity review date 01/01/22.
1.3	Evidence the provider encourages and supports service users to always express their view, choices and preferences about the way their care and support is delivered.	**Met**	Evidence of choices and preferences being offered such as types of cake and puddings. One Service User chooses not to socialise with others. Evidence of information provided on entering the home and on noticeboards such as sending messages to the Queen re the death of Prince Philip.
1.4	Put service users at the centre of their care by giving them adequate information in an appropriate and meaningful way to enable them to make informed decisions about the care and support they receive.	**Met**	
1.5	Evidence that the provider takes account of service users' choices and preferences and discusses and explains their care and support options with them.	**Met**	Observed staff explaining and listening to Service Users regarding choices such as where to sit.
Standard 2 (CQC Outcome 2)	**Consent (Care planning & assessment stage) and where appropriate**		
2.2	Evidence that the provider assesses the service users capacity to give informed consent required and that this is reviewed regularly.	**Part Met**	Unclear understanding of informed consent. See additional notes below. MCA documents copied and pasted with incorrect documentation. Person centred documentation regarding End of Life wishes although not Advanced Decisions. Use of RESPECT document at the front of the care plan. Evidence of DOLS in care plan and in separate folder. Log of which have been authorised.
2.6	Evidence that the provider has followed advanced decisions in line with the Mental Capacity Act 2005 (where appropriate).	**Met**	
2.7	Evidence that the provider has taken account of restrictions in line with the Deprivation of Liberty Safeguards when providing care and support (where appropriate).	**Met**	
Standard 3 (CQC Outcome 4)	**Care & Welfare of Service Users (Care planning & assessment stage)**		
3.1	Evidence that Service Users (and where appropriate their stakeholders) are involved in their care and support planning.	**Met**	Evidence of Service Users being involved in their care -such as not consenting to activities, having a key to their room. Evidence of key worker recorded in the care plan at the front of the folder and the room folder (daily records, fluid and food charts). The care plans monitored, evidenced strengths and interests. One care plan showed how important her family was to her. Evidence of Risk assessments in place, but information regarding body maps unclear and not recorded clearly. In one set of body maps, inventory and property on the back of the sleeve. Robust risk assessments in place such as waterlow, choking, MUST, visiting throughout covid. PEEPS stored in the middle of the care plan -this would have been better placed at the front of the care plan with DNACPR & or RESPECT. Evidence of care plans being reviewed on a monthly basis or if the level of need changes. Observation of surrounding garden area out the back of property appear untidy and full of weeds -unattractive for Service Users and potentially a risk.
3.2	Evidence that service users know who their care worker / key worker is and how they can contact you as the provider of their service.	**Met**	
3.3	Evidence that the provider assesses & plans care & support in a way that reflects service users strengths, abilities and interests enabling them to meet all of their needs and preferences.	**Met**	
3.4	Evidence that the provider assesses & plans care & support taking into account the needs of the service user including risks to their health and wellbeing.	**Part Met**	
3.5	**Evidence that the assessment & delivery of care and support ensures the service user remains safe; their needs are adequately met; and their welfare is protected.**	**Part Met**	
3.6	**Evidence that the provider regularly reviews the effectiveness of care and support plans and ensures that these are kept up to date to support the changing needs of the individual.**	**Met**	
3.7	**Evidence that the provider assesses the risk of harm to the service user, including environmental risks, and ensures that this is effectively managed and reviewed regularly to keep the service user safe.**	**Part Met**	
3.8	Provide services in an effective and enabling way to help maximise the service user's independence and quality of life as well as reduce the number of emergency admissions.	**Not assessed**	
3.9	Evidence that service users are supported in setting goals to help maximize their independence and improve the quality of their life.	**Not assessed**	

Standard 4 (CQC Outcome 5)	**Meeting Nutritional needs (Care planning & assessment stage)**		
4.1	Evidence that service users are supported to make healthy choices and lead healthy lifestyles and provide access to information about healthy and balanced diet.	**Met**	Evidence of Service Users encouraged to choose healthy options. Menu evident in the dining room. Service Users are offered choice of meals.
4.4	The provider uses an appropriate malnutrition screening tool such as the Malnutrition Universal Screening Tool (MUST) to carry out a full nutritional assessment (where this is indicated).	**Met**	Evidence of MUST being recorded on all of the care plans. Evidence of weekly weights on some care plans where MUST was high.
4.5	Evidence that the provider supports service users to access specialist services, guidance and advice where required.	**Met**	Observed one care plan whereby a referral to the dietician had been sent on 16/09/20.
Standard 8 (CQC Outcome 9)	**Management of Medicines (Care planning & assessment stage)**		
8.4	Evidence that the provider Involves people in their decisions regarding their medications.	**Met**	Evidence of one Service User completing a Self medication assessment enabling them to self administer.

Total for Section A **87.1%**

Daily Records & Reviews

A(i)	**DAILY RECORDS: Do daily records reflect care plan and are elements identified fed back into care plan. Any health issues / accidents and / or incidents noted in the file**	**Met**	Evidence of room folders that contain "Ensuring Resident Dignity", overview of care -no signature, topical medication, hourly checks, daily oral care, repositioning, fluid and food charts -one chart calculated incorrectly on three days. Daily records, however, very task centred. Triangulation between daily notes, incident report and safeguardng referral.
A(ii)	**CARE REVIEWS: Has the care needs been reviewed appropriately / regularly and / or when a change has been identified**	**Met**	Care needs are reviewed on a regular monthly basis or if there is a change in need.

Total for A, A(i) & A(ii) **86.3%**

Section A Additional notes for the Provider

On the day of the visits two care plans were monitoried by K Dix -NC and TG and two were monitored by Fran Goodwin -PH (respite) and SS. On the second day K Dix monitored two more care plans -PS & DH.
One Service User is clearly able to consent to decisions. It was recorded and signed that she did not wish for her photos to be used in identification for any other professionals, media. However, CCC was given this care plan to monitor. There did not appear to be a robust understanding of MCA's and Best Interest Decisions. Good practice would advise that MCA's be stored behind the care plan need and risk assessment. Manager to review these.
Management assured CCC that visitors and Service Users do not use the POD out the back, however, it is not very user friendly. Quotes for providing concrete to have better access has been sought

Section B Service User Experience (Observation)

Discussion with SU / Observation of interaction / Activities / Other feedback etc

		Select one answer from the drop down list below:	Note: To insert a new line, you press the "Alt" key plus the "enter" key
Standard 1 (CQC Outcome 1)	**Respecting & Involving Service Users (SU experience)**		
1.1	Evidence that Staff do not discriminate against people because of their age, disability, gender, race, religion etc. (see standard 1 for protective characteristics) and that they have policies that will incorporate respect for both their Staff and Service Users .	Met	Respondents stated that they did not think their relative was discriminated against because of their age, disability, gender. The Service User Guide and Employee handbook relating to how Service Users should be treated. Respondents all said that their relative's privacy and dignity was maintained. Two relatives said that the Service User was not able to express choices due to poor cognition, however, one said all the time regarding preferences.. Evidence of information being provided in an appropriate way such as the Service User Guide and in the entrance foyer. Relative feedback said that they were encouraged to provide feedback or speak to the Manager who has an open door policy
1.2	Evidence that there are systems in place that uphold and maintain the Service User's privacy, dignity and independence.	Met	
1.3	Evidence the provider encourages and supports service users to always express their view, choices and preferences about the way their care and support is delivered.	Met	
1.4	Put service users at the centre of their care by giving them adequate information in an appropriate and meaningful way to enable them to make informed decisions about the care and support they receive.	Met	
1.6	Evidence that the provider encourages & supports service users to give them feedback about how they can improve their services and acts on the feedback given.	Met	
Standard 2 (CQC Outcome 2)	**Consent (SU experience)**		
2.1	Evidence that staff know and understand when to obtain consent, when to take verbal or implied consent and how to document records of consent.	Met	Observed staff asking permission to move a resident to go for lunch. Staff are aware that they need to record consent in the daily notes
Standard 3 (CQC Outcome 4)	**Care & Welfare of Service Users (SU experience)**		
3.1	Evidence that Service Users (and where appropriate their stakeholders) are involved in their care and support planning.	Met	Feedback from the questionnaires indicated that Service Users are involved in their care planning. One relative said no due to covid restrictions, however, is encouraged to point and make gestures re choice. Two of the respondents were not aware who their relative's key worker was or their role. Evidence n the care plans and room folder both clearly indicated the name of the key worker. Relatives were unsure if care plans were reviewed yearly, one relative said that covid had prevented access to the plans. However, evidence in the care plans indicates they have been reviewed.
3.2	Evidence that service users know who their care worker / key worker is and how they can contact you as the provider of their service.	Part Met	
3.3	Evidence that the provider assesses & plans care & support in a way that reflects service users strengths, abilities and interests enabling them to meet all of their needs and preferences.	Part Met	
3.6	Evidence that the provider regularly reviews the effectiveness of care and support plans and ensures that these are kept up to date to support the changing needs of the individual.	Met	
3.10	Not used	Not assessed	
Standard 4 (CQC Outcome 5)	**Meeting Nutritional needs (SU experience)**		
4.1	Evidence that service users are supported to make healthy choices and lead healthy lifestyles and provide access to information about healthy and balanced diet.	Met	Evidence from the respondents that they think their relative is provided with enough food and drink. One relative said their resident had a PEG feed inserted but was managed well. Service Users have access to snacks and drinks 24 hours a day. There is information in the dining rooms with menus. Service Users are able to identify preferences, this was observed on the days of monitoring. Service Users are provided with choice of whether they wish to eat in the dining room, lounge or in their individual rooms
4.2	Service users have 24hr access to a choice of food and drink that takes into account their preferences, diverse needs and dietary requirements. Ensure there is accessible information about meals and meal times.	Met	
4.3	Food and drink are provided in environments that promote service users dignity and independence and they have a choice about whether to eat alone or with company.	Met	

Standard 8 (CQC Outcome 9)	**Management of Medicines (SU experience)**		
8.4	Evidence that the provider Involves people in their decisions regarding their medications.	**Not assessed**	Two of the respondents did not answer this question and one responded by saying they were not able to be involved due to cognition
Standard 11 (CQC Outcome 12)	**Requirements relating to staff recruitment (SU experience)**		
11.7	Evidence that the provider has robust and effective arrangements around the appropriate behaviour of staff, particularly in their relation to their code of professional conduct and the assessment of stress and other work-related hazards.	**Met**	Feedback from the questionnaires indicated that the relatives felt staff behaved appropriately. Staff are all provided with an Employee Handbook on starting employment re conduct.
Standard 12 (CQC Outcome 13)	**Staffing and Staff Deployment (SU experience)**		
12.1	Evidence that the provider ensures that there are sufficient staff on duty with the right knowledge, experience, qualifications and skills to provide effective care and support.	**Met**	Relatives said that they felt there were sufficient staff on duty with the correct knowledge and experience to care and support the Service Users.
Standard 15 (CQC Outcome 17)	**Complaints (SU experience)**		
15.1	Evidence that service users and / or their carers are provided with adequate information, in an appropriate and suitable format, about the complaints process, including information on how to contact the Local Authority and the Local Government Ombudsmen.	**Met**	Family members who responded to the questionnaire all felt that there is suffient information regarding complaints and how to contact the LGO, Local Authority, CQC. There have been compliments about the service, however, no complaints this year. Evidence that the provider has responded to safeguarding concerns/complaints in a time effective manner. Any complaint is followed up with a Lessons Learny scenario/staff meeting to improve services .
15.2	Evidence that the provider supports service users where appropriate to raise a complaint or make comments about the service.	**Met**	
15.3	Evidence that the provider considers fully, responds appropriately and resolves, where possible, any comments and / or complaints made.	**Met**	
15.6	Evidence that following a complaint that learning is taken forward and shared to improve the experience of service users who use the services.	**Met**	

Total for Section B **97.2%**

Section B Additional notes for the Provider

Due to Covid 19 restrictions, K Dix did not ask individual residents or relatives their opinions on the care at Orchard House. Questionnaires were provided instead. Unfortunately only three were returned.
More information regarding Service User key worker scheme would be beneficial perhaps at the review.
Evidence of the menu and food intollerances/allegens in each day's menu such as nuts, gluten. diary.

Section C Care workers (Observation of Staff Practice & Staff Interviews / Discussions)

Observation of: Dignity / respect / language / attitude / enabling independence

		Select one answer from the drop down list below:	Note: To insert a new line, you press the "Alt" key plus the "enter" key
Standard 1 (CQC Outcome 1)	**Respecting & Involving Service Users (staff obs. & interviews)**		
1.1	Evidence that Staff do not discriminate against people because of their age, disability, gender, race, religion etc. (see standard 1 for protective characteristics) and that they have policies that will incorporate respect for both their Staff and Service Users	Met	Observed no discriminatory behaviour towards Service Users. All staff receive an Employee handbook on starting employment. Equality & Diversity policy review date 01/01/22. Staff said "they cover them up with towels and close the door and pull the curtains when completing personal care" and to involve them in all conversations and decisions where possible. Staff responses said they would "ask the resident what they would like to wear and show them". Also look at the care plan re choices
1.2	Evidence that there are systems in place that uphold and maintain the Service User's privacy, dignity and independence.	Met	
1.3	Evidence the provider encourages and supports service users to always express their view, choices and preferences about the way their care and support is delivered.	Met	
Standard 2 (CQC Outcome 2)	**Consent (staff obs. & interviews)**		
2.1	Evidence that staff know and understand when to obtain consent, when to take verbal or implied consent and how to document records of consent.	Met	Staff said to ask for consent, "allow time to respond", document in care notes. Information from staff questionnaires indicated that many of them thought DOLS related to MCA, some thought it related to taking away someone's freedom, but not clear.
2.7	Evidence that the provider has taken account of restrictions in line with the Deprivation of Liberty Safeguards when providing care and support (where appropriate).	Part Met	
Standard 3 (CQC Outcome 4)	**Care & Welfare of Service Users (staff obs. & interviews)**		
3.1	Evidence that Service Users (and where appropriate their stakeholders) are involved in their care and support planning.	Met	Evidence from the staff responses that they are aware how to involve Service Users in decisions around their care, explaining processes. Staff said completing risk assessments and reviewing them as and when necessary. Staff said they would review care plans monthly or if the need changes. Different responses were recorded, such as opportunities to have more physiotherapy, encouragement to take part in activities, interaction with other residents. Staff said to ask the person what would mazimise their quality of life.
3.5	Evidence that the assessment & delivery of care and support ensures the service user remains safe; their needs are adequately met; and their welfare is protected.	Met	
3.6	Evidence that the provider regularly reviews the effectiveness of care and support plans and ensures that these are kept up to date to support the changing needs of the individual.	Met	
3.7	Evidence that the provider assesses the risk of harm to the service user, including environmental risks, and ensures that this is effectively managed and reviewed regularly to keep the service user safe.	Met	
3.9	Evidence that service users are supported in setting goals to help maximize their independence and improve the quality of their life.	Met	
Standard 4 (CQC Outcome 5)	**Meeting Nutritional needs (staff obs. & interviews)**		
4.1	Evidence that service users are supported to make healthy choices and lead healthy lifestyles and provide access to information about healthy and balanced diet.	Met	Staff said that the residents have access to snacks and drinks in the communal areas. Any dietary requirements are catered for routinely. Staff said that Service Users have 24 hour access to food and drinks. Staff said that they receive Food Safety training via e-learning yearly. Evidence from the training matrix confirmed this.
4.2	Service users have 24hr access to a choice of food and drink that takes into account their preferences, diverse needs and dietary requirements. Ensure there is accessible information about meals and meal times.	Met	
4.6	Evidence that staff who are involved with food preparation have up-to-date food and hygiene training.	Met	
Standard 6 (CQC Outcome 7)	**Safeguarding People who use the Service from abuse (staff obs. & interviews)**		
6.1	Evidence that the provider takes appropriate action to identify and prevent abuse from happening in the service and responds appropriately when it is suspected that abuse has occurred or is at risk of occurring.	Met	Staff who responded to the questionnaire were able to describe how to respond if abuse was suspected. Staff explained they would report to the Team leader/Manager. Although the provider has a safeguarding policy review date 01/01/22, they have responded by saying it does not follow the Local Authority's Safeguarding and Whistleblowing policy. Information from the training matrix shows that 90% of staff have received safeguarding training. However, staff were unable to explain when their last training took place. Evidence from the responses in the questionnaires indicated that staff do not have a robust understanding of DOLS.
6.2	Evidence that the provider is aware of, and follows, their responsibilities under the Local Authority's safeguarding and whistle-blowing policy and procedures.	Part Met	
6.3	Evidence that the appropriate guidance and training about safeguarding adults from abuse is accessible to staff, put into practice, implemented and monitored.	Met	
6.4	Evidence that, where possible, the provider only uses Deprivation of Liberty Safeguards when it is in the best interest of the service user and in accordance with the Mental Capacity Act 2005.	Part Met	

Standard 7 (CQC Outcome 8)	**Cleanliness & Infection (staff obs. & interviews)**		
7.2	Evidence that service users, staff and visitors are provided sufficient information about infection prevention and control matters.	**Met**	Observed staff using appropriate Infection Prevention & Control measures such as use of PPE, hand washing, monitoring visitors entering the home. Information from the training matrix identifies that 92% of staff have received training in Infection Prevention & Control and COSHH via e-learning and work practice.
7.4	Evidence that staff are provided with appropriate training relating to infection prevention and control and waste management.	**Met**	
Standard 10 (CQC Outcome 11)	**Safety, Availability & Suitability of Equipment (staff obs. & interviews)**		
10.1	Evidence that equipment is suitable for its purpose, available, properly tested and maintained, used correctly and safely, is comfortable and promotes independence and is stored safely << also see ADASS equip protocol on EoE Website>>.	**Met**	Observed staff using correct equipment when moving Service Users. Equipment is maintained and serviced correctly. (Bath 03/21).
10.2	Evidence that staff are appropriately trained on how to use equipment safely.	**Met**	Staff responded by saying they had received Moving & Handling e-learning theory and practical training. Staff felt competent to use equipment.
Standard 12 (CQC Outcome 13)	**Staffing and Staff Deployment (staff obs. & interviews)**		
12.1	Evidence that the provider ensures that there are sufficient staff on duty with the right knowledge, experience, qualifications and skills to provide effective care and support.	**Met**	From the questionnaires, 14 staff felt there were sufficent staffing levels, 5 did not. One said that "the dependency tool does not always reflect the complex and diverse needs for the residents".
12.3	Evidence that the provider has robust mechanisms in place to manage both expected and unexpected changes in the service in order to maintain safe, effective and consistent care (for example to cover sickness, vacancies, absences and emergencies).	**Met**	All the 19 staff who responded said that shifts would be offered to other staff members or agency staff would be contacted.
Standard 13 (CQC Outcome 14)	**Supporting Staff**		
13.1	Evidence that all staff receive appropriate induction at the start of their employment in line with the Skills for Care common induction standards / Care Certificate.	**Met**	Evidence that all staff who responded were able to describe their training on their Induction such as fire awareness, first aid, safeguarding. Of the 19 respondents 12 staff were uncertain as to regularity of supervision , 4 recorded nothing and 3 said monthly. CCC Contract stipulates bimonthly, therefore non- compliant. Staff said that their mandatory training was up to date, this could be cross referenced with the training matrix. No temporary staff employed due to the pandemic so not assessed. Evidence of staff having a robust understanding in relation to bullying and harassment . They are aware of the policies and mechanisms in place and who to report to such as their Manager.
13.2	Evidence that all staff receive appropriate supervision at least (measure against local requirement), that their performance is appraised and that they receive an annual review.	**Not Met**	
13.3	Evidence that all staff undertake mandatory training and refresh this as required. (Measure against local requirements).	**Met**	
13.5	Evidence that any temporary staff have the appropriate training and skills to undertake their role.	**Not assessed**	
13.8	Evidence that the provider has appropriate policies and mechanisms in place to prevent and manage incidents of bullying, harassment and violence towards staff.	**Met**	

Total for Section C **86.0%**

Section C Additional notes for the Provider

19 Staff questionnare were returned for the purposes of monitoring.
If Service User refuses, responses included, document and let the senior carer know.
Some staff had a better understanding of MCA ,BI and DOLS than others. Would benefit some extra support regarding this area.
In response to safeguarding quite a number of staff responded by saying "Told/Seeit -Document it-Report it".
Some staff felt regarding staffing levels that there are enough supporting 40 residents, however, would need more if at full occupancy.

Section D Care worker/s (Records / Files)

Recruitment Files: Applications / References X2 / gaps in employment
Induction Records: Meet Skills for Care Common Induction Standards
Training Records: Mandatory training completed
Supervision: Regular & appropriate
Annual; Appraisals: Completed when required includes professional development

		Select one answer from the drop down list below:	Note: To insert a new line, you press the "Alt" key plus the "enter" key
Standard 11 (CQC Outcome 12)	**Requirements relating to staff recruitment**		
11.2	**Evidence that all relevant employment checks are carried out when staff are employed, including (but not limited to) ensuring that all staff have a suitable DBS check before starting work, that the member of staff has the right to work in the UK and that they are registered with any relevant professional body and, where necessary, are allowed to work by that body. <<Ensure meets local requirements>>.**	**Part Met**	Three recruitment folders monitored. Evidence of application form, references, DBS, Interview sheets, some had scoring some didn't. (See Additional notes below). Some of the folders had no job offer present. Evidence that the provider uses agency staff when required. They will block book them to maintian continuity and safety.They complete an Induction and shadow shifts Evercare). Persons who provide additional services are either covered by their own professional registration such as chiropodist, District Nurse or have to provide evidence of DBS, Indemnity Insurance. Limited evidence of Job Description on file.
11.3	Evidence that when staff are provided by an external organization that those staff, whether agency, bank or voluntary, have been subject to the same level of checks and similar selection criteria as employed staff.	**Met**	
11.4	Evidence that any other person who provides additional services are subject to any appropriate and necessary checks.	**Met**	
11.5	Evidence that all staff, including temporary and agency staff, students and trainees, have a clear understanding of their role and responsibilities.	**Part Met**	
Standard 13 (CQC Outcome 14)	**Supporting Staff (Induction / Supervision / Training Records)**		
13.1	Evidence that all staff receive appropriate induction at the start of their employment in line with the Skills for Care common induction standards / Care Certificate.	**Met**	The provider was able to evidence a 5 day induction programme. New staff attend a 5 day corporate induction and then 1 week shadowing. Evidence form the supervision matrix show that supervisions are taking place but not in line with CCC Contractual Compliance which is bimonthly. Evidence of the appraisal process having commenced. Clear evidence from the training matrix that training is on schedule. Evidence of Medication tracker and competency checks.The provider monitors staff training and this is evident on the training matrix with those outstanding in different colour. Certificates can be printed by staff. Management keep copies in
13.2	Evidence that all staff receive appropriate supervision at least (measure against local requirement), that their performance is appraised and that they receive an annual review.	**Part Met**	
13.3	Evidence that all staff undertake mandatory training and refresh this as required. (Measure against local requirements).	**Met**	
13.6	Evidence that the provider maintains up to date training records (including evidence of attendance) for all staff.	**Met**	

Total for Section D **81.3%**

Section D Additional notes for the Provider

Three recruitment folders monitored: JC, JB & HB. Claire Sylvester explained that new recruitment documents are being brought in by RCH with model answers to specific questions that match the job role. By the end of the first day, the recruitment folders had been amended.
Due to the pandemic, visitors have not been allowed such as the hairdresser.
The recruitment folders would benefit from some better organisation as not all of them were the same format. Two had an index at the front, one didn't.

Robust Induction programme for different roles of staff.
A new trainer has been recruited in December 2020 to cover all RCH homes. Overall mandatory training statistics -92.8%. A new Hospitality Manager has been employed to manage all aspects of the dining room experience, menu planning.

Section E (Environment & General Safety)

Audit: Observation & Records Audit

		Select one answer from the drop down list below:	Note: To insert a new line, you press the "Alt" key plus the "enter" key
Standard 7 (CQC Outcome 8)	**Cleanliness & Infection Control**		
7.1	Evidence that the provider has effective arrangements in place to maintain appropriate standards of cleanliness and hygiene for the prevention, management and control of infection as identified in The Health & Social Care Act, Code of Practice for health and adult social care on the prevention and control of infections and related guidance.	Met	Evidence of robust Infection Prevention & Control measures in place. Temperature, evidence of LFT testing, correct use of PPE. Evidence of Health & Safety, COSHH & Infection Control policy review date 01/01/22.
7.2	Evidence that service users, staff and visitors are provided sufficient information about infection prevention and control matters.	Met	Obsereved information in the entrance re Covid and correct use of PPE, wahsing hands, and hand washing notices in the toilets.
7.4	Evidence that staff are provided with appropriate training relating to infection prevention and control and waste management.	Met	Information from the training matrix evidences that 92% of staff have received their Infection Prevention & Control training.
Standard 8 (CQC Outcome 9)	**Management of Medicines**		
8.2	Evidence that medicines are stored and administered safely including any homely remedies and covert medication.	Met	Medication was reviewed by CCG collegue. All medication appeared to be stored correctly. Controlled drugs monitored and all correct.The provider maintains records around administration, monitoring and review of medication.
8.3	**Evidence that the provider keeps appropriate records around the (prescribing) administration, monitoring and review of medications.**	Met	
Standard 9 (CQC Outcome 10)	**Safety & Suitability of Premises**		
9.1	The provider protects people, staff and others against the risks of unsafe or unsuitable premises.	Part Met	Evidence of Legionella Certificate -due May 21, PAT testing, Local Fire plan 11/03/21, Cambs Fire Service Risk Assessment 05/02/21. Potential risk of trip hazard out the back of building near the POD. Oxygen being used in the care home, however, no notice on the front entrance -fire hazard. Notice on Service User's door. Key safes in place to ensure Service Users are safe. Staff maintain security when checking re Covid (LFT test).
9.2	The premises take account of service users with specific needs and that effective risk management is in place to reduce identified risks.	Part Met	
9.3	Evidence that the provider has appropriate security arrangements in place to address the risk of unauthorized access to protect the people who use the premises.	Met	
Standard 10 (CQC Outcome 11)	**Safety, Availability & Suitability of Equipment**		
10.1	Evidence that equipment is suitable for its purpose, available, properly tested and maintained, used correctly and safely, is comfortable and promotes independence and is stored safely << also see ADASS equip protocol on EoE Website>>.	Met	Equipment is suitable for purpose, properly serviced and records kept which can be cross referenced with dates on equipment. Information from the training matrix evidences that 94% staff have received Moving & Handling training and 86.49% staff have received Moving & Handling Practical training.
10.2	Evidence that staff are appropriately trained on how to use equipment safely.	Met	

Total for Section E **90.0%**

Section E Additional notes for the Provider

Every member of staff is a fire marshall, fire drill completed regularly.

Section F (Provider Management, Staff Deployment & QA Systems)

	File Audit: QA Report (SU Feedback / Learning and Changes made from QA Data and SU / CW feedback / Complaints / Complaints Policy / Records… Staffing Audit: Rotas, Robustness / Training & Skills, matching CW to SU	**Select one answer from the drop down list below:**	
Standard 12 (CQC Outcome 13)	**Staffing and Staff Deployment**		**Note: To insert a new line, you press the "Alt" key plus the "enter" key**
12.1	Evidence that the provider ensures that there are sufficient staff on duty with the right knowledge, experience, qualifications and skills to provide effective care and support.	**Part Met**	Information from the pre-monitoring tool, the staff rota and signing in sheet on the dates of 16/04/21 & 17/04/21 were cross referenced. Sufficient staff were on duty on nights on the 16/04/21 but not on the 17/04/21. See below.
12.3	Evidence that the provider has robust mechanisms in place to manage both expected and unexpected changes in the service in order to maintain safe, effective and consistent care (for example to cover sickness, vacancies, absences and emergencies).	**Met**	Evidence of the provider having robust mechanisms in place to cover unexpected changes to the service by offering shifts to other
Standard 14 (CQC Outcome 16)	**Assessing & Monitoring the Quality of Service Provision**		
14.1	Evidence that the provider continually gathers and evaluates information about the quality of services delivered to ensure that people receive safe and effective care and support.	**Met**	Evidence that the provider gathers and collates feedback on the quality of service by on line questionnaires (22/04/21), resident meetings weekly as a coffee morning. Minutes are taken.
14.3	**Evidence that the provider has mechanisms in place to enable people, including staff, to raise concerns about risks to people and poor performance openly.**	**Met**	The provider has information regarding complaints, whistle blowing and safeguarding in the foyer.
Standard 15 (CQC Outcome 17)	**Complaints**		
15.3	Evidence that the provider considers fully, responds appropriately and resolves, where possible, any comments and / or complaints made.	**Met**	There is evidence of a complaints and compliments folder. On the day of the visit there were no complaints, however, three compliments. Process of how to record a complaint, log at the front of the folder. Lessons are learnt re safeguarding concerns that are stored in the safeguarding folder.
15.6	Evidence that following a complaint that learning is taken forward and shared to improve the experience of service users who use the services.	**Met**	
15.7	Evidence that adequate records about the complaint, including any relevant and factual information about the investigation, responses, outcome and actions taken are kept.	**Not assessed**	The provider was happy to share any complaints with the Local Authority.
15.8	Evidence that the provider shares details of complaints and the outcomes with the Local Authority.	**Met**	
Standard 16 (CQC Outcome 17)	**Records**		
16.1	Evidence that the personal records of service users receiving services are clear, accurate, factual, complete, personalised, fit for purpose, up-to-date, held securely and remain confidential.	**Part Met**	The care plans were a little disorganised. Daily records were very task orientated. Care plans personalised but grammar and use of English language requires attention. Care plans are stored securely. Evidence of medication, kitchen and care plan audits.
16.8	**Evidence that the provider monitors the standards of practice through a programme of effective audits.**	**Met**	

Total for Section F **86.1%**

Section F Additional notes for the Provider

There appeared to be some discrepancies between which staff were supposed to be on shift, however, different staff had signed in on the signing in sheet. On the 17/04/21 there appeared to be 2 Team Leaders and I carer. There was no Nurse on shift which even with less residents is a concern. I am aware one of the Team Leaders may be CHAPS trained but I would still expect to have a Nurse on shift on Nights. The signing in sheets are incomplete with some staff not signing out, some staff not requesting a new sheet, therefore 5 columns became 4 with half of the staff not signing out. This could be potentially a fire risk. The provider uses carehome.co.uk to gain feedback (Recently scored 9.5).
Limited information regarding actions being completed and followed up in the care plan audits.

Orchard House can accommodate 63 rooms over two floors. The Ground floor is for Service Users who have Nursing needs. The first floor can accommodate Service Users who have Residential needs and are living with Dementia. There is also a 7 bedded Residential unit on the first floor.
On the day of the visit 8 Service Users were funded by CCG, 21 by the Local Authority, 5 Joint funded and 6 priviately funded totalling 40. There is 23 available beds.
The Manager Maxine Bain has handed in her notice and is presently on annual leave. Sarah Watson who was the Deputy Manager has now taken on the position of Acting General Manager for 6 months. They are presently interviewing for the Deputy Manager post.
Clare Sylvester (Head of Operations and Quality) is providing weekly support to Sarah.

Provider: **Orchard House**
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Standard	Standard results			
	Met	Part Met	Not Met	Not assessed
1. Respecting & Involving Service Users	100.0%	0.0%	0.0%	0.0%
2. Consent	66.7%	33.3%	0.0%	0.0%
3. Care & Welfare of Service Users	61.9%	23.8%	0.0%	14.3%
4. Meeting Nutritional Needs	100.0%	0.0%	0.0%	0.0%
5. Co-operating with other Providers	0.0%	0.0%	0.0%	0.0%
6. Safeguarding People who use the Service from Abuse	33.3%	66.7%	0.0%	0.0%
7.Cleanliness & Infection Control	100.0%	0.0%	0.0%	0.0%
8. Management of Medicines	75.0%	0.0%	0.0%	25.0%
9. Safety & Suitability of Premises	33.3%	66.7%	0.0%	0.0%
10. Safety, Availability & Suitability of Equipment	100.0%	0.0%	0.0%	0.0%
11. Requirements Relating to Staff	60.0%	40.0%	0.0%	0.0%
12. Suitability of Staffing	80.0%	20.0%	0.0%	0.0%
13. Supporting Staff	66.7%	11.1%	11.1%	11.1%
14. Assessing & Monitoring the Quality of Service provision	100.0%	0.0%	0.0%	0.0%
15. Quality of Management (Complaints)	87.5%	0.0%	0.0%	12.5%
16. Records	50.0%	50.0%	0.0%	0.0%

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	Section results				
	Met	**Part Met**	**Not Met**	**Not assessed**	**Max per section**
Section A Care Plan & Assessment	16	4	0	2	**22**
Section B Service User Experience (Observation)	17	2	0	2	**21**
Section C Care workers (Observation of Staff Practice & Staff Interviews / Discussions)	22	3	1	1	**27**
Section D Care worker/s (Records / Files)	5	3	0	0	**8**
Section E (Environment & General Safety)	8	2	0	0	**10**
Section F (Provider Management, Staff Deployment & QA Systems)	7	2	0	1	**10**
					98

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	Total score per section
Section A Care Plan & Assessment	101
Section B Service User Experience (Observation)	70
Section C Care workers (Observation of Staff Practice & Staff Interviews / Discussions)	96
Section D Care worker/s (Records / Files)	26
Section E (Environment & General Safety)	36
Section F (Provider Management, Staff Deployment & QA Systems)	31
Overall score	360

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Domain scores

	% score	Met	Part Met	Not Met	Not assessed	Max score per domain
Domain 1: Involvement & Information	**89.6%**	64	3	0	0	72
Domain 2: Personalised care & Support	**95.5%**	115	9	0	-7	140
Domain 3: Safeguarding & Safety	**88.3%**	60	8	0	-4	80
Domain 4: Suitability of Staffing	**83.8%**	52	8	0	-4	76
Domain 5: Quality of Management	**87.5%**	40	1	0	-4	48
		331	**29**	**0**	**-19**	**416**

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Overall Summary

Section A Additional notes for the Provider

On the day of the visits two care plans were monitoried by K Dix -NC and TG and two were monitored by Fran Goodwin -PH (respite) and SS. On the second day K Dix monitored two more care plans -PS & DH.
One Service User is clearly able to consent to decisions. It was recorded and signed that she did not wish for her photos to be used in identification for any other professionals, media. However, CCC was given this care plan to monitor. There did not appear to be a robust understanding of MCA's and Best Interest Decisions. Good practice would advise that MCA's be stored behind the care plan need and risk assessment. Manager to review these.
Management assured CCC that visitors and Service Users do not use the POD out the back, however, it is not very user friendly. Quotes for providing concrete to have better access has been sought.

Section B Additional notes for the Provider

Due to Covid 19 restrictions, K Dix did not ask individual residents or relatives their opinions on the care at Orchard House. Questionnaires were provided instead. Unfortunately only three were returned.
More information regarding Service User key worker scheme would be beneficial perhaps at the review.
Evidence of the menu and food intollerances/allegens in each day's menu such as nuts, gluten. diary.

Section C Additional notes for the Provider

19 Staff questionnare were returned for the purposes of monitoring.
If Service User refuses, responses included, document and let the senior carer know.
Some staff had a better understanding of MCA ,BI and DOLS than others. Would benefit some extra support regarding this area.
In response to safeguarding quite a number of staff responded by saying "Told/Seeit -Document it-Report it".
Some staff felt regarding staffing levels that there are enough supporting 40 residents, however, would need more if at full occupancy.

Section D Additional notes for the Provider

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Due to the pandemic, visitors have not been allowed such as the hairdresser.
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A new trainer has been recruited in December 2020 to cover all RCH homes. Overall mandatory training statistics -92.8%. A new Hospitality Manager has been employed to manage all aspects of the dining room experience, menu planning.

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Section F Additional notes for the Provider	There appeared to be some discrepancies between which staff were supposed to be on shift, however, different staff had signed in on the signing in sheet. On the 17/04/21 there appeared to be 2 Team Leaders and I carer. There was no Nurse on shift which even with less residents is a concern. I am aware one of the Team Leaders may be CHAPS trained but I would still expect to have a Nurse on shift on Nights. The signing in sheets are incomplete with some staff not signing out, some staff not requesting a new sheet, therefore 5 columns became 4 with half of the staff not signing out. This could be potentially a fire risk. The provider uses carehome.co.uk to gain feedback (Recently scored 9.5). Limited information regarding actions being completed and followed up in the care plan audits.
Additional Notes	Any other notes will be added in this box