Mrs P M Hannelly

The Orchard

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

The Orchard is a family run care home in rural Buckinghamshire, it can accommodate up to 11 people over the age of 65. At the time of our inspection 9 people were living there. Accommodation is over two floors. The Orchard has a 'family home' atmosphere and has a number of different seating areas for people to use.

We previously inspected the service on 08 May 2015. The service was meeting the requirements of the regulations at that time. This inspection took place on 07 and 09 October 2015 and was unannounced. This meant staff and the provider did not know we would be visiting. The inspection was planned in response to concerns raised by a member of the public.

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

People were not consistently protected from avoidable harm. Staff were not always knowledgeable regarding how to recognise abuse and what actions they would take if concerns were highlighted.

Summary of findings

People were not protected from the risk of fire because advice from the fire officer had not been followed. For example, removing wedges and other items holding fire doors open. Risk assessments for fire had not been updated.

Some of the required pre-employment checks had not always been completed. For example, some staff had been recruited using an interpreter. This was because English was not their first language and they were unable to take part in interviews without this support. This also impacted on the staff ability to effectively communicate with people and understand their needs.

We found staffing levels were not sufficient to supervise people to ensure their safety. Staff had received training in key areas, however we poor practice in particular communication and manual handling.

Medicines were not managed safely. For example, we observed poor practice in how medicines were administered and recorded, which placed people at risk of harm.

Personal risk for people were routinely reviewed, however we found evidence of failure to reduce the risks relating to the health, safety and welfare of people and others who may be at risk. In addition, there was a failure to assess, monitor and improve the quality and safety of the services provided. The systems in place had not identified the shortfalls we found for people or driven improvement in the quality of care or service provided.

We found a number of breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found a breach of The Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

The service was not safe.

People were placed at risk of harm as medicines were not managed safely.

People were not adequately protected from the risk of fire. This was because the risk assessment had not been updated and fire exits were obstructed.

People were not consistently supported by staff with the right skills and attributes because robust recruitment procedures were not used by the service.

Is the service effective?

Inadequate 

The service was not effective.

People were not protected against the risk of unsafe and ineffective care

because staff had not been appropriately supported through regular

supervision and appraisal.

People were not supported consistently by staff who understood individual rights under the Mental Capacity Act 2005. People were limited to what support they could receive due to the environment.

Is the service caring?

Requires improvement 

The service was not always caring.

There was limited engagement between staff and the people they supported. They did not provide people with explanations on their care and did not promote their involvement.

Staff did not always present good communication and manual handling techniques.

People's privacy was not always protected. This was because visitors and people who were not employed by the service had unprotected access through the building, close to toilets, bedrooms and lounge areas.

Is the service responsive?

Inadequate 

The service was not responsive.

People did not always receive person centred care. This was because preferences for bathing were not always respected as facilities were not available.

People were not always supported to engage in meaningful activities and they were not enabled to make choices and decisions on their care through the lack of staff engagement and ability to communicate effectively with them.

Summary of findings

Is the service well-led?

Inadequate 

The service was not always well-led.

There were ineffective systems in place to monitor the quality of the service and drive forward improvements.

The registered manager was not aware of all the serious occurrences or incidents that must be reported to the Care Quality Commission. This meant we could not always see what action they had taken in response to these events, to protect people from the risk of harm.

The Orchard

Detailed findings

Background to this inspection

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

The inspection took place on 07 and 09 October 2015 and was unannounced. The inspection was planned in response to concerns raised by a member of the public. The inspection team consisted of three inspectors. Prior to the inspection, we reviewed information we held about the home and contacted the local authority contracts team.

We spoke with eight people, the registered manager, seven staff, six relatives and two healthcare professionals. We reviewed medication and care files for all residents, we reviewed electrical and gas safety certificates.

We had contact with the local authority contract team. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. As a result of information received prior to inspection and what we found, we made referrals to Buckinghamshire Fire and Rescue and Environmental Health.

Inadequate

Is the service safe?

Our findings

People living at The Orchard were not always protected from avoidable harm. Staff we spoke with had a mixed understanding and knowledge of how to recognise abuse and what actions they would take should concerns be raised. Staff were encouraged by the provider to attend training and most staff had received training on safeguarding people. One staff member had not received training on safeguarding was able to discuss with us their understanding of what constituted abuse and what actions they would take. Two staff we spoke with could not communicate effectively with us, due to their use of English, what their understanding was of abuse or safeguarding people and the actions they would take, despite training on the subject.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service did not ensure that staff understood their responsibilities to safeguard people.

We saw evidence that accidents and incidents were recorded; falls were recorded, risk assessments were completed for a number of key areas. These included mental health, physical health, moving and handling, nutrition and falls and behaviour. These were reviewed monthly by the senior care worker. We saw that risk assessments were reviewed and some notes were amended following significant events, however, there was little evidence of remedial actions required to reduce risks. For example, one person who was identified at high risk of falls had no identified actions to minimise risk detailed in their care plan. On day two of our inspection, we witnessed the person in a high risk situation. They were attempting to come down the stairs with a walking aid; staff were unaware that the person had left their room. The staffing levels at the time were two staff plus the registered manager. One hour later the planned staffing levels were to be one staff and the registered manager. We asked the registered manager how they would have managed that situation if it had occurred an hour later; we were advised that they would call upon one of the live in staff, who would be off duty at the time. We asked the registered manager how they would deploy staff to be able to respond to this near miss, they stated that they would be able to support or call upon live in staff. Prior to the end of our inspection, the registered manager advised us they had ordered a motion sensor to alert staff when the person was leaving their room.

This was breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because reasonable steps had not been taken to reduce potential risks to people living at the service.

We asked the registered manager to demonstrate how they ensured equipment used in the home was safe; we were provided with the last electrical safety testing sheet. This consisted of three pages, the date on two of the pages was 13 and 14 September 2012, the other page had an overwritten date of 13 September 2013. We observed a number of electrical devices; we found that some items had not been tested since 2011. For instance, the stair lift had not been tested since 9 August 2011. The label stated the next test was due in August 2012, but there was no evidence that this had happened.

A floor lamp in a lounge had not been tested since September 2011 and the label stated the next test was due in August 2103. We saw no evidence of a more recent test. Therefore there was mixed practice in maintaining the safety of equipment used at the home. The registered manager advised us that they had already requested a visit by an electrician to undertake further testing and they were due shortly after our inspection. There was two steps down into lounge/dining area. There was no ramp or handrail to enable people with poor mobility and people in wheelchairs to get down safely. We observed staff bump people down the stairs backwards in their wheelchairs.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service did not ensure that equipment was regularly maintained and potentially placed people at risk.

We observed staffing levels throughout our inspection and reviewed staff rotas. We were initially informed that three members of staff worked a morning shift; however on day two of our inspection we were informed by the registered manager that two carer workers plus a cleaner worked in the morning. Staffing rotas showed four shifts patterns are operated through a 24 hour period. We observed two weeks of working patterns and noted that on three days only one care staff member was rostered to work from

Inadequate

Is the service safe?

13.00 until 16.00. We asked the registered manager how they would manage to support people in an emergency. They stated that they would call upon staff that live on site even if this was outside of their working hours.

The registered manager told us they provided four members of staff with accommodation. One care worker and their family lived on the top floor of the home and two other members of staff lived in a mobile home within the grounds. We were advised by the registered manager that the partner of the worker who lived in the home did not work for them. They also told us children lived in the house and in the mobile home. We asked the provider what actions they had taken to ensure residents were protected in respect of people living onsite who did not work for the service. They advised us that no risk assessments had been undertaken around these people.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service did not ensure that people living at The Orchard always had their privacy protected and were placed at risk at associated risks with unchecked people living at the service.

There were not always enough staff on duty to support people. One person we spoke with stated "Sometimes there is enough staff, other times I have to wait ages for them to answer call bells." Another person stated that "Staff come when I need them." We observed a bingo session being undertaken; at the time the member of staff leading the activity was the only staff member on duty in addition to the registered manager. The call bell was activated twice during this session, the staff member left the activity to respond. The registered manager did not attempt to respond. On day one of our inspection we made observations of the length of time people were left unattended in the lounge. We saw one person who was sat in a chair at 12.25pm and was still seated in the same position at 15.20pm and 18.10pm. We did not see any staff presence in the lounge until 16.25pm when tea was distributed to people in the lounge. We observed staff were not present throughout the meals times and people did not have easy access to a call bell at these times.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service did not ensure that staffing numbers were adequate to meet the needs of the people in the service all the time.

We looked at the recruitment processes for staff; we noted that the provider recruited staff another country within the European union. All staff had a criminal records check and references. References were addressed to 'to whom it may concern'; a recommendation was previously made to the provider about ensuring that references were addressed to the person requesting it. We asked the provider about this and they stated that the overseas staff bring the references with them. We also noted that no health checks had been undertaken. This meant the provider had not ensured staff were physically and mentally fit to work with vulnerable people. We also found one member of staff had not completed an application form.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service did not ensure they had carried out all required pre-employment checks.

Medicines were not managed safely or in line with current best practice. Medicines were stored in a lockable cabinet secured to the wall. On day one of the inspection, we received mixed information from the registered manager as to which staff administered medicines. Initially we were advised that it was the registered manager and the senior care staff, yet later we were advised that all staff had received medication awareness training, but four staff were identified by the registered manager who administered medicines. This was not what we found in practice.

On day one of our inspection, we were advised that medicines had been dispensed in the morning by the night staff, who finished working at 08.00am. We found clear plastic medicine pots with small strips of paper with handwritten names of residents. We asked the registered manager about this and they advised us that medicines were handed to staff to administer. We told the registered manager this did not follow current best practice and left room for medicines errors.

We asked to observe the lunchtime medicines round. However, when we went to find the member of staff we found them in the office signing all the medicine charts after giving people their medicines. We questioned the member of staff and they stated this was usual practice as they could not carry all the medicines and the charts around with them. The member of staff confirmed that

seven people were supported with medicines and they carried around everyone's medicines at the same time. This practice was also observed on day two of the inspection. This was not in line with the provider's policy on medicines.

On day one of our visit, we had found an empty blood glucose machine box in the medicines cabinet at lunchtime. We asked the registered manager who used the machine; initially they stated it was used to test urine. They later confirmed it was used to test blood but they were not aware who it was used for but stated that either the district nurses or the senior care worker used it. We asked the district nursing team about this and they stated they did not use the machine. We found a box of lancets in a bedroom of one person using the service, next to it was a sharps bin. The secure lid had been tampered with and resealed using sticky tape. This meant used lancets were accessible. The last recorded blood glucose test for the person was 19 March 2015. We found no evidence in care plan of how often the blood needed to be tested. This meant that people health and risks associated with them were not managed in a safe way and staff did not have information available to them to provide safe person centred care.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because the service did not ensure safe care and treatment was provided at all times.

At approximately 15.30pm we asked the registered manager to open the medicine cabinet to replace the blood glucose machine box. The registered manager was unable to open the medicine cabinet; we observed them attempting access for six minutes. We were advised that four people were due medicines at 18.00. No other medicines trained staff were on duty. On the second day of inspection we asked the registered manager whether they had been able to access to the medicine cabinet at tea time. They advised us that another member of staff opened the cabinet and people were supported with their medicine at the usual time of around 18.30pm.

On day one of our inspection, we were provided with a copy of a pharmacy audit conducted on 7 April 2015. This made a recommendation that a record should be made of how much medicine has been received by the service and of medicines in stock. The provider had a policy in place for medicines, which was undated and appeared to be a copy from another home, as the name of the home had been crossed out and 'The Orchard' had been hand written above. The provider had an additional 'Homely Remedies Policy'. The policy stated that 'stock levels should be reviewed regularly and excess stock returned to the pharmacy'. We found no evidence that medicines received we counted or signed for or a record of stock was made

We observed that medicines currently not prescribed were still present in the medicines cabinet and two medicines were not used. We found one medicine with a dispensed date of 27 August 2014 and an expiry date of May 2015. The staff member we spoke with stated it had never been opened. We found four boxes of pain relief medicine for the same person. We asked the registered manager regarding any records for stock control. They advised us that the senior care worker ordered medicines but confirmed that no actual records of stock were kept. On day two of our inspection we were advised that morning medicines had been given by the night staff apart from two residents who were still in bed. We were advised by the provider at 09.00am that the medicines were ready for when they woke. We asked the provider to clarify what was meant by this. They told us that it was on their desk and they showed us two clear plastic pots containing the medicine and name labels for the residents. At approximately 09.30am we witnessed the registered manager took the two pots from their top pocket and handed them to a staff member and said "that one is for X and this one is for Y." The medicine had been exposed to oxygen for over an hour and a half and were not dispensed and administered in line with the provider's policy or national guidance on safe handling of medicines This also placed people at risk of receiving incorrect medicines and medicines not safely stored.

This was a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. This was because the service did not ensure that medicine were stored safely.

The provider did not ensure that people were protected from fire. We found fire doors were obstructed by furniture and walking aids. We observed that fire doors were propped open, either by a plastic door stop and in one case, a hot water bottle. Fire exits were not always signed. A referral had been made to Buckinghamshire Fire and Rescue service, following concerns about fire doors. The registered manager advised us of the initial feedback from the Fire Service. We noted that some immediate remedial

Inadequate

Is the service safe?

actions had not taken place. For instance, the provider was advised to remove all combustible items on a landing however, they were still present on both days of our inspection.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as the service did not ensure that premises were suitable for the purpose.

Inadequate

Is the service effective?

Our findings

We found the service was not always effective. Staff did not receive training to enable them to fulfil their roles effectively. We observed that one member of staff was supporting with meal delivery and manual handling. We checked their training records which showed they had not received food hygiene or manual handling training. We also observed poor practice by staff who had not received appropriate training with regards to manual handling. On both days of our inspection we observed people being supporting under the arm to help with a transfer. This placed people at risk of injury and is not in line with best practice.

Three staff we spoke with were unable to communicate if they had had supervision or an induction period. We reviewed their personnel files and found little evidence of supervisions or appraisals. We spoke with the registered manager who confirmed that they had not met with all staff on a one to one basis regularly.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service did not ensure that staff had appropriate training and support to undertake their role.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. There was mixed practice for people living at The Orchard. We saw evidence that some applications had been made to the supervisory body. One application had been considered by the supervisory body and a decision had been made that the person was not being deprived. We found no evidence of review of this process following changes in the health of the person. One application had been authorised by the local authority. The provider had not informed the Commission of the decisions made by the supervisory body which is a requirement. We spoke with two staff who were not able to communicate their understanding of the Mental Capacity Act or DoLS.

Consent was not clearly demonstrated within care records we reviewed or in daily records of support provided. We observed staff supporting people on a number of occasions. Staff did not always seek consent from people and on occasions gave people commands, for instance we overheard a staff member say “Please eat.” and “You come with me.” We reviewed care files for people living at The Orchard, although there was a section in the care risk assessment file for consent this was not routinely signed by people using the service.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service did not ensure that people were involved in decisions around their care.

We observed practice over two days. On both days we witnessed passive restraint being used. Two people were supported to be sat in the lounge area, both were not able to mobilise without support from staff. On both days we witnessed that a table was placed in front of them, which potentially acted as a barrier to prevent movement. On two occasions on the inspection we witnessed people supporting one another as staff were not around. On day one of our inspection one resident moved the table away from their peer to allow them movement.

People told us that “food is good”, “meals are good”, “food not bad”, however one person told us “I tell them I don’t like fish pie, I don’t recall ever been given something else.” Relatives told us “I don’t see that they get a choice.” We saw copies of menus from previous days. These showed there was a choice of meals available; this is not what we found. We observed four meals throughout our inspection and did not see or hear any discussion around choice of meals. We witnessed staff delivering meals to people and placing it in front of them without any words or explanation being given on what the meal was. On both days of our inspection we witnessed vegetables, potatoes, carrots, peas and beans were cooking on the stove from the morning; on day two vegetables were on the stove from 08.45am until being served at 12.15pm. The registered manager advised us that an additional member of staff works four mornings to support with meals. We did not observe that food was probed to ensure adequate temperature had been reached. We asked the registered manager about this and they were unable to provide us with any evidence of food being probed. We asked a member of staff about this, they were able to show us the probe, but no records were available.

We had received concerns from members of the public and professionals that people were not supported to have enough to drink. We found no evidence of this. On both days of our inspection people were supplied with fluids throughout.

Inadequate

Is the service effective?

On day one of our inspection we saw that the freezer in the kitchen was thick with frost, food was uncovered and not labelled, not sealed and frost damaged. We asked the registered manager about this and they stated it was for the services cat. It was difficult to determine which food was intended for people living at The Orchard and the cat. We saw seven freezers in the garage. There was a mixture of food storage for example, in four of the freezers we found uncovered food which had been exposed to frost, one freezer thermometer had a display of plus 10.8 another had minus 27. We have reported our concerns to the environmental health department.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service did not ensure that equipment was properly maintained clean and suitable for its purpose.

People had access to healthcare professionals. Health care professionals we spoke with confirmed that concerns regarding people's health was reported. The registered manager showed us a communication book which captured healthcare concerns. We saw evidence that specialist healthcare visits had been undertaken.

Requires improvement

Is the service caring?

Our findings

One person living at The Orchard told us the staff are "reliable, kind and friendly." Another stated "staff are nice." Relatives told us that "X is fantastic, X there are a solid person", "it's a smashing place to be and staff are fabulous", "X is very good with people" and "they (staff) are caring." We received feedback from professionals involved in the home and from relatives in regards to their experience of The Orchard. We were told it depended on who was on duty. One relative stated they had "concerns when X was off duty as X carry's the place," Another relative stated "it can be difficult to communicate with some staff; we tend to speak with X and Y."

We observed practice over the course of two days. We found there was some good practice. On the second day of our inspection we observed a bingo session. People engaged in the process and appeared happy. We observed laughter and staff were talking with people throughout the activity. At the time of the activity there was one staff working and the registered manager. The call bell rang twice and the staff member had to leave the activity to respond to the needs of other people.

We witnessed interactions between staff and people who lived at The Orchard did not always demonstrate kindness. We witnessed a staff approach a person. They did not talk to them, raised their feet from a foot stool and lowered them down, then placed a table in front of them and put a tea tray on the table and stated "please eat." No explanation or other interaction was made. On another occasion we witnessed a member of staff going up to a person who was seated in a wheelchair at a table. Without any discussion the staff pulled the person back in the chair and moved them to another part of the lounge. On three separate occasions we witnessed staff supporting people by using manual handling techniques that were not in line with best practice. We observed that staff did not always knock on doors when entering a room, and some did not always communicate what they were intending to do.

This is a breach of Regulation 9 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. This was because care did not support people to understand choices available to them.

We observed where people had chosen to remain in their room this was respected by the staff, people told us " I like my own company", relatives also advised us where their relatives remain in their room it was their choice.

On day two at 18.15pm we observed three people sitting in the lounge in a state of darkness. The people had been seated in the lounge since lunchtime. A member of staff was supporting someone to transfer from being sat down to a standing position. No lights were on in the lounge at the time and it was at dusk.

Care plan files reviewed captured information about people preferences, for instance how many pillows they would like. People we spoke with stated that their preferences were not always taken into consideration. One person stated "I had cornflakes and thin hard toast, I would have preferred Weetabix." Another stated that "they put me to bed too early." We observed call bell being answered, these were responded to quickly and this is what people told us "they come when I call", "they come as soon as they can, it is always answered."

People were not always involved in decisions about their care. We were informed by the registered manager that someone was having a quiet day. We could not find evidence this was their choice. Later the person was found on the stairs as they had wanted to get up. After staff had resolved the immediate risk, the person was supported down the stairs. At this point the person was chastised by the registered manager for their actions. We also heard people throughout the day apologising to staff for their behaviour. We asked the person living at The Orchard why they needed to apologise and they stated "that's just me."

People's privacy was not always protected. Relatives of staff who lived on site had to walk pass peoples bedrooms to access their own accommodation. We ask the provider if they had undertaken a risk assessment for this. We were advised that this was not necessary as "I know them all", "I am sure X is not interested in accessing any bedrooms."

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the service did not ensure people's privacy was protected.

The registered manager informed us that following a sudden death, they had reviewed people's preferences for end of life care. They had arranged for a GP to visit to discuss end of life treatment with everyone that lived in the home. We reviewed the do not resuscitate forms and found

Requires improvement

Is the service caring?

that some had no reason for not attempting resuscitation and some were only discussed with family. These forms were not obviously available to staff as they were stored within a box file with the care plans. This meant there was a risk to people in an emergency situation. Although a separate list was available in the office.

Inadequate

Is the service responsive?

Our findings

Pre-admission assessments were conducted prior to people moving into the home. These were undertaken by the registered manager or the senior carer. The assessment covered a wide range of information to enable the home to make a decision on whether they could meet the person's needs.

Each person living at The Orchard had an individual care plan which covered a number of key domains, including mental health, physical health, and oral health. The service used a system which covered a 12 month period. We found information regarding health did not always transfer from one 12 month period to the next. For instance we found no evidence of health in the current file for a person who had a diagnosis of diabetes. The registered manager and staff were unaware the person had diabetes and a diabetic diet was not given. Instead the person was given cake for pudding.

Some person centred information was gathered to enable staff to support people however; this was not fully evidenced for everyone we reviewed. One person told us that they would prefer to have a shower but this was not possible due to the environment. No shower or baths were available for them to use. Staff we spoke with had little understanding of people preferences and could not communicate how they would ensure person centred care. Another person told us they would like to go to bed later, but they "did not want to make a fuss.", as they knew only one member of staff was employed to work after 20.00pm. We reviewed this person care plan and those preferences had not been recorded. This meant that choices were not always respected.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the care people received did not reflect their preferences.

People we spoke with stated "I don't think there are activities" and "not a lot happens." Relatives informed us "nothing goes on; I think they have bingo from time to time." We observed interactions between staff and people who live at The Orchard. On day one of the inspection no activities took place. Instead people sat in the lounge from morning to evening with limited engagement between them and staff. One day two we witnessed a session of bingo being undertaken; however people were not involved in this. We witnessed a member of staff going into the lounge and announcing "we are going to play a game of bingo." Cards were placed in front of everyone in the lounge, one person responded and stated "I do not want to play", another person slept through the whole activity.

We looked at the records for activities; this demonstrated that activities were not routinely undertaken.

The registered manager advised us they act on complaints. We were shown the complaints folder. The file contained one complaint from 2004 to September 2015. This complaint was responded to by the registered manager. Relatives we spoke with told us that "If I had concerns I would feel happy to raise them", "if I was bothered by anything X and Y would sort it out." The registered manager did not analyse feedback, they advised us that if issues were bought to their attention they just deal with it.

Inadequate

Is the service well-led?

Our findings

A registered manager was in post at the time of our inspection. They are also the provider and lived on site. The registered manager is extremely dedicated and they have been working in the care industry for over 55 years. They are proud of the service they run and the staff they employ. The personal living accommodation is linked to the care home. One person who lives at The Orchard described the provider as "having the highest ethical standards" and "they have the highest integrity." Relatives told us that X was "always kind to and about X"

The registered manager told us they invest in their staff and feels having live in staff is very important as it "make the place safer, as X can help out in the event of a fire." Staff we spoke with stated that "happy working here, X is approachable and home is well managed", another member of staff told us "it's a lovely home." The registered manager took pride in the 'homely' atmosphere and talked of the staff as family.

The registered manager did not always respond to actions required of them. The fire service had issued some guidance regarding the removal of combustible items three days prior to our second visit. We witnessed these items had not been removed. The fire service also advised that all fire doors should not be obstructed or propped open. On both days of our inspection we found fire escapes were obstructed and four fire doors propped open. The service did not have a satisfactory fire risk assessment. The registered manager advised us that arrangements had been made for a re-assessment of fire risks.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Because the service did not evidence that they assessed, and reduced risks relating to fire safety.

We spoke with the registered manager about their duties to inform us of certain events. They were unaware of the guidance on notifications. A notification is information about important events which the provider is required to tell us about by law. We noted that we had not received notifications in two key areas. One where someone had suffered a serious injury and another where the local authority had authorised a deprivation of liberty.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009. This was because the service did not ensure that notifications required were made.

We asked the registered manager to explain how they ensured staff provide a high quality of care. They advised us that they are on duty every day and addressed issues with staff as they arose. We found little evidence of learning from events, in respect of staffing issues or complaints. The registered manager failed to keep themselves and staff abreast of current best practice. We saw that two staff had completed the Care Certificate. The Care Certificate sets out explicitly the learning outcomes, competences and standards of care that will be expected care. However we observed poor practice in manual handling, medicine management and communication. We spoke with the registered manager on day one about our concerns regarding medicine management, however on day two we observed the registered manager undertaking poor practice. It was clear they had little insight into poor practice.

We asked the registered manager how they address poor performance with staff who first language is not English; they informed us that they used gestures to explain issues to them. We found no written evidence of support given to staff to increase their knowledge of best practice. The registered manager did not seek the views of staff to improve the service.

We asked the registered manager about what actions they undertook to monitor the quality of care and information they gathered on their performance of running of the home. On day one of our inspection they stated that they do not undertake any. On day two we were shown a new policy folder which included a quality assurance file. The registered manager advised us they were positive about the new policy folder as they hoped it will drive improvements. We reviewed a business continuity plan, we were provided with a folder which had no information only templates for completion. We were later provided with another folder which was undated and had some information completed. We discussed this with the registered manager and they confirmed that no other information was available. We were informed by the registered manager that they were always on duty and could be called upon to respond to emergencies. On site

Inadequate

Is the service well-led?

'live in staff', were also available. However we found no contingency planning for an unplanned absence of the registered manager. This meant that there was a lack of effective quality assurance and auditing processes.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

There is a requirement for providers to display ratings provided by The Commission. We noted that the rating issued in May 2015 was not on display and the manager was not aware of the requirement to do so.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service did not display performance assessment.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider had not ensured that service users received person centred care that reflected their individual needs and preferences.** Regulation 9 (1) (a) (b) (c) 3 (a) (c) (f) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider had not ensured that service users were treated with dignity and had their privacy protected.** Regulation 10 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider had not ensured that consent was gained.** Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The provider had not ensured that equipment was in good repair and bathing facilities were not always available.** Regulation 15 (1) (c) (e)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The provider did not ensure that all pre-employments checks and information was available.** Regulation 19 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA (RA) Regulations 2014 Requirement as to display of performance assessments **The provider failed to display previous assessment rating.** Regulation 20A (2) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The provider failed to notify CQC of events, significant injury and DoLS authorisation** Regulation 18 (1) (2) (a) (c)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured the safety of service users by assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. Medicines were not stored safely and best practice around administration was not observed. Regulation 12 (1) (2) (a) (b) (c) (d) (e) (g)

The enforcement action we took:
We have issued a warning notice. We have asked the provider to meet the regulation by 18 December 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure that staff were aware of signs of abuse. The provider did not have systems in place to ensure that people living at the service who were not employed did not present a risk to service users. Regulation 13 (1) (2)

The enforcement action we took:
We have issued a warning notice. We have asked the provider to meet the regulation by 18 December 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured that service users were protected from unsafe care and treatment by the quality assurance systems in place. Regulation 17 (1) (2) (a) (b) (c) (e) (f)

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We have issued a warning notice. we have asked the provider to meet the regulation by 18 December 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure staff numbers were sufficient to manage potential risks at all times. The provider did not ensure staff received appropriate training, supervision and appraisal as is necessary. Regulation 18 (1) (2) (a)

The enforcement action we took:
We have issued a warning notice. We have asked the provider to meet the regulation by 18 December 2015