The Orchards Residential Care Home

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## Inspection report

The Orchards Mill Lane
Bradwell
Great Yarmouth
Norfolk
NR31 8HS

Tel: 01493652921

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | Requires Improvement |
| Is the service effective? | Requires Improvement |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Requires Improvement |

# Summary of findings

## Overall summary

This inspection took place on 28 July 2016 and was unannounced.

The Orchards Residential Care Home provides accommodation and care for up to 13 older people, some of whom may be living with dementia. At the time of this inspection there were 11 people living in the home.

A registered manager was in post. They were also one of the two partners in the business. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The other partner in the business, who was also present during our visit, is referred to as the provider throughout this report.

At this inspection we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Whilst risks specific to individuals were well managed we found that some environmental aspects of the home required attention. Some windows lacked window restrictors and the water system needed appropriate inspecting and maintenance. Improvements were required to ensure that some practices in the home did not pose a risk of cross contamination. The provider's monitoring systems had not identified these concerns.

Staff ensured people's consent was obtained for day to day matters. A closed circuit television camera was in place in the lounge. However, there were no records to indicate that people living in the home and others had consented to this and privacy issues had not been considered. We have made a recommendation that the provider seeks guidance in relation the use of the camera.

There were enough staff available to ensure that people's needs were met in a timely and personalised manner. People were cared for by staff who treated them with kindness and respect. Medicines were managed and administered to people in a safe way.

People, and where necessary, those acting on their behalf were involved in making decisions about care and support arrangements.

People were offered choices about what to eat and drink and specific dietary needs were catered for. People were caringly and respectfully encouraged to eat their meals. Staff were well trained and supported to undertake their roles effectively.

The home was well organised and there were systems in place to obtain the views of people and their

relatives.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

Environmental risks such as window restrictors, the risk of legionella and some infection control practices needed addressing.

Risks specific to individuals were identified and plans were in place to reduce the risks as far as was possible.

Staff levels were adequate to meet people's individual needs.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

Improvements were required to ensure that the service operated in accordance with the Mental Capacity Act 2005.

Staff received suitable training and support from the manager and provider.

People had good access to healthcare services.

### Is the service caring?

**Good**

The service was caring.

Staff had developed positive relationships with people and had a good understanding of their needs.

People were treated respectfully and their dignity was promoted. People benefited from the calm and relaxed atmosphere in the home.

### Is the service responsive?

**Good**

The service was responsive.

The care people received met their needs and preferences and this was reflected in their care plan.

The provider's complaints guidance available to people required updating.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well led.

Improvements were required to ensure that the monitoring of environmental matters was robust.

The service management had fostered a positive and open culture in the home.

# The Orchards Residential Care Home

**Detailed findings**

## Background to this inspection

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

This inspection took place on 28 July 2016 and was unannounced. It was carried out by one inspector.

Prior to this inspection we reviewed information that we held about the service. We had requested feedback before the inspection from the local authority quality assurance team and clinical commissioning group.

Providers are required to notify the Care Quality Commission about events and incidents that occur including injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us.

During the inspection, we spoke with one person who used the service and relatives of four people living in the home. Most people living in the home were living with conditions which meant that they were unable to give their views about the service in any detail. We used observations to help understand people's experiences of the service they received. We also spoke with the manager who was a partner in the business, the other partner in the business who is referred to in this report as the provider and three care staff members.

We carried out general observations and looked at the care records of three people and other information relating to their care and the recruitment records of two staff members. We also looked at records relating to how the quality of the service was monitored.

Requires Improvement

# Is the service safe?

## Our findings

During this inspection we found environmental risks that could pose a risk to people's safety or welfare. Most people living in the home were living with dementia. On the first floor a few windows were without window restrictors. Windows without restrictors could put people living with dementia or visual impairments at risk of a fall from height.

There was no legionella risk assessment in place and effective controls were not in place to minimise the risks of the legionella bacteria. One of the ways to reduce the risk of the legionella bacteria is the effective control of water temperature. Some, but not all, water outlet temperatures were being monitored. However no temperatures had been recorded since April 2016. It was not recorded whether the one temperature sampled in various rooms was from the hot or cold water tap. The temperatures recorded of between 22 to 23 degrees centigrade in several rooms were outside of the recommended range to inhibit the growth of any legionella bacteria.

We noted that it was common practice to store clean towels, facecloths, soap and toothbrushes on top of toilet cisterns. This presented a significant risk of cross contamination. We sampled the condition of the bed linen in four rooms and found that whilst laundered, two items of bedding were stained. A commode in one person's room was old and worn. The washable coating had worn away at the rims of the fabric which meant that dirt could permeate the cushioning. In the upstairs wet room a wooden filigree radiator cover was in place. The radiator was situated close to the shower. Wood is a permeable material and was not suitable for use in the wet room as it would be impossible to clean. These issues presented risks of cross-contamination to people.

Risks specific to individuals were identified, assessed and actions were taken to minimise the risks to people as far as was possible. For example risk assessments were in place in relation to nutrition, skin integrity and falls. There was significant information and guidance for staff in relation to all identified risks to people's welfare. Timely referrals were made to healthcare professionals such as the falls team or the dietician as necessary.

For people at risk of falls, there was guidance for staff on how to support people to move safely around the home and what equipment was required. There were also plans in place detailing what sort of assistance people would require in the event of an emergency. These took account of people's likely mental cognition in an emergency situation as well as what their physical needs would be. The manager reviewed all accidents and incidents within the home on a regular basis to identify any trends or new risks posed to people's health and safety, particularly in relation to falls.

Staff were knowledgeable about what type of concerns could constitute abuse and the actions they would need to take. They knew which organisations would need to be informed of any concerns. Relatives told us that they had no concerns about their family members' safety in the home. Training records showed that staff had received training in safeguarding matters.

There were enough staff deployed to meet people's needs. Relatives and staff we spoke with had no concerns regarding staffing levels. Staff told us that the manager often helped out which we observed. Two care staff were on duty during the day and there was one waking night staff and one sleeping night staff member on the premises overnight. The manager told us they would be reviewing the sleeping night staff provision because one person had recently begun to need regular repositioning during the night which necessitated two staff members to be available.

We reviewed the recruitment records for two staff members. Both records contained suitable references and checks had been made with the Disclosure and Baring Service (DBS) to ensure that the applicants were not prohibited from or unsuitable to work in the care sector. These checks had been returned before staff commenced work in the home. However, there was no proof of identity for them on record. The manager said that they had seen proof of identity during the recruitment process but had not kept a copy for their records. They told us that they would arrange for this to be obtained for all staff members.

People's medicines were well organised and managed safely. One person's medicines were being crushed with their permission. The suitability of the medicines for crushing had been confirmed by the pharmacist and this was recorded on their prescription. Another person was on pain relieving patches. The positioning of these patches needed rotating to minimise the risks of skin sensitivity. Skin patch positioning records showed us that the patches were being applied safely. Medicines Administration Record (MAR) charts were correctly completed and stock levels of people's medicines agreed with the records. We observed good administration practice during the lunch time medicines round.

Requires Improvement

# Is the service effective?

## Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Most of the people living in the home were living with dementia. People are considered to lack capacity in relation to a specific matter if they are unable to make a decision for themselves due to a cognitive impairment. Under the MCA a person is unable to make a decision if they cannot understand, retain and weigh the information provided and communicate their decision.

Care records showed that where people had limited capacity to make day to day decisions that staff were to support them with decision making where possible before making a decision in the person's best interests. A staff member told us how they often showed one person with limited mental capacity a choice of outfits they could wear for the day as this helped the person to make their own decision. Staff told us that if given adequate support most people were able to make their own decisions about day to day matters.

The manager had a good understanding of DoLS and what restrictions would necessitate an application needing to made to the local authority. They had requested authorisation to restrict some people's freedoms in order to ensure their safety and were awaiting the outcome of these applications.

Records showed that some people's relatives had Lasting Power of Attorney (LPA). However, it was not always recorded whether this was in relation to people's finances or their health and welfare. This meant that the provider could not be sure that some relatives had the legal authority to make decisions on behalf of their family member.

The home had closed circuit television (CCTV) installed in the communal lounge. The provider told us that this been installed about five years ago. They told us that they had carried out a consultation exercise at the time, but were unable to provide any records of this. There were no mental capacity assessments in place in relation to the use of the CCTV. Most people living in the home would not have been able to understand or consent to the use of CCTV.

People were supported with their meals as necessary. We saw that some people utilised double handled beakers to drink from or spoons to eat with as this was easier for them. People received gentle encouragement to eat their meals and were offered alternatives if they changed their mind about what to

eat. Those requiring a diabetic diet received slightly different versions of what other people had. On the day of our inspection a reduced sugar rice pudding was offered to people living with diabetes in a slightly smaller portion size. A staff member described how they slightly changed the proportions of starchy or sugary foods in main meals where possible. Drinks were available to people throughout the day. The service utilised plenty of fresh fruit and vegetables.

People had choices about what to have for their meals. Staff asked them what their preference was each morning. However, some people appeared unsure of what they had chosen at lunchtime and may have benefited from a menu or a pictorial indication of what was for lunch.

Staff told us that they received good training and support from the manager and that they were encouraged and supported to obtain care qualifications. One staff member told us, "[The manager] is hot on training. We should be getting training on diabetes soon." The manager was accredited to train staff on moving and handling techniques. Newer staff members were completing the care certificate. This is a set of care standards that are covered in the induction training of new staff. The small staff team was stable with some having worked for the provider for several years. Staff told us that they received frequent supervisions and annual appraisals.

People had access to a range of health professionals to support them with their health. These included community nurses, mental health practitioners and chiropodists. A local GP carried out a weekly visit to the home but would also come out sooner if required. Staff were observant when people's needs began to change and timely interventions were made to obtain the assistance of health professionals. One relative told us how staff recognised the signs that their family member may have had a urinary tract infection and took prompt action.

Good

# Is the service caring?

## Our findings

One person told us, "They're really good to me in here." One person's relative said, "Staff are very kind here. I've seen them sitting with people in the lounge watching the television of an evening, it's all very homely." Another relative said, [A particular staff member] is amazing. They interact so well with people."

The atmosphere in the home was positive and friendly. Throughout our visit we saw that people were treated with respect and in a kind and caring way. We saw that staff took the time to speak with people about their interests and have general conversations with them throughout the day when opportunities arose. People looked content and were at ease in the presence of staff.

Staff had developed positive and meaningful relationships with the people they supported and their visitors. They knew people well and could anticipate their needs or when something wasn't to their liking and intervene appropriately. This helped to minimise any distress people might experience.

We observed that staff were discreet when supporting people to uphold their dignity and used humour in a positive way. A staff member saw that one person needed to wipe their mouth after lunch and offered them a tissue, subtly indicating by actions what the person needed to do. The person wiped their mouth, smiled and shrugged their shoulders in a cheerful manner. The staff member winked back at them and returned the person's smile.

A relative told us that even though their family member used continence aids that staff did not rely on this and helped ensure their family member's dignity by assisting them to the bathroom.

Staff were patient and ensured that they answered people's questions clearly and gave them time to consider what had been said. One staff member was administering people's medicines when one person asked them what their medicine was for. This was explained to them in a straight forward manner so that the person could understand. After a few moments the person nodded and then took the offered medicine.

Some relatives we spoke with were aware of the CCTV camera in the lounge and did not express any concerns. However one relative was surprised when we told them as they hadn't been aware of it. The provider showed us that notices about this were in place. However, they had not considered any implications this might have in relation to people's expectations of privacy.

We recommend that the provider seeks advice to ensure that they are acting in accordance with relevant legislation and best practice regarding the use of CCTV.

Care records we reviewed showed that people, when possible, or their relatives were included in in the planning and implementation of people's care. One relative told us, "The manager has gone through [family member's] care records with me. I am happy to sign to them." Another relative told us, "It had been arranged for the falls team to come in and assess [their family member]. Staff made sure I was told when this was so

that I could come along too. Having me there made it easier for [family member] and I know what is going on too."

Good

# Is the service responsive?

## Our findings

The service utilised a computerised care records system which helped enable detailed care plans and records to be easily maintained. People's care records were specific to their needs and how they wished them to be met. This was recorded in detail and there was suitable guidance for staff in how to support people appropriately. People's care plans were up to date.

One relative told us that the pre-admission assessment that the manager carried out before their family member was admitted to home gathered a lot of information. This included details about people's physical and emotional needs and their interests. Life histories and considerable detail about people's preferences were noted in people's care records. We observed how staff referred to people's life experiences when speaking with them to help foster positive engagement.

We saw that people's preferences were noted and acted upon. For example, one person's records stated that they liked three pillows and we saw that these were in place. One person's relative told us, "They're good at moving people around sufficiently to reduce friction." One person had recently begun to require repositioning. Records clearly indicated that this was being carried out at appropriate intervals. The service had only just received guidance on this by a community nurse and the required actions had been implemented promptly.

We observed the morning to afternoon shift handover session. All oncoming shift staff attended and most of the staff going off shift were present too. This helped ensure that information was passed on first hand and enabled all oncoming staff to ask questions. The manager led the handover and it was clear that they were well versed in people's immediate needs and any matters requiring action. They gave a brief recap on anything outstanding, for example health appointments, and changes to peoples' support in recent days so that staff who hadn't been on shift for a few days were updated.

Some relatives felt that there wasn't enough for people to do in the home. One told us, "There's little to do, there's no stimulation. And the television needs to be up on the wall so people can see it better." Another relative told us they had asked the manager about the possibility of a visit from a 'Pet as Therapy' (PAT) dog, but the manager had vetoed this on health and safety grounds. The relative added, "I'm sure that many people would have enjoyed that."

However, other relatives felt that people were not interested in doing much. One relative told us that their family had physical limitations which meant that they didn't watch television, listen to the radio or read. Their family member did enjoy sitting out in the garden and staff often took them outside and had taken them to the local shops on occasions. The gardens were well maintained and an attractive place for people to spend some time. Another relative said that they frequently observed staff trying to encourage people with individual or group activities but with limited success. Minutes from a residents meeting showed that they had been asked their views on how they would like to spend their time and people had said that they enjoyed reminiscence, ball games and puzzles.

Staff told us that they struggled to engage people in activities. One said, "Most people just want to relax and chat or watch what goes on here." On the day of our visit we observed some people were enjoying a singalong, but others were not engaging with the activity. Staff told us that spending time chatting with people individually in the lounge interspersed with short periods of puzzles, ball games or perhaps a game of eye spy was what people seemed to prefer.

People's relatives told us that they were confident that if they had need to raise any concerns with the manager or provider that they would be listened to an appropriate actions would be taken to remedy their concern. The provider's procedure for complaints was available to people in the main hallway. The manager told us that they had received no complaints in the previous 12 months. This required updating as it referred to obsolete organisations for people to raise concerns to and did not take account of whether organisations had the authority to investigate complaints on behalf of people.

Requires Improvement

# Is the service well-led?

## Our findings

A system of audits was in place. However, those relating to the environment were not always effective. A commode audit had been carried out in June 2016, but this did not identify the concern that we found. A health and safety audit did not identify the missing window restrictors. The most recent infection control audit had been carried out in January 2016. However, this was more of a documentary exercise than a practical check on the cleanliness in the home. For example, it asked such questions as whether toilets were visibly clean and free from lime scale or staining. However, no sampling of toilet cleanliness was carried out to support the assertion that there were no concerns in these areas. Environmental auditing needed improvement to ensure that risks were being identified.

The manager and provider had poor knowledge in relation to the risks of the legionella bacteria. The control systems in place were not effective. No steps had been taken to identify potential sources of risk in the water system or determine the condition and suitability of storage tanks and pipework systems.

Suitable actions had not been taken to identify and mitigate environmental risks in the service.
These concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were positive about working in the home. Some had worked there for several years and told us that the manager and the provider were supportive, helpful and good to work for. One staff member told us how the manager had given them considerable support to build up their confidence. Another staff member told us that staff opinions were always sought and taken into account when decisions were made about the running of the service.

Staff were motivated and everyone understood their roles and responsibilities within the home. We saw minutes from staff meetings and staff told us that they were encouraged to raise any concerns or queries they had.

Our observations and discussions with staff demonstrated that they understood the provider's vision and values for the service. Staff understood and recognised the need to support people's dignity, privacy and independence. One staff member told us, "We've all got our own families. We remember that each person here could be our mum or dad. We treat them with respect, just as we would want to be treated."

Relatives told us that they had confidence in the management of the home and were satisfied that their family members were well cared for. One relative told us that the manager was always 'upbeat' and that they had fostered an open and positive culture in the home.

There were clear arrangements for the day-to-day management and running of the service. The manager told us they were supported by a good staff group who worked well together and supported each other to ensure people received a good service. The manager understood their role and responsibilities and had an inclusive approach to the way they managed the service.

People, or their relatives, had been given questionnaires to establish their views about the service people received. The responses received were positive and complimentary.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Robust systems were not in place to identify risks to the service and individuals. |