AMAFHH Healthcare Limited

Quorn Orchards Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Quorn Orchards Care Home is a residential care home providing personal care for up to 30 older people. At the time of our inspection, there were 27 people using the service.

During this inspection we carried out a separate thematic probe, which asked questions of the provider, people and their relatives, about the quality of oral health care support and access to dentists, for people living in the care home. This was to follow up on the findings and recommendations from our national report on oral healthcare in care homes that was published in 2019 called 'Smiling Matters'. We will publish a follow up report to the 2019 'Smiling Matters' report, with up to date findings and recommendations about oral health, in due course.

People's experience of using this service and what we found
Improvements were needed to records where people were at risk from poor skin integrity. The provider had not ensured effective contingency planning where work was in progress to improve and upgrade the environment, to ensure people were protected from the potential risk of harm. People's medicines were administered safely. Further improvements were needed to ensure all medicines were stored safely and in line with best practice guidance.

Oversight of the service required further development. The provider and registered manager had identified where improvements were required, though not all the concerns we found during the inspection had been identified.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People were protected from abuse, systems and processes were in place to identify and report any abuse or harm. Staff were kind, caring and attentive and understood people's individual needs well. There were enough staff deployed to meet people's needs and keep them safe. People and relatives described a responsive, compassionate service led by an approachable and supportive registered manager.

Rating at last inspection
The last rating for this service was good (published 31 October 2019)

Why we inspected
The inspection was prompted in part due to concerns received about care and support. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions

were used in calculating the overall rating at this inspection.

We found evidence the provider needs to make improvements. Please see the safe section of this report. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. You can see what action we have asked the provider to take at the end of this full report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Quorn Orchards Care Home on our website at www.cqc.org.uk.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always safe.
Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.
Details are in our well-led findings below.

Quorn Orchards Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of two inspectors.

Service and service type
Quorn Orchards Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Quorn Orchards Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we held about the service and the service provider. We looked at notifications

and any safeguarding alerts we had received for this service. We sought feedback from the local authority and professionals who work with the service. Notifications are information about important events the service is required to send us by law.

The provider had completed provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We looked around the service and met with the people who lived there. We spoke with four people to understand their views and experiences of the service and we observed how staff supported people. We spoke with five staff including the nominated individual, the registered manager and care staff. We contacted four relatives by telephone to gain their views about their family member's care and support.

We reviewed the care records of four people and a range of other documents. For example, medicine records, staff training records and records relating to the management of the service. We also looked at staff rotas, three staff recruitment folders and records relating to health and safety. After the inspection, we continued to seek clarification from the provider to validate evidence found, including training information and key policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question as good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely

- Accurate and up to date records were not always kept in relation to people's skin integrity. For example, one person's records did not reflect an area of skin damage. There had also been a failure for a second person, to record the nature, grading and progression of the wounds to ensure safe and effective care.
- Environmental risks, for example, those relating to the service's fire arrangements were in place and these included individual Personal Emergency Evacuation Plans (PEEP) for people using the service. We found information in PEEP forms was limited in terms of providing guidance and information on how to evacuate each person safely.
- At this inspection we found some internal doors to high risk areas had been left unlocked. This included doors to the attic room, boiler room and sluice room.
- The nominated individual told us some doors had been replaced prior to our inspection as new fire doors and were awaiting new locks so had been left closed but unlocked over the weekend.
- We were not fully assured that the provider was promoting safety through the layout and hygiene practices of the premises. The overall cleanliness of the home needed to be improved to ensure that people lived in a clean and hygienic environment. . We found a shower room on the first floor required a deep clean to remove in-grained mould and grime. A metal coated support frame around a separate toilet was rusty and presented a risk of infection for people. The sun lounge, an area used for visiting, had not been cleaned and had remains of discarded food on the floor. The provider told us they would replace the toilet frame and ensure a deep clean was undertaken but audits had failed to identify this concern.
- We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. We observed staff using a toileting sling for one person, then using the same sling to support a second person to go to the toilet. This presented a risk of cross infection.
- Further improvements were needed to ensure safe storage of people's prescribed creams in line with best practice. We found creams, which contained flammable substances, had been left exposed in two people's rooms. In one room, the cream was left out on top of a radiator. We raised this with the registered manager who told us they would ensure creams were locked away after administration.

Although we found no evidence that people were harmed as a result of incomplete records and environmental risks, the failure to maintain accurate records to maintain effective oversight of people's risks, to carry out contingency planning to ensure environmental risks were managed and to ensure medicines were stored safely meant people could be at potential risk of harm. These were breaches of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider took immediate action and fitted new locks and adjusted doors so the doors were locked and made safe during our inspection visit.
● The registered manager was aware of failings around care records and was in the process of addressing oversights with staff. Reminder notices around documentation were displayed in offices and the registered manager was working with staff to bring about an improvements in records.
● People's care plans included detailed, person-centred guidance for staff to follow in the event they became distressed or anxious.
● We observed a medicines round. Staff consulted with people about their medicines and administered them safely and in their preferred way.
● Staff had received training in administering medicines safely. Their competency was regularly re-assessed by the registered manager and, if staff were approved to administer insulin injections, by the district nurses.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. The communal dining room was cluttered with inappropriate items used as storage, including lateral flow test kits and continence aids. This made it difficult for people to access this area. The provider began to clear the area during our inspection visit, however, relatives told us they frequently found this area cluttered and difficult to access.
● We were somewhat assured that the provider's infection prevention and control policy was up to date. The policy required further review to ensure it was reflective of current guidance and best practice.

Systems and processes to safeguard people from the risk of abuse
● People were kept safe from the risk of abuse.
● The registered manager provided safeguarding training to staff and staff could describe what they would do if they had concerns. One staff member told us, "People are safe because we are quick to notice if something is wrong. We write everything in people's care notes and discuss in handovers."
● People told us they felt safe using the service. One person told us, "I feel safe here and have never seen anything of concern. If I did, I would go straight to the manager. Staff have a lovely approach and the atmosphere is always calm."
● People's relatives told us staff kept people safe. One relative told us, "It is always a pleasant atmosphere to walk into, no matter what the time of day is. Staff deal with everything in a soothing way. Within two days of [family member] moving in, I was totally at ease they were safe and well cared for."
● There were policies and information available for staff. However, these required review and updating. For example, the safeguarding policy failed to refer to modern day slavery as a form of abuse.

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 MCA 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)
● We found the service was working within the principles of the MCA and if needed, appropriate legal

authorisations were in place to deprive a person of their liberty. We observed staff sought consent before supporting people with any tasks, and mental capacity assessments had been completed when people lacked capacity to make decisions.

● The registered manager had made DoLS applications to the local authority when necessary and kept them under review until a response had been received.

● Staff had received training in the principles of the MCA and understood their role and responsibility in upholding those principles.

Staffing and recruitment

● There were enough staff to meet people's needs. We observed staff had time to spend with people and provided care and support without rushing. One person told us, "There are always enough staff around to help me get to where I need to go without waiting for very long." A relative told us, "I have always found staff to be very helpful and have never experienced any problems with lack of staff, even at weekends."

● Staffing was based on the dependencies of the people living at the service and reviewed as new people moved into the service.

● The registered manager completed checks to ensure staff were of good character before supporting people. Disclosure and Barring Service (DBS) checks were completed on staff, along with checking work histories. The DBS provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Lessons learnt

● Accidents and incidents were recorded, reviewed and analysed each month. This helped to identify any additional measures that could reduce or prevent further occurrences.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.

- Systems and processes to ensure oversight required improvement. The registered manager completed a variety of audits and checks and these were used to drive improvements. However, the impact of these improvements, and evidence to support these were sustainable, was not evident at the time of our inspection.
- A third person's care plan referred to catheter care but provided no guidance around this. When we asked staff to clarify, they told us the person no longer required a catheter. The care plan had not been updated to reflect this.
- The registered manager had identified improvements were needed to records and addressed this with staff. Actions included discussions in staff meetings, re-training and reminder notices in offices. We found records required further improvements, particularly around skin care. This demonstrated improvements were not yet embedded in staff working practices.

- The registered manager had reminded staff to keep the environment clean. We found areas which required deep cleaning and excessive clutter in other areas. This demonstrated this improvement had yet to have a positive impact on the environment.
- The nominated individual had replaced fire doors in line with requirements from a recent fire inspection. They had failed to implement any contingency planning whilst waiting for locks to be fitted to doors. Although they took immediate action and rectified this during our inspection visit, there was risk people could have accessed these areas in the interim period and sustained harm.
- Staff understood people's individual needs. People and relatives told us that staff responded to people and were kind. One person told us, "I like it here, I wouldn't change anything as it's nice and ordinary. They [staff] are lovely and I feel safe here." We observed consistently caring and attentive interactions between people and staff throughout our inspection visit and staff demonstrated they knew people well.
- Relatives felt involved in their family members' care and felt staff achieved positive outcomes with people. One relative told us, "I had a lengthy meeting with [registered manager] before admission as they wanted lots of information about [family member]. This really put me at ease. I have been impressed with the levels of care, attention and compassion staff have shown to residents."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were able to share their views through resident meetings and individually through informal and formal discussions about their care. A resident meeting in April 2022 recorded people's involvement in discussions around new staff, meals and the environment.
● Relatives confirmed they could share their views directly with the registered manager who took these on board. They were also involved in formal meetings where they were consulted about their family members' care.
● Staff confirmed they attended regular staff meetings. We reviewed minutes of meetings and saw these were used to discuss where improvements were required and remind staff about best practice. Staff described the registered manager as supportive and approachable. One staff member told us, "We can ring the [registered] manager if we need any help or guidance. We have contacted [name] if there is an emergency at night and [name] will come out and support us."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● Complaints were appropriately recorded and managed. People and relatives told us they knew how to complain, and when they had concerns these were listened to and the concerns rectified.
● The registered manager understood their responsibility under the duty of candour. The duty of candour requires providers to be open and honest with people when things go wrong with their care and to give people support and truthful information.

Continuous learning and improving care. Working in partnership with others
● All staff involved were open and transparent throughout the inspection. Concerns raised during feedback were considered and actions put into place.
● We saw referrals were made to external professionals as required and their advice was followed.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not consistently ensured areas of the premises were always safe and people were consistently protected from the risk of infection. Accurate and up to date records were not always kept in relation to people's skin integrity. Medicines were not always stored safely.