Health & Care Services (NW) Limited

Orchid Lawns

Inspection report

Steppingley Hospital Grounds
Ampthill Road
Steppingley
MK45 1AB
Tel: 01525 713630
Website: www.craegmoor.co.uk

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Ratings

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

Overall summary

This unannounced inspection took place on 05 January 2016. At our previous inspection in June 2015 we found that there was insufficient activity to support people with their interests, there was no registered manager in place and quality assurance systems had not been embedded. During this inspection we found that an activities coordinator had been appointed and the quality assurance system was effective. A new manager was in place but their appointment was not popular with all of the staff and relatives of people who lived at the home.

Orchid Lawns provides nursing care and support for up to 24 older people with dementia and needs relating to their mental health. At the time of our inspection there were 21 people who lived at the home.

The home had not had a registered manager, as required by the Care Quality Commission (CQC), since May 2014, although the recently appointed manager had applied to become the registered manager. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

During our inspection we found that people were not always safe at the home. Staff were aware of the safeguarding process. Personalised risk assessments were in place to reduce the risk of harm to people, as were risk assessments connected to the running of the home. These were reviewed regularly. Accidents and incidents were recorded and the causes of these analysed so that preventative action could be taken to reduce the number of occurrences. There were effective processes in place to manage people's medicines and referrals to other health and social care professionals were made when appropriate to maintain people's health and well-being. However, people's personal emergency evacuation plans contained insufficient detail for staff to be able to safely evacuate them in case of an emergency and staff who administered medicines were repeatedly interrupted when doing so. This meant that there was an increased risk of errors being made and delays in people receiving their medicines.

There were enough skilled, qualified staff to provide for people's needs. Staffing levels had been calculated in accordance with current guidance and based on the dependency levels of the people who lived at the home. Although a number of permanent staff had indicated that they would be leaving the service a recruitment exercise was underway and the provider was taking steps to dissuade staff from leaving. Robust recruitment and selection processes were in place and the provider had taken steps to ensure that staff were suitable to work with people who lived at the home. They were trained and supported by way of supervisions.

People or relatives acting on their behalf had been involved in determining their care needs and the way in which their care was to be delivered. Their consent was gained before any care was provided and the requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met. Relatives were involved in the regular review of people's care needs and were kept informed of any changes to a person's health or well-being.

People had choice of good nutritious food that they liked and their weight was monitored with appropriate referrals made to other healthcare professionals when concerns were identified.

There was an up to date complaints policy in place and a notice about the complaints system was on display in the entrance of the home. However, the manager had not always followed the policy when dealing with expressions of dissatisfaction. There were a number of other information leaflets on the notice boards around the home which included information about the service and organisations that could be contacted for support or to report concerns.

There was a very friendly, family atmosphere about the home. People, relatives and staff were able to make suggestions as to how the service was provided and developed, although they had not always been consulted on changes made to the home.

An effective quality assurance system was in place.

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?
The service was not always safe.

People's personal emergency evacuation plans were not sufficiently detailed to ensure that they would be evacuated safely in the event of an emergency.

Staff who administered medicines were repeatedly interrupted when doing so, even though they wore an appropriate tabard to indicate that they should not be interrupted during this task.

Staff were aware of the safeguarding process and appropriate referrals had been made to the local authority.

Personalised risk assessments were in place to reduce the risk of harm to people.

Requires improvement

Is the service effective?
The service was effective.

The requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

People had a good choice of nutritious food and drink.

People were supported to access other healthcare professionals to maintain their health and well-being.

Good

Is the service caring?
The service was caring.

Staff were kind and caring.

Staff promoted people's dignity and treated them with respect.

People were provided with information about the service.

Good

Is the service responsive?
The service was not always responsive.

Care records did not always contain comprehensive details about people's medical history or incidents that had occurred.

Although there was a complaints policy in place this had not always been followed by the manager.

Staff responded quickly when people needed assistance.

Requires improvement

Is the service well-led?
The service was not always well-led.

Requires improvement

Summary of findings

Most relatives and staff members disliked the newly appointed manager.

Some staff were excluded from staff meetings.

There was an effective quality assurance system in place.

Orchid Lawns

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 05 January 2016 and was unannounced. The inspection team was made up of two inspectors, a Specialist Advisor who is a registered nurse with knowledge of caring for people who exhibit behaviour that challenges others and an Expert by Experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information available to us about the home, such as notifications. A notification is information about important events which the provider is required to send us by law. We also reviewed information about the home that had been provided by staff and members of the public.

During the inspection we spoke with seven relatives of people who lived at the home, six care workers, a housekeeper, the cook, the activities coordinator, the manager, the area manager, who was supporting the manager, and the provider's Operations Director. We carried out observations of the interactions between staff and the people who lived at the home.

We reviewed the care records and risk assessments for seven people, checked medicines administration and reviewed how complaints were managed. We also looked at six staff records, reviewed information on how complaints were managed and looked at how the quality of the service was monitored and managed

Requires improvement

Is the service safe?

Our findings

Relatives of people we spoke with told us that they felt their relative was safe and secure living at the home. One relative told us, "We feel [Relative] is very safe." Another relative said, "I think they do the best they can, given the circumstances." We saw that the exits to the building were protected by way of a numbered key code so that people were unable to leave the building unless they knew the key code or were accompanied by a member of staff.

The provider had up to date policies on safeguarding and whistleblowing. Whistleblowing is a way in which staff can report misconduct or concerns within their workplace without fear of the consequences of doing so. Information about safeguarding was displayed on a noticeboard in the entrance hall together with details of the telephone numbers to contact should people wish to. The staff we spoke with told us that they had received training on safeguarding procedures and were able to explain these to us, as well as describe the types of abuse that people might suffer. One member of staff said, "I have been trained to recognise the signs of abuse and I would take any concerns to the manager." Another member of staff told us, "If I've seen it, it is up to me to make sure that the people who should know about it get to know." Records showed that the staff had made relevant safeguarding referrals to the local authority and had appropriately notified CQC of these. Staff said that they were aware of and understood the provider's whistleblowing policy. One member of staff told us, "We are open and honest as a staff team and tell each other if we do not agree with any practices."

There were personalised risk assessments in place for each person who lived at the home. The actions that staff should take to reduce the risk of harm to people were included in the detailed care plans. These included the identification of triggers for behaviour that had a negative impact on others or put others at risk and steps that staff should take to defuse the situation and keep people safe. One relative told us, "They know how to stop a situation before it started." Risk assessments were reviewed regularly to ensure that the level of risk to people was still appropriate for them. We noted that where people had been assessed as at risk of sustaining falls a risk assessment was in place and a record kept of every fall that the person experienced to enable potential causes to be identified. However, when we checked the record of falls for one person against the incidents that had been documented we noted that one of the falls they had experienced had not been recorded.

Staff told us that they were made aware of the identified risks for each person and how these should be managed by looking at people's risk assessments, their daily records and by talking at shift handovers. Staff therefore had up to date information and were able to reduce the risk of harm. However, staff told us that the handovers were done before or after their shifts and they were not paid for this time. The outgoing senior staff member conducted the process with the oncoming staff, whilst other staff left at the end of their shift. Although there was no evidence that people had experienced a lack of care as a result of this process, it had the potential to create a perfunctory handover or leave people without appropriate supervision. We spoke with the area manager and the regional manager who told us that the nurses would undertake the handovers and these were completed during time for which the nurses received payment.

Each person had a personal emergency evacuation plan (PEEP) in place. However, one we looked at had been poorly completed and provided little guidance on the actions that should be taken. This left them at risk of inappropriate actions being taken if an evacuation situation occurred.

The manager had carried out assessments to identify and address any risks posed to people by the environment, including fire and portable electrical equipment. There was an emergency plan in place, which included information of the arrangements that had been made for major incidents such as the loss of all power or water supply.

Accident and incident forms were completed appropriately and were analysed monthly to identify any trends or changes that could be made to reduce the risk of harm to people who lived at the home.

During this inspection we saw that the staffing levels were sufficient to care for people appropriately, including the provision of one to one supervision for one person. Staff appeared to have time to spend with people without appearing to be rushed or stressed. Relatives, however, told us they believed the service would benefit from additional care staff. One relative said, "They could do with more staff." Another relative told us, "They need more staff."

Requires improvement

Is the service safe?

Staff told us that there were always sufficient staff on duty and the manager would engage agency staff if the permanent staff complement could not cover all of the shifts. Staff also said that there had been a significant amount of staff turnover which had meant that more bank and agency staff had been used to cover shifts. These staff did not know the people who lived at the home as well as the permanent staff did and would be unable to recognise the triggers for behaviour that could have a negative effect on others and therefore prevent incidents as quickly as the permanent staff. One relative told us, "The agency staff are inexperienced. Some do very well; some don't know [how to defuse a situation] at all." A number of the staff we spoke with told us that they planned to leave their employment at the home. We noted that there was a recruitment exercise underway and on the day of the inspection four new members of staff were on their first day of induction at the home. The area manager and the provider's Operations Director told us of their plans to talk with members of staff who were proposing to leave in an attempt to prevent this.

We looked at the recruitment files for four staff that had recently started work at the home. We found that there were robust recruitment procedures in place. Relevant checks had been completed to ensure that the applicant was suitable for the role to which they had been appointed before they had started work.

We saw that people received their medicines as prescribed and that medicines were stored and administered in line with current guidance and regulations. Only qualified nurses administered medicines and they confirmed they had received regular training updates. We observed a medicines round and saw that medicines were administered correctly. We saw that the nurse ensured that people had safely taken their medicines before signing to confirm the medicines had been administered. However this did mean that the medicines round took almost 2 hours and that spacing between the morning and the lunchtime medicines was compromised.

Although the nurse wore a tabard that told staff and visitors they should not be disturbed, we saw this was not effective and the nurse was often interrupted, which further increased the time the medicines took to administer to everybody. Each medicines administration record (MAR chart) included information about any 'as required' (PRN) medicine or homely remedies a person took, including information about the medicine and any possible contra-indication with their regular medicines. There was also some additional documentation for those people who had medicine delivered by way of patches applied to their skin. This documentation had not always been completed so could suggest the medicine had not been given even though the MAR chart confirmed it had been.

We looked at the MAR charts for all of the people living at the home and saw that these had been completed correctly and medicines received had been recorded. We checked stocks of medicines held which were in accordance with those recorded. There were robust processes for auditing medicines administration.

Good

Is the service effective?

Our findings

Relatives we spoke with were confident in the ability of the staff to provide effective care for the people who lived at the home. One relative told us, "The care is excellent." Another relative said, "Yes I have been here 7 years. We've always said the staff are brilliant."

Staff told us they received training to help them undertake their roles. One member of staff said "There are different training sessions most months that covers lots of areas". Records demonstrated the variety of training available to staff which was provided by both internal and external sources. However staff did tell us that much of their training was done electronically and they had to do a lot of it outside of their working hours which meant they often got behind with it. Staff told us that they were not always paid for the time they spent training. One member of staff told us that they had recently spent six hours completing electronic induction training modules but had been paid for only two hours. Staff were supported to obtain nationally recognised qualifications in social care. The manager told us that they checked that staff were up to date with their training at supervision meetings.

We looked at supervision records which demonstrated that since the new manager had been in post staff had been supervised every other month. The records indicated that the manager used the time to discuss any issues with the staff, but we did not see examples of staff being able to talk with their supervisor about issues or training needs.

People's capacity to make and understand the implication of decisions about their care were assessed and documented within their care records. Staff had received training on the requirements of the Mental Capacity Act 2005, and the associated Deprivation of Liberty Safeguards.

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

People can only be deprived of their liberty to receive care and treatment 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 saw that best interest decisions had been made on behalf of people following meetings with relatives and healthcare professionals and were documented within their care plans. In one record best interests decisions had been made in respect of the delivery of personal hygiene care to a person who was resistant to receiving such care but had been assessed as not having the mental capacity to understand the decision. Following a meeting with the person, their family, GP and the staff it was agreed that it was in the person's best interests to be provided with such care.

Applications for the deprivation of liberty had been made for all the people who lived in the home as they could not leave unaccompanied and were under continuous supervision. This made sure that these decisions, which impacted on their rights to liberty, were made within the legal framework to protect people's rights. However, care needed to be taken to ensure that where a power of attorney was in place for people that a copy of the documentation supporting this was included in the care records.

Staff told us of ways in which they gained consent from people before providing care. They explained that they used non-verbal methods of communication by using gestures, pictures and showing people items to gain consent and give them choices. Our observations confirmed that these methods were used effectively to gain consent and understand people's needs. There was evidence where people had refused to accept care and this was acknowledged. For example, one person was prescribed routine clinical observations (Temperature, Pulse, Respiration and Blood Pressure Monitoring). They refused to allow staff to undertake these clinical observations and this was recorded as appropriate. However, they had noted the rate of respiration, which was the only observation that required no physical contact and could be taken by simple observation. Thus the staff had recorded what they could, whilst acknowledging the resident's refusal to allow any observation that required physical contact.

We observed good interactions between staff and people using the service at lunchtime in order to make it a social occasion and involve family members who were visiting and liked to help at mealtimes. Staff encouraged people to

Good

Is the service effective?

sit at the dining table and offered support appropriately. Where people found it difficult to sit at the table the cook provided foods that could be eaten while moving around (finger foods). The was some evidence of picture menus but staff told us they knew what people liked and often had to decide menu choices for them. We spoke with the cook who told us that fortified meals were provided for people who required this. A list of people needing food supplements was provided by care staff and retained in the kitchen.

We saw that jugs of drinks were available in all communal areas and that staff encouraged and supported people to take fluids outside of mealtimes. All the care records included nutrition assessments and associated eating and drinking care plans. People's weight was monitored and food and fluid charts were completed, for people where there was an identified risk in relation to their intake, which provided detailed information on what they had consumed.

We noted from care records that one person had been admitted in October 2015 with a Grade 2 pressure ulcer on their sacrum and a moisture lesion on their left buttock. However, more recent skin evaluations had reported that these wounds were now healed. This was of note because pressure ulcers can develop and deteriorate very quickly. That the care of the person had enabled the wounds to heal suggested that good basic care techniques had been applied.

The care records showed that people were assisted to access other healthcare professionals to maintain their health and well-being. When healthcare professionals visited people at the home the reason for the visit and the outcomes had been recorded. In one care record we saw that the GP had recently visited to administer the influenza vaccine. There was evidence that staff had appropriately responded to people's needs as they arose, such as making referrals to their GP, a podiatrist or mental health services.

Good

Is the service caring?

Our findings

The relatives we spoke with told us that the staff were kind and considerate. One relative told us that the staff were, "Devoted to their job, absolutely super, very caring, conscientious, always hands on. You can always talk to them. There has always been a good relationship." Another relative described staff as, "Friendly, caring, approachable." A third relative told us, "I have no problem with how the carers look after [relative]. I am quite happy."

Positive, caring relationships had developed between people who used the service and the staff. Staff were able to demonstrate that they knew the people they cared for well, were aware of their life histories and were knowledgeable about their likes and dislikes. We observed the staff interacting appropriately and continually with people throughout the day. Staff told us that they also used body language and other non-verbal forms of communication, such as facial expressions and picture cards, to understand people's needs. Staff described how they offered people choices about what they wore by holding up two garments if they were not able to respond orally.

We saw that people were able to make decisions about their care. We observed people having breakfast up to 11 o'clock in the morning and being able to choose when they got up and went to bed. Care records for one person showed that on occasion they would refuse to go to bed at night, preferring to sit in an armchair in one of the communal areas. The care plan was to respect this choice and make them comfortable and warm in the chair on these occasions. Thus, their choice was supported, whilst seeking to ensure their comfort.

Relatives told us that the staff protected people's dignity and treated them with respect. One relative told us, "From what I can see they are very respectful." Another relative said, "Dignity and respect – yes, all of them, even the new ones."

Staff made sure people's privacy and dignity was respected. We observed that they knocked on people's bedroom doors and waited for permission before entering and they ensured doors were closed when personal care was provided. During our inspection a person had a fall from their chair in a communal area. They were made comfortable while waiting for assistance and their dignity was promoted as far as possible by covering them with a blanket.

Staff and relatives told us that relatives were free to visit at any time during the day and evening. One relative told us, "You can visit at any time." Another relative said, "I can visit any time. I have been told I can come day or night if I want to."

Information about the service, safeguarding, the complaints policy and fire evacuation instructions was clearly displayed on notice boards around the home.

Requires improvement

Is the service responsive?

Our findings

Care records showed that people and their relatives had been involved in deciding what care they were to receive and how this was to be given. They had been visited by one of the managers who had assessed whether the provider could provide the care they needed before they moved into the home. They undertook a thorough pre-admission assessment that fed into the assessment of needs that determined the care plans that were necessary.

These care plans followed a standard template which included information on their personal history, their individual preferences and their interests. They were individualised to reflect people's needs and included clear instructions for staff on how best to support people with specific needs. However, we found that some information, such as comprehensive details about people's medical history or how staff had dealt with an incident had not always been included in the care records. We saw evidence that relatives had been involved in the regular review of people's care needs and were kept informed of any changes to a person's health or well-being.

We observed that staff responded to people's needs and call bells were not left unanswered. When people requested assistance, such as to go to the toilet or to have a drink, this was provided in a timely fashion.

We spoke with the activities coordinator who had been in post for four months at the time of our inspection. They told us that it was difficult to provide activities that everybody could join in with as each was at a different stage of their illness. However, most people took part in the morning activity where they were read the provider's newsletter, the Daily Sparkle. The activities coordinator showed us the programme of joint activities that they had planned. This included a visit from a flute player once a month which was funded by a relative of a person who lived at the home. The planned activities also included attendance at a church service, a musical entertainer and a puppet show. They told us that they devised plans for each person by asking them what they wanted to do and spent time with people on an individual basis to provide activities such as hand massage and nail care.

The activities coordinator told us of planned improvements to the environment that included different rummage boxes and sensory items, such as cushions and sleeves that people could play with. They explained that they had held fund raising activities, such as a raffle at the Christmas Party, to fund improvements in activities as they had a very small monthly budget to cover the costs of the activities. The monies raised were held by the activities coordinator who was personally accountable for how these were spent.

The activities room had recently moved into one of the communal areas. New hairdressing facilities had also been provided in a room opposite the new activities area. This move had not been universally accepted by either relatives or staff. Relatives and staff told us that the change had been imposed by the manager who had taken over the former activities room as their office.

There was an up to date complaints policy in place and a notice about the complaints system was on display in the home. We looked at the records of two recent expressions of dissatisfaction that had been received at the home about the laundry service and saw that these had been investigated by the manager. However the manager had not recognised these to be complaints and had not recorded them within the provider's complaints system. The laundry assistant had been spoken with by the manager following receipt of each complaint and had been given conflicting instructions as to what they were to do with regard to the marking of people's clothing. The manager told us that they had not responded to the complainants in accordance with the provider's policy as they had dealt with the issue. We also found that a complaint made by a relative during a recent satisfaction survey had not been recognised as a complaint. When we discussed this with the manager they told us that it would be dealt with as part of the survey. They later agreed that it should have been dealt with as a complaint.

Requires improvement

Is the service well-led?

Our findings

There was no registered manager in post at the time of our inspection. A recent recruitment exercise had resulted in a new manager, who knew the home well, being appointed. They were in the process of applying to become the registered manager with CQC.

However, relatives of people who had lived at the home for some time were unhappy about their appointment. One relative told us, "I think [they are] a poor manager, it gets peoples backs up, staff appear to be very unhappy and are leaving in droves" Another relative said, "We think [they're] on an ego trip. There have been several issues with [them]. [They are] the second worst manager we have had here. [They] won't listen to us, we don't have any nurses now, only bank or agency staff." Another relative told us, "It is a nightmare since the new manager came. [They have] no idea about managing. I have tried to talk to [them] about doing things on the floor." However, a relative of a person who had moved into the home only recently said, "The manager made me welcome when we came to visit and I am confident [they] look[s] after [Relative] well."

Staff also told us that they were unhappy with the appointment of the new manager. One member of staff said, "There is a lot of complaining. Staff don't like the manager." Another member of staff told us, "I have tried to talk to the manager about the way staff are feeling but [they don't] listen" A third member of staff commented, "Most of the carers are not happy. Good nurses are leaving."

We spoke with the area manager and the provider's Operations Director about the concerns that had been raised. The Operations Director told us that they had identified that, although the new manager had excellent clinical skills, they required support with their interactions with people and staff. The area manager had been appointed to provide them with this support and would be working closely with them throughout the coming months of their probationary period to develop the skills they needed.

On the day of our inspection a meeting of relatives of people who lived at the home, the area manager and the provider's Operations Director had been arranged. We were told by relatives and staff that this was to discuss the changes that the manager had imposed at the home.

Despite the difficulties with the manager we noted that there was a very friendly, family atmosphere about the home. There was a good rapport between staff, relatives and the people using the service which gave a very homely feeling and helped to stimulate people.

The manager held meetings with the relatives of people who lived at the home. The minutes of the latest meeting held in December 2015 showed that they had discussed the appointment of a new hairdresser, the new salon, a planned visit by an optician and the uniform policy. They also discussed staffing, the appointment of new staff and ways in which the home would be more closely linked with another home within the provider's organisation.

Staff told us that the manager also held meetings with staff. However, not all staff were invited to these meetings. One member of staff told us that when they had asked the manager why they had not been invited to the meeting they had been told, "We don't have any issues with you." This meant that the manager had missed an opportunity to allow staff to contribute ideas for improvements to the service.

The manager had sent survey forms to relatives of people to assess the level of satisfaction with the service provided. Most of the forms indicated that relatives were satisfied with the service in areas such as food, care and health and safety.

The manager had carried out a number of audits of the quality of the service. These had included infection control, the environment, care plans and the kitchen. We noted that action plans were devised following these audits where improvements had been identified. For example in November 2015 the audit of the kitchen had noted that food needed to be labelled and fly screens needed to be replaced. During the audit completed in December 1025 it was noted that these actions had been completed.

In addition the provider's Operations Director carried out monthly quality audits of the service during which they spoke with people, their relatives and staff. They also reviewed management records, care documentation, medicines management, maintenance and internal and external compliance. Following the Operations Director's audit in November 2015 we saw that an action plan had been devised to address the areas for improvement identified. The Operations Director confirmed that these actions were monitored to ensure completion of them.

Requires improvement

Is the service well-led?

We noted that an action plan had been devised following our last inspection in June 2015 and information on the actions taken were displayed on the noticeboard by the entrance to the home.

People's records were stored in a locked cupboard within an office used by staff that was accessible only by using a key pad. This meant that people's records could only be accessed by persons authorised to do so.