Mr & Mrs M Sharif

Orchard Views Residential Home

Inspection report

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Barnsley
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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
Orchard Views is a residential care home that provides accommodation and personal care for older people. The home can accommodate up to 40 people in one adapted building. At the time of this inspection there were 31 people using the service.

People's experience of using this service and what we found
At the last inspection some of the provider's governance systems required improvement to ensure people continued to receive good quality and safe care. At this inspection we found the providers governance and quality assurance systems needed further improvements.

Medicines were not always managed safely which placed people at risk of harm. Staff did not receive competency checks on their performance and abilities to ensure they carried out their roles and responsibilities safely. Risks associated with people's care were identified but were not managed in a way that kept people safe.

Appropriate health and safety checks to the buildings and premises had not been carried out, placing people at risk of harm. People were not always protected by the risk and spread of infection.

The provider had a recruitment process in place which showed staff were recruited safely. The provider had systems in place to safeguard people from the risks associated with abuse. Staff were knowledgeable about how to safeguard people.

For more details, please see the full report which is on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 25 December 2019).

Why we inspected
We received concerns in relation to quality assurance systems, the management of the service and staffing. 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.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence the provider needs to make improvement. Please see the safe and well-led questions in this report.

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 the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to medicines, assessing risk, infection control and governance.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Orchard Views Residential 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.

Inspection team
This inspection was completed by two inspectors 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.

Service and service type
Orchard Views is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with CQC. A manager was in post and was in the process of submitting an application to register with CQC. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since our last inspection. We sought feedback from the local authority and Healthwatch (Barnsley). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We

used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection, due to the timing of the 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 spoke with three people who used the service and ten relatives about their experience of the care provided. We spoke with six members of staff including the manager, care staff and ancillary staff. We spoke with a community health professional and a representative of the provider who were visiting the home on the day of this inspection.

We reviewed a range of records. This included three people's care records and various documents from one other care record. We checked multiple medication records and a variety of records relating to the management of the service, including three staff files and various policies and procedures.

We spent time observing the daily life in the service and we looked around the building to check environmental safety and cleanliness.

After the inspection
We sought some more documents from the manager. They were provided in a timely manner and were used to inform our judgements.

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 the last inspection this key question was rated good. At this inspection this key question has deteriorated 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.

Using medicines safely

- Systems to manage medicines safely were not always effective.
- Staff involved in handling medicines had not received recent training around medicines. After the inspection, the provider ensured the appropriate staff were trained and assessed as competent to support people with their medicines.
- One person's medicine was not accurately checked. They were not given medicine as prescribed over a period of two weeks. There was not record of another person's topical medicines being applied as prescribed for three months. This meant there was an increased risk of harm because people had not received their medicines as prescribed
- One person was prescribed a pain relief patch. However, the transdermal patch chart had not been completed since November 2021. This meant we could not see if the patch had been applied according to the prescriber's instructions. This left people at continued risk of pain and discomfort.
- Protocols to guide staff were not in place where people were prescribed medicines to be given as when required. For example, some people were living with dementia and were not able to tell staff when they required medicines such as pain relief. Following our inspection, the manager has told us this information has now been put in place.

We found no evidence people had been harmed; however, people had been placed at the risk of harm from unsafe administration and management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We fed back our concerns throughout the inspection and these were acknowledged during and after the site visit. The manager told us they had now put measures in place to minimise any future risks regarding medicines. We will review the effectiveness of these measures at our next inspection.

Preventing and controlling infection

- Infection control management required improvement.
- During our inspection, the registered manager made us aware of a member of staff who worked a number of shifts whilst only having received a single dose of the COVID-19 vaccine. This was after the recent government deadline for all staff working in care homes needing to be doubly vaccinated. Appropriate action was taken by the provider to make sure the staff member could no longer work in the home until they were fully vaccinated.
- At the time of our inspection, COVID-19 guidance indicated visiting professionals are required to show they are vaccinated or exempt for medical reasons and show evidence of a negative COVID-19 test before

entering the home. During our inspection we observed a number of visiting professionals arriving and none of these measures were followed. Following our inspection, the registered manager confirmed they had put a system in place to monitor visitors.
● The provider did not have an adequate system for adequately monitoring the take up and testing of staff. Following our inspection, the manager confirmed they had put a system in place to monitor staff testing. We will review the effectiveness of these measures at our next inspection.

This was a breach of regulation 12(1)(2)(h)(3) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as government guidance around managing the ongoing pandemic was not being followed.

● The home was found to be clean. There was a sufficient supply of PPE and staff were observed wearing PPE correctly.

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Assessing risk, safety monitoring and management

● Care plans were detailed, however we identified not all care plans and risk assessments were reviewed regularly. As a result, not all care plans and risk assessments reflected people's needs. For example, one person was no longer able to weight bear and this information had not been changed in their mobility support plan. This increased the risk of people's needs not being met adequately.
● We identified shortfalls in relation to reviews of people's risk assessments. For example, in one person's care file we saw they were assessed as high risk for pressure damage to their skin and should have their skin checked twice daily. However, there was no record of these checks being completed. We spoke to the manager who said they would take immediate action to address this concern.
● Checks of the fire safety were completed, however, the fire risk assessment had not been reviewed since it was completed in 2017. The risk assessment recommended that the provider complete a five-year electrical test to reduce the risk of fire. At the last inspection in 2019, the work on the home's electrical installation had started. During this inspection we found this work was still ongoing. This meant there was limited assurance about safety and there was an increased risk that people could be harmed.

We found no evidence that people had been harmed, however, risks associated with people's care were not always mitigated. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke to the provider about our concerns regarding health and safety checks and asked them to take immediate action to address this concern. The provider took immediate and responsive action to address this concern.

Systems and processes to safeguard people from the risk of abuse

● People and their relatives felt they were safeguarded from abuse. One person said, "Oh yes I feel safe, the staff are brilliant they do really good job." Relatives commented, "Yes, [person is safe], they seem to know what they're doing, staff are very kind, very good" and "Safe, definitely [person] is safe; it's the staff, they are caring. There are no problems, [person]) thinks it's a hotel."
● Staff we spoke with were able to describe the signs that could indicate a person was being abused. They told us they would report this to their management team if they witnessed this.
● Safeguarding incidents were recorded in a log which showed the action taken to protect people.

Staffing and recruitment

● The service had employment checks in place to ensure suitable staff were employed to care for

people at the service. These checks included police checks and references from previous employers.
● The provider told us they used a staffing tool to determine the number of staff required to safely operate the home. We received mixed feedback from people and staff around staffing levels. Some staff felt levels were appropriate. However, other staff felt levels needed to be increased, especially when the home had more people with high dependency needs. We fed this back to the provider for consideration.

Learning lessons when things go wrong
● The manager completed an accident and incident analysis to identify trends and patterns. This helped identify what went wrong and lessons were learned to prevent reoccurrences.

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 requires improvement. At this inspection this key question has remained the same. 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.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Systems in place to monitor the service were not effective. Some quality monitoring had taken place but had not identified the issues we found during this inspection.
- Audits did not always identify areas for improvement and development. For example, medicine audits were not sufficiently robust and were not designed or completed in a way that would effectively identify and address any issues. For instance, the audits did not include consideration of staff training and competence requirements, or medication reviews to check that the medicines prescribed were still appropriate. We looked at the infection control audit and found no areas of concern had been found. This did not reflect the concerns we identified during our inspection.

We found no evidence people had been harmed due to our findings on inspection; however, people had been placed at the risk of harm from a lack of oversight of the operations of the home. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Staff felt able to raise issues with the management team and felt their contributions were listened to.
- Relatives were complementary about the management team. One relative said, "I do know [named manager] yes. She's lovely, very good. She will help the staff, she's friendly. I think she would deal with any concerns." Another relative said, "She [the manager] is a good manager because she's a good listener and sorts things out."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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

- Throughout the inspection the manager was honest and open with us. They acknowledged the shortfalls identified at this inspection and were eager to put processes in place to ensure people receiving care and support were safe and protected from harm.
- The provider understood their legal responsibilities to be open and transparent about when things went wrong.
- The manager was aware of their obligations for submitting notifications to CQC, as required by law.

● Staff spoke about people in a caring way and were knowledgeable about people's preferences.

Working in partnership with others

● The service worked closely with other health and social care professionals to ensure people received consistent and timely care. This included family members, social workers, nurses and GPs.

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 People had been placed at risk as government guidance around managing the ongoing pandemic was not being followed. This was a breach of regulation 12(1)(2)(h)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Risks associated with people's care were not always mitigated. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People had been placed at the risk of harm from a lack of oversight of the operations of the home. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

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