SHC Clemsfold Group Limited

Orchard Lodge

Inspection report

Tylden House Dorking Road
Warnham
Horsham
West Sussex
RH12 3RZ

Tel: 01403242278
Website: www.sussexhealthcare.co.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service

Orchard Lodge is a residential care service that is registered to provide accommodation, nursing and personal care for people with learning disabilities or autistic spectrum disorder, physical disabilities, and younger adults.

The service was registered for the support of up to 33 people. At the time of the inspection 13 people were using the service. The service consisted of two separate bungalows, Orchard and Bouldings Lodge, and was in private grounds in the countryside near a large town.

Orchard Lodge is owned and operated by the provider Sussex Healthcare. Services operated by Sussex Healthcare have been subject to a period of increased monitoring and support by local authority commissioners. Due to concerns raised about the provider, Sussex Healthcare is currently subject to a police investigation. The investigation is on-going, and no conclusions have yet been reached.

People's experience of using this service and what we found

There was unsafe assessment, monitoring and management of risk for people with support needs regarding behaviours that may challenge, sexuality, constipation, aspiration, respiration, skin integrity, mobility and posture. Staff did not always have the required competencies or knowledge to meet people's individual needs safely. This had meant people had been exposed to risk of harm and had been harmed.

Staff practice, and reporting systems to safeguard people from abuse, were not always effective to ensure people were safe from harm. Lessons were not always learnt, and actions not taken to investigate safety incidents and prevent them re-occurring. This had exposed people to actual and high risk of harm over prolonged periods.

People's care records were not always up to date or accurate. Service management and the provider's wider quality assurance and governance systems had not always ensured actions were taken to address any issues and risks in a timely manner. The provider had failed to act upon known areas of concern, non-compliance and risk to improve the quality of care for people at Orchard Lodge. This had exposed people to on-going poor care and risk of avoidable harm.

Medicines were not always managed safely. People had not always received their medicines as intended when required. PRN protocols were not always accurate according to what was prescribed or gave clear instructions for staff to manage people's medicines. This increased the risk people's medicines may not be given safely or effectively.

Feedback from partnership agencies indicated staff were taking steps to improve their engagement and

initiative to refer people for outside help, although work was required to make sure all recommendations were then acted on. We found examples where ineffective partnership working had impacted on people's safety.

Staff practice regarding risks associated with service users deteriorating health and hydration had improved since the previous inspection, although more work was needed to make sure staff practice was consistent in these areas.

Arrangements to make sure the premises were kept clean and hygienic on a day to day basis were not always effective. There were offensive odours caused by urine in one person's room and significant unidentified staining on walls in other people's bedrooms. This increased the risk of infection.

The provider had taken action to manage infections during the Covid-19 pandemic. Additional infection prevention and control measures in line with Department of Health and Social care guidelines had been put in place to ensure people's safety.

Staff always wore personal preventative equipment (PPE) when supporting people. The provider had ensured there were adequate stocks and supplies of PPE available. Staff had alerted appropriate external agencies in when they had displayed signs and symptoms of Covid-19. This had helped prevent infection and maintain people's health and well-being

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:

The model of care and setting did not maximise people's choice, control and independence.

The model of care delivery at the service focused on people's medical, rather than their social support needs.

The location of the service was geographically isolated, and people relied exclusively on staff to be able to leave. Opportunities for people to access the local community were limited.

Staff wore uniforms and name badges to say they were care staff when supporting people inside and outside the service.

The size of the service was larger than current best practice guidance. There were identifying signs on the road before the service's private drive, the service grounds and on the exterior of each bungalow to indicate it was a care home.

Right care:

Care was not always person-centred or promoted people's dignity, privacy and human Rights.

People's privacy and dignity had not always been considered, respected or understood by staff.

Staff did not always respond in a timely or compassionate or appropriate way when people experienced pain or distress.

Right culture:

The provider told us they planned to make changes to ensure they could provide compassionate and inclusive support that promoted people's choice and independence.

However, significant work was still needed to change the existing culture, ethos, attitude and practice of staff at Orchard Lodge in order to achieve this vision.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection and update

The last rating for this service was inadequate (published 21 February 2020). The service remains rated inadequate. The service has been rated inadequate for the last four consecutive inspections.

At the last inspection we found multiple breaches of regulations. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected

This was a planned inspection based on the previous rating.

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.

We carried out an unannounced comprehensive inspection of this service on 20 and 21 November 2019. Breaches of legal requirements were found. We undertook this focused inspection to confirm the provider now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has not changed. This is based on the findings at this inspection.

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

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 four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regulations 12, 13, 17, 18 in relation to: safe care and treatment, safeguarding people from abuse, good governance and staffing.

We have also identified a breach of Care Quality Commission (Registration) Regulations 2009 in relation to failing to notify CQC of incidents regarding abuse or allegations of abuse in relation to service users.

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location. Orchard Lodge is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Orchard Lodge

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

This inspection took place between 14 and 24 September 2020. The inspection team consisted of three adult social care (ASC) inspectors, and a medicines inspector.

On 18 September two ASC inspectors carried out an inspection visit to the service. Between 14 and 24 September all four members of the inspection team reviewed care and medicine records and spoke with staff remotely.

Service and service type

Orchard Lodge 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.

The service did not have a manager registered with the Care Quality Commission. This means the provider held sole legal responsibility for how the service is run and for the quality and safety of the care provided.

The service had a manager who had been in post since February 2020 and was in the process of registering

with the CQC.

Notice of inspection

We gave the service 48 hours' notice of the inspection. This was because we needed to work with the provider to agree the safest way to inspect during the Covid-19 pandemic to minimise the risks to people who live at the service, staff and our inspection team.

What we did before the inspection

Before the inspection, we reviewed information we held about the service. We considered the information which had been shared with us since the last inspection by the provider as well as the local authority, other agencies and health and social care professionals. We requested medicine and care records, incident reports, rotas and quality assurance records. We worked with the provider to plan the safest way to inspect the service during our site visit.

During the inspection

We spoke with the service manager, the clinical lead, a registered nurse (RGN) and various support staff. We reviewed people's care and medicine records. We spent time talking to and observing people being supported, including during lunch. We visited some people's bedrooms.

After the inspection

We continued our review of people's care and medicine records, training records, rotas, incident reports and quality assurance records. We spoke with the manager, an RGN, three healthcare assistants, a registered nurse and two relatives of people using the service via telephone.

Inadequate

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 as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people, regarding management of people's health care concerns and risks associated with service users' epilepsy, constipation, behaviours that may challenge, aspiration, PEG care and skin integrity safely. The provider had failed to learn lessons and make improvements when things go wrong.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the provider had failed to deploy staff who had received appropriate support, training and personal development and evidence the service had assured themselves of their competence to carry out the duties they are employed to perform.

This was is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12 and 18.

Assessing risk, safety monitoring and management, Learning lessons when things go wrong

● Risks relating to people's physical and non-physical behaviours that may challenge were not always assessed, monitored or managed safely. During the inspection we reviewed four people with recognised behaviours that may challenge support needs. Some of these people had recently written positive behaviour support (PBS) plans. These plans did identify proactive and reactive support to offer people to help prevent behaviours that may challenge occur or escalate. However, people's PBS plans lacked details and guidance about the best way to manage risks associated with their behaviours. This increased the chance people and staff may come to harm.

● Incidents where other people had displayed behaviours that may challenge were not always adequately monitored. We were told information was being gathered via the use of behaviour monitoring forms to better assess the reason behind people's challenging behaviours to help create more effective PBS plans in future.

●However, behaviour monitoring forms lacked detail and often recorded instances where people were not displaying behaviours that may challenge. This meant there was not enough information to be able to check

people were being supported safely or help inform the completion of safer and more effective behaviour support plans for people. This increased the risk staff could continue not to be able to recognise when people needed support with their behaviours or know how to safely support them.

●Behaviour monitoring forms we reviewed consistently showed staff were not following the directions in people's existing PBS plans. Staff we spoke with were not always aware of actions in people's PBS plans and confirmed they were not using suggested support strategies when asked. This increased the chances these incidents would re-occur, placing people and staff at risk of harm.

● People had come to harm as a result of not having adequate support with behaviours that may challenge. We had recently received notifications of abuse regarding re-occurring incidents where people had physical altercations with other people at the service. Behaviour monitoring forms we reviewed showed people repeatedly biting themselves, but staff had failed to offer the correct support interventions to reduce harm to the person. Other forms showed a person repeatedly grabbing staff which their 'Emotional well-being' and PBS plans advised may suggest they were in pain. However, staff had not acted to offer pain relief as suggested in their emotional well-being plan.

● During our visit we observed staff not following suggested actions in people's PBS plans to intervene when people displayed behaviours that may challenge, including physically challenging behaviours such as hitting themselves repeatedly for prolonged periods.

● People were not supported to monitor or manage risks associated with their sexuality needs. There were no sexuality care plans or risk assessments for people who needed them. People's behaviour support plans referred to their sexuality needs but lacked detail about how to manage any risks associated with their sexuality support needs. Staff told us they supported people in ways that were potentially unsafe. This exposed people to risk of harm.

● Information in people's plans about their sexuality needs did not specify how staff should support them safely or how staff practice should be recorded and monitored. We spoke with the manager and staff who confirmed there was no formal guidance or direction about how to support people with their sexuality needs, or how this was monitored. This meant people may not be supported safely and there was not an effective system to check this.

●Staff had not received training and were not aware of appropriate, evidence-based practical advice and guidance to help them provide sexuality support for people. It was not evident that prior to our inspection people had been offered appropriate opportunities to help them understand their sexuality needs or involve them in decisions about how the support they needed. This increased the risk people may not receive support that was safe, in their best interests and was not unnecessarily restrictive or intrusive of their privacy.

●Actions that had been identified to help keep people safe if they became constipated were not always taken by staff. One person had not received support to be given laxatives when they had become constipated and needed them. This placed them at risk of harm.

●Monitoring records of people's bowel movements were not always completed with the correct information. This meant it could not be confirmed if people had been supported to seek further medical advice or be given laxatives when they had been constipated for long periods. This increased the chance staff may not know when to act to keep people safe or confirm that they had consistently done this when

necessary.

● Risks of aspiration (breathing in liquids, food or saliva) and choking for people were not always assessed, monitored or managed safely. Two people required oral suctioning on an 'as and when' (PRN) basis to reduce the risk of them aspirating on their saliva. There was no protocol to advise staff how to provide suction safely or when this might be necessary.

● Only four staff and the clinical lead from a core team of approximately 30 agency and permanent staff had received training to carry out oral suctioning from the provider or had their competency to deliver oral suctioning to people assessed to check they could do this safely. This meant people could come to harm including from aspirating as staff may not know or be able to carry out oral suctioning safely or correctly.

● Risks from aspiration for people with PEG support needs were not always assessed, monitored or managed safely. A percutaneous endoscopic gastrostomy (PEG) is a tube that is inserted into a person's abdomen, so they can receive liquid food, fluids and/or medicines directly to their stomach.

●People at the service with a PEG tube required support to be sat up, or elevated at a specific angle, both whilst receiving their food and fluids and for a period afterwards. People also required support to have their PEG feeds paused for a period before they moved from an elevated position, for example to lie down or transfer out of their wheelchairs. This was to reduce the risk of aspiration.

●There were inconsistencies about the correct angles people should be elevated to, how long they needed to be elevated after having their feeds, and when to pause their feeds in their support guidance documents. This increased the risk staff may not know or support them to be sat up at a safe angle, increasing the risk of aspiration.

●There had been a recent incident where one person had not been elevated to the correct angle during or after having their feed, water or medicines via PEG. Staff had not been aware this was necessary and information about how to support them at a safe angle had not been detailed in their care plans. This had placed the person at direct risk of aspirating.

● Some people living at the service had been diagnosed with reflux. Reflux can lead to aspiration for some people. There was a lack of detail in people's care plans about how this diagnosis had been assessed to identify any potential risks and what action might be necessary. A registered nurse we spoke with could not explain how they supported people to safely manage any risks associated with their reflux needs. This meant people could be at risk of harm.

● Risks to people with skin integrity needs were not always assessed, monitored or managed safely. One person required support to change their continence pad regularly to avoid the risk of skin breakdown and pressure sores and could not do this themselves. There was inconsistent and conflicting advice in the person's various care plans and risks assessments about how often they needed help to change their pad. Some plans said 2-4 hourly every 24 hours, others said every 4-5 hours. Staff told us the person required support to change their pad 5-6 hourly. This increased the risk the person may experience skin integrity damage.

● Actions that had been identified to manage risks to this person's skin integrity needs were not always being carried out. The persons bowel and positioning monitoring charts showed they had recently not been supported to have pad changes as often as any of the guidance in their plans many times. On one recent

occasion, records showed they had been changed only once in a 22-hour period.

● We asked staff how often people were having pad changes, including this person. Staff told us they thought people mostly had changes when they needed them but also said people often wait to go to the toilet due to the staffing levels. One staff said, "All three people living here need two people with personal care and we only have three staff on the floor for these people. People's needs do not get met and they can't go to the toilet at the same time. Some people might get upset when they wait, there isn't always someone available to intervene and the nurse is busy".

● One person was at risk of injury when they moved around the service without their mobility equipment. The person's current risk assessment stated staff should always support them in this instance to help reduce the risk of injury. The provider sent us information following the inspection confirming it had been agreed at a best interest meeting to allow the person to move around on their bottom with less restrictions, providing they were supervised, and this was reviewed regularly to check it was safe.

●There had been repeated incidents since the last inspection where the person had experienced skin breakdown and bruising. The person's notes and incident forms that had been completed by staff concluded these injuries were thought to have been caused by their moving around unassisted.

●We observed the person moving around without their mobility equipment or staff support during our visit. Staff we spoke with confirmed it was not always possible to support the person one to one when they moved around without their mobility equipment due to not having enough staff on shift. Despite this, there had been no action to review the person's current risk assessment and identify further actions to make sure this activity was a safe enough thing for them to do.

● Risks to people with epilepsy were not always being monitored, assessed or managed safely, exposing them to risk of harm. There were inconsistencies in seizure monitoring documents. This increased the risk that staff may not know how often people were experiencing seizures or what type of seizure they were experiencing to check they were getting the right support. Some people had not always received the correct amounts of their anti-epileptic seizure medicines, increasing the risk of seizures.

●Systems in place for staff and management to report, review and investigate safety incidents, and act to prevent them re-occurring were not always effective. This increased the risk that incidents would not be investigated and acted on to prevent them from happening again. During this inspection, we identified issues relating to safety incidents that had either not been reported or had not been adequately acted on in relation to people's behaviours that may challenge, sexuality, constipation, skin integrity, continence, aspiration and postural support needs.

●We had identified issues and risks associated with people's behaviour support needs for four people during our previous inspection in November 2019. However, we found the same issues remained at this inspection.

●Similarly, in November 2019 we had highlighted the risks regarding people's constipation, epilepsy and PEG care needs, but found the same risks remained. We had raised concerns regarding inadequate support for people's sexuality and skin integrity risks to people in November 2019, but also found risks remained in these areas of practice at this inspection.

●We received information from external health and social care professionals showing they had highlighted

to the provider's clinical lead about the risk of aspiration for all people using their services, including Orchard Lodge, with reflux and physiotherapy support needs over recent months. However, this had not led to adequate risk measures being taken to keep people safe.

●The themes of risks and concerns found at this inspection relating to behaviours that may challenge, epilepsy, choking and aspiration, behaviours that may challenge, constipation, skin integrity, postural support have been highlighted in inspection reports about many of the provider's other services. This information had not led the provider acting to prevent similar risks to people at Orchard Lodge being reduced.

The provider had not done all that is reasonably practical to assess and mitigate risks and provide safe care and treatment to service users and thoroughly review, investigate, monitor and act to make improvements in relation to incidents that affect the health safety and welfare of service users. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●During the inspection we brought issues regarding people's sexuality risks to the immediate action of the provider and asked they act to address them without delay. Following this inspection, we received information that the provider had begun the process of addressing the risks.

●At our previous inspection in November 2019 we identified issues regarding systems to monitor people's healthcare needs, and the ability of staff to recognise and act to escalate concerns and support people to access healthcare support and services quickly.

●At this inspection we found that recently the service had changed their healthcare monitoring systems. There had been no recent instances where staff had failed to monitor or act to help people receive further medical support as quickly as possible if they needed it.

●At our previous inspection in November 2019 we had found that people with complex eating and drinking needs were at risk of dehydration and malnutrition. At this inspection we found people had been supported to identify recommended daily amounts of fluids and recent records showed they had received this consistently. People had been supported to have enough to eat. Their weight and food had been monitored and action taken to refer to dieticians for nutritional advice if there were any concerns.

Staffing and recruitment

● There were insufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs. This had a significant impact on people's safety and their care and treatment.

● One person could require PRN chest therapy during their regular weekly physiotherapy session, or more frequently if they were unwell, to help clear secretions that could cause them to aspirate. There had been an extended period of several months where physiotherapy staff had not been available to support people at the service.

●A staff member told us that carers would sometimes give chest physiotherapy for the person, but there was no record staff had been trained to do this properly or safely. The risk of there being no trained staff available to give chest physiotherapy for this period had not been assessed, and no other actions had been identified to make sure the person was kept safe. This left the person at significant risk of harm.

● Risks to people with postural support needs were not always assessed, monitored or managed safely. People living at the service required regular weekly physiotherapy and hydrotherapy support from staff at the service to help improve or maintain their posture and other health needs. There had been a period of several months where not enough physiotherapy staff had been available to support people at the service to access as many sessions as they needed, and the hydrotherapy pool had been closed. This placed people at risk of deterioration to their health, mobility and well-being.

● The risk of there being no trained physiotherapy staff available to provide people's required support had not been assessed on an individual basis. Both the clinical lead and the manager told us they were very worried about the impact this could be having on people due to the high risk of potential harm.

●We were told the clinical lead and manager had acted to inform senior management of their concerns. This had not resulted in any action to reduce the risk to people until two weeks before our inspection when some more physiotherapy staff had been hired. However, the clinical lead told us this had not resolved the issues. They said, "There are issues with the physio staff, and we hired some locums to work with the staff, the Locum was meant to be here today and Wednesday, but they will not come always when they are meant to. Sessions are still not happening regularly."

The failure deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●There was on-going work between the local NHS Trust and the Provider to re-assess people's postural and respiratory physiotherapy needs at all the provider's services, including Orchard Lodge. The joint working aimed to also look for solutions to provide enough staff to deliver what was needed for people, in both the short-and-long term future.

Systems and processes to safeguard people from the risk of abuse

At our previous inspection we had found the provider failed to ensure systems and processes protected people from abuse and improper treatment.

This was a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

● Systems in place for staff and management to report, review and investigate safety and safeguarding incidents were not always effective. People had been harmed and placed at risk of harm from abuse due to staff failing to provide their constipation, aspiration, skin integrity and behaviours that may challenge support safely.

●The provider had failed to monitor and improve the implementation of safeguarding practices by staff. People's dignity and respect in relation to their sexuality needs had been compromised. There had not been effective action to support people to understand about how to keep safe when expressing their sexuality needs and reduce their exposure to risk of abuse.

The provider failed to ensure systems and processes protected people from abuse and improper treatment. This is a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●After our inspection, the manager told us about new face to face safeguarding training that was being arranged for staff, to help improve their ability to recognise and act to help prevent people from abuse or possible abuse situations. The manager also told us how the current monthly manager meetings contained time to review safeguarding themes across the service and this was being reviewed by a new director of quality to help improve their effectiveness.

●We received a mixed response from relatives we spoke with when we asked them if they thought their family member was safe from abuse. One relative told us they were in regular contact with their family member and prior to Covid-19 lockdown restrictions had visited once a week. They said had never had any concerns about abuse at the service. Another relative was not confident systems and processes at the service kept their relative safe from abuse. They told us this was specifically regarding empowering and supporting people, staff and relatives to feel empowered to raise concerns.

Using medicines safely

● People's medicines were not always managed safely or effectively.

● Some people had not always received the correct amounts of their anti-epileptic seizure medicines, increasing the risk of seizures. One person had missed one of their prescribed doses when staff did not give this to them.

●Guidance was in place for medicines prescribed on an 'as required' (PRN) basis. However, these were not always accurate and did not give staff clear directions. This increased the risk people may not receive their medicines safely, or as intended. One person had not received support to be given laxatives when they had become constipated and needed them. This placed them at risk of harm.

● Staff carried out monthly and weekly medicines audits. Action plans to improve compliance were mostly completed before the next audit cycle. However, audits identified that people's pain assessments were not always completed, but no action had been taken to address this. This increased the risk people may not receive medicines for pain relief when they needed them.

●Body maps were used to show staff where on the body people's creams and patches should be applied. However, it was not clear from the records that patch application sites were rotated. This increased the risk that medicines may not be effective as possible.

●Nurses recorded when medicines were given, there had been several occasions including recently where medicines administration records had not been signed to show medicines administered. The clinical lead had acted to re-assess nurse competencies in medicine administration.

The provider failed to ensure medicines were managed safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

. 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 assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

●We identified some areas of improvement as arrangements to make sure the premises were kept clean and hygienic on a day to day basis were not always effective.

●There were offensive odours caused by urine in one person's room and significant unidentified staining on walls in other people's bedrooms.

●When brought to their attention during our visit to the service, the manager acted to arrange for additional carpet cleaning. Shortly after our inspection visit the manager told us they had replaced the carpet and requested re-decoration of people's rooms.

Inadequate

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 Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

● At the last inspection, we had found that the provider was in breach of seven Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of CQC (Registration) Regulations 2009, was rated Inadequate and remained in Special measures.

●At this inspection we found that people remained at risk of receiving unsafe, poor quality or inadequate support. We found repeat breaches of regulations 12, 13,17 and 18 in relation to safe care and treatment, safeguarding service users from abuse, good governance and staffing. We found the breach of CQC Registration Regulations 18 had also continued.

●The risks and concerns found at this focused inspection have been highlighted in inspection reports about many of the provider's other services. This information had not led to similar risks to people at Orchard Lodge being reduced.

●The imposition of provider level and service level conditions had not been effective in driving improvement or preventing repeat themes of concern re-occurring in relation to people's safety or the quality of care at Orchard Lodge.

●The provider had failed to act upon known areas of concern, non-compliance and risk to improve the quality of care for people at Orchard Lodge. Following the November 2019 inspection, we wrote to the provider detailing our serious concerns regarding our findings at the November 2019 inspection and our subsequent review of statutory notifications and monthly condition reports submitted by the provider since then. to the Commission by the provider to date of our letter.

●These concerns were specific to inconsistent use, documentation and escalation of people's healthcare needs, management of people's health care concerns and that risks associated with service users' epilepsy, behaviours that may challenge, aspiration, PEG care and skin integrity needs were not assessed, monitored and managed safely.

●We also had identified significant concerns at and since the November 2019 inspection that systems in place for staff and management to report, review and investigate safety and safeguarding incidents were not always effective. Quality assurance and governance systems were not operating effectively, meaning risks to service users' safety were not always proactively identified or assessed, monitored and managed safely. Records related to the management of the service were not adequately maintained, and service performance had not always been evaluated and improved upon.

●We had received written assurances and a copy of the service improvement plan from the provider in June 2020 indicating how the provider had acted or planned to act to address the breaches. However, our findings from this inspection identified these concerns and breaches of compliance remained.

●Systems and processes to assess, monitor and improve the quality and safety of the service were not operating effectively. Since the last inspection, there had been audits of all areas of practice at the service carried out by the manager and clinical lead. There had been consistent additional support and oversight from the organisations 'Quality Team' and nominated individual and senior management team.

●There was a centrally accessible service improvement plan (SIP) that actions from various audits were added to, along with a timeframe for when they should be addressed and to show they had been completed. We reviewed the SIP and saw actions relating to constipation, behaviours that may challenge, skin integrity, epilepsy, PRN protocols, respiration and updating care plans were marked as complete. However, we found during this inspection many of these actions were unresolved and issues in these areas remained unmet. Where actions had been completed for these areas of practice, we also found these had not been effective in preventing unsafe practice.

●During this inspection, we found the provider had not assessed, monitored and reduced risks relating to the health and safety of service users. Failure to manage constipation risks had resulted in people not receiving PRN medicines. Adequate support had not been provided and risks to people who presented behaviours that may challenge remained. This had resulted in incidents of people causing themselves, other service users, and staff harm, and had exposed people to on-going risk of this re-occurring.

●Lack of trained physiotherapy staff had meant people had been placed at risk due to not receiving their assessed respiration and postural care and support. People had been exposed to risk when being supported with their sexuality needs. Failure to manage on-going risks relating to epilepsy, skin integrity, aspiration, PEG care and behaviours that may challenge also created risks for people.

● The provider had not ensured that an accurate and contemporaneous record in respect of each service user was in place. Care plans had recently been re-written and transferred to a new electronic system. We found people's care plans, risk assessments and monitoring forms regarding sexuality, aspiration and PEG care, epilepsy, behaviours that may challenge and constipation risks were not always accurate, complete or up to date.

●The provider had not ensured that staff at all levels understood their responsibilities and managed staff accountability effectively. Staff had not always met people's support needs or reported and acted in response to quality and safety issues. Staff continued to not always have the right, skills, knowledge or experience to manage risks and deliver safe care for people. The service continued to employ only agency nurses. The clinical lead told us they continued to have issues with the standard of the agency nurses work, and fulfilment of their responsibilities.

Working in partnership with others

●We found specific examples during this inspection regarding the provider failing to work effectively with partnership agencies to ensure people's physiotherapy, respiration and hydrotherapy needs were met and associated risks managed safely. This has been reported in more detail in the Safe section of our report.

● The local authority and local NHS partnership trust provided feedback there had been a recent improvement in the provider's approach to partnership working across the organisation, although information sharing remained a concern.

●Regarding Orchard Lodge, healthcare professionals told us the service had been more proactive since the last inspection about approaching their services for support where necessary. However, they told us more work was needed to make sure recommendations they had made were followed up to ensure people received the care they needed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people, Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The service had not had a permanent registered manager in post since May 2018. The service had recruited a permanent manager in February 2020, whose CQC application was in the process of being processed. The manager told us they had a clear vision of how they wanted the service to deliver care. They said, "We want to promote independence where possible and for staff to be warm, kind, caring and compassionate. We want people to live their life their way."

●We discussed with the manager how we had found that during this inspection, staff had not always displayed values consistent with the provider's vision of service delivery, including engaging and involving people considering their equality characteristics to ensure they achieved good support outcomes. For example, when assessing people's sexuality needs and how to ensure they were supported safely to meet these needs as they wished.

●The manager acknowledged there was a need to improve the culture of the service. The manager told us the biggest challenge they faced was getting staff to take on board and embed recommendations to change their ways of working, so they would be able to deliver more personalised and inclusive care.

●The provider had recently invested in an independent learning disability specialist organisation to review their service delivery across their services. This review had highlighted significant and multiple shortfalls in the provider's model and approach. The review concluded significant changes were needed to be able to deliver safe, person-centred, open, inclusive and empowering support which achieved good outcomes for people that fully considered their equality characteristics.

●The provider had acknowledged the validity of the reviews' conclusion and the corresponding levels of concern this presented. The senior management team was currently undergoing an internal review of the report findings to agree the best way to adopt the recommendations in the review. The provider had also recently made several changes to their senior management structure and recruited a new head of quality to try and make improvements in safety and quality across their organisation.

●Some staff told us the change in management had been positive and had improved morale as previously

there had been a consistent turnover of managers which had created uncertainty. Relatives also told us they thought the manager had brought new enthusiasm and seemed committed to trying to improve the service. One relative said, "The constant change in managers has been disruptive - can only think they weren't supported by their managers. I have spoken with staff and they think the new manager is supportive".

The provider had failed to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, service performance was evaluated and improved.

The service was not always open and transparent with service users and other relevant persons and had not always worked effectively in partnership with other agencies.

The service had not ensured there was a positive and open culture that achieved good outcomes for people. People's equality characteristics had not always been considered when engaging or involving people using the service, the public or staff.

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

●Since the last inspection, there had been an increase in the provider sending statutory notifications when required. However, there remained instances where the provider had not always informed relevant partnership agencies such as the local authority safeguarding team, local NHS trust partnership or CQC about notable safety incidents, risks or events that stop the service, as per their statutory and contractual responsibilities. For example, people not being provided with their assessed physiotherapy or hydrotherapy needs due to staffing issues, people not being elevated to the correct angle when receiving their PEG feeds, and people not receiving their constipation medicines when required.

●A relative we spoke with raised on-going concerns the manager and provider was not giving serious consideration to their feedback when they were concerned something may have gone wrong or was unsafe with their relative's care. They told us they were concerned despite several changes in management at local and wider organisational level since the last inspection, there continued to be a closed culture of failing to be open and honest, including when things had gone wrong.

●The failure to ensure that all statutory notifications of incidents related to services of a regulated activity being provided at the location were submitted as required is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents Failure to ensure that all statutory notifications of incidents related to services of a regulated activity being provided at the location were submitted as required

The enforcement action we took:

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location. Orchard Lodge is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not done all that is reasonably practical to assess and mitigate risks and provide safe care and treatment to service users and thoroughly review, investigate, monitor and act to make improvements in relation to incidents that affect the health safety and welfare of service users.

The enforcement action we took:

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location. Orchard Lodge is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure systems and processes protected people from abuse and improper treatment.

The enforcement action we took:

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location. Orchard Lodge is now de-registered and the provider is no longer able to provide

regulated activities at or from this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, service performance was evaluated and improved. The service was not always open and transparent with service users and other relevant persons.

The enforcement action we took:

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location. Orchard Lodge is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Failure deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff

The enforcement action we took:

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location. Orchard Lodge is now de-registered and the provider is no longer able to provide regulated activities at or from this location.