SHC Clemsfold Group Limited

Orchard Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This service has been subject to a period of increased monitoring and support by commissioners. The service has been the subject of multiple safeguarding investigations by the local authority and partner agencies. As a result of concerns raised, the provider is currently subject to a police investigation. No conclusions have yet been drawn from this.

In July and November 2017 we identified the care provided as 'Inadequate' or 'Requires Improvement'. In January 2018 we found the provider had not made required improvements and therefore their rating did not improve. In April 2018 the service was again rated as requiring improvement overall, with the 'Well-led' domain being rated Inadequate.

At this inspection, some improvements were seen and acknowledged; but these were not sufficient or wide-spread enough to improve the final rating. The overall rating has reduced to 'Inadequate' despite some of people's experiences and documentation being better in some areas. This is because there was evidence at this inspection that risks to people's safety remained; and that similar themes had been raised at our last inspection of Orchard Lodge and at several others of the provider's services. This showed that information about risk was not being appropriately used or shared between services for the purpose of driving improvement. The failure by the provider to fully address these known and significant risks has led to the rating of the Safe section being reduced to 'Inadequate' as a result.
The service will remain in special measures. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This was the fifth inspection since July 2017 where the provider remained in breach of Health and Social Care Regulations.

We imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at a number of services operated by the provider. The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and monitor the provider's services and actions to improve, and to inform our inspections.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This

will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Orchard Lodge has not had a registered manager since April 2017. Since that time there had been four separate managers who had submitted, but later withdrew their applications to become registered with the CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Orchard Lodge is a residential care home that also provides nursing care. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Orchard Lodge provides accommodation in two units called Boldings and Orchard East, which are all on one site. Orchard Lodge provides nursing and personal care for up to 33 people who may have a learning disability, physical disabilities and complex health needs. Most people had complex mobility and communication needs. At the time of our inspection there were19 people living at Orchard Lodge.

Orchard Lodge has not been operated and developed in line with the values that underpin the Registering the Right Support and other best practice guidance. Orchard Lodge was designed, built and registered before this guidance was published. However, the provider has not developed or adapted Orchard Lodge in response to changes in best practice guidance. Had the provider applied to register Orchard Lodge today, the application would be unlikely to be granted. The model and scale of care provided is not in keeping with the cultural and professional changes to how services for people with a learning disability and/or Autism should be operated to meet their needs.

We continued to find that known risks to people had not been appropriately minimised. This included risks related to percutaneous endoscopic gastrostomy (PEG) feeding, constipation, skin care and aspiration. Lessons had not been learned effectively in these areas, which had all been raised at previous inspections.

Incidents when people had experienced harm or risk of harm had not consistently been referred to the local safeguarding authority, so they could decide whether an independent investigation should happen.

People's health care needs were not always managed effectively. Some care records were confusing or out of date, creating a risk people would not receive the right care or treatment.

Staff were not always mindful of treating people with dignity and respect and people's communication needs and right to accessible information had not been fully considered. The response to complaints was not always effective because action was not taken promptly to address them.

Activities had improved overall but further work was needed to involve all people as fully as possible.

There had been insufficient oversight by the provider to identify the concerns found at this inspection. This resulted in continued breaches of Regulation and the safety and quality of the service being compromised.

Medicines were managed safely and the service was clean and fresh. Any environmental and fire risks were routinely monitored and assessed.

There were sufficient, trained staff deployed to meet people's needs and there was a robust recruitment system in operation.

MCA assessments had been carried out and most best interest decisions had been documented. DoLS authorisations were monitored and reapplication dates recorded.

People were supported to receive adequate nutrition and hydration. People's likes and dislikes were thoughtfully documented and staff knew people well. Religious and spiritual needs were met. People and relatives were given opportunities to be involved in their care at resident and care plan review meetings.

Staff said they felt supported by senior managers and worked well together. Relatives gave positive feedback about staff and the care they delivered.

Statutory notifications were made to CQC appropriately and the provider had displayed their CQC rating in the service and on their website.

At this inspection we found the service was in breach of six of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 consistently safe.

Risks related to PEG feeding, constipation, skin care and aspiration had not been minimised appropriately. Lessons had not been learned effectively in these areas.

Not all safeguarding concerns had been referred to the local safeguarding authority for review.

Medicines and infection control were managed safely.

There were sufficient staff deployed to meet people's needs.

Recruiting systems were thorough and robust.

Environmental risks were regularly assessed and addressed.

Is the service effective?

Requires Improvement

The service was not always effective.

People's health care needs were not always managed effectively.

MCA assessments had been carried out appropriately and best interest decisions recorded for all but one person reviewed.

Staff had attended training specific to the needs of the people they were supporting.

People were supported to eat and drink and PEG feeding regimes were in place and followed by staff.

The premises were suitably adapted to meet people's needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were not always mindful of treating people with dignity and respect.

People's independence was promoted when staff supported them with personal care and meals, but more could be done to encourage independence with activities.

People and relatives were given opportunities to be involved in their care at resident and care plan review meetings.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some care records were confusing or out of date, creating a risk people would not receive the right care.

People's communication needs and right to accessible information had not been fully considered.

The response to complaints was not always effective.

Activities had improved overall but further work was needed to involve and interact with all people.

People's likes and dislikes were thoughtfully documented and staff knew people well. Religious and spiritual needs were met.

Is the service well-led?

Inadequate

The service was not Well-led.

There had been insufficient oversight by the provider to identify the concerns found at this inspection.

Continued breaches of three Regulations were evidenced and two new breaches were found.

There had been no registered manager in post since April 2017.

Staff said they felt supported by senior managers and worked well together.

Statutory notifications were made to CQC appropriately.

The provider displayed their CQC rating prominently.

Orchard Lodge

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 checked 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 12 and 13 November 2018. The first day was unannounced and the inspection team consisted of two inspectors, a specialist advisor 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. Their area of expertise included learning disabilities and people with complex health needs. The second day of inspection consisted of three inspectors and the same specialist advisor. The specialist advisor had specialist clinical experience in supporting people with a learning disability, autism and/or complex heath needs.

Prior to the inspection, we reviewed the information we held about the service. This included information from other agencies and statutory notifications sent to us by the manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. No PIR had been requested before this inspection.

Due to the nature of people's complex needs, we were not always able to ask people direct questions about the care they received. Most of the people who lived at the service could not tell us about their experiences of it. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent time observing the care and support that people received during the morning, at lunchtime and during the afternoon over both days. We spoke with two visiting relatives during the inspection and contacted three others afterwards. We spoke with two senior managers, the interim manager, two registered nurses and four care staff.

During the inspection, we also observed medicines being administered to people. We reviewed a range of records about people's care which included eight care plans. We also looked at three care staff records

which included information about their training, support and recruitment. We read audits, minutes of meetings with people and staff, policies and procedures, accident and incident reports, Medication Administration Records (MAR) and other documents relating to the management of the home.

Inadequate

Is the service safe?

Our findings

At our last inspection, the provider had made improvements to the overall safety of care. However, not everything practicable had been done to reduce known risks in some areas. This resulted in a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we again found the management of specific risks needed greater input to ensure all people were kept safe.

People living at Orchard Lodge had complex health conditions, physical disabilities and communication needs. They were fully reliant on staff to support them with all aspects of their care. At our last inspection, information about a person's specialised diet had not been transferred to their care plan about nutrition, exposing them to risk of receiving inappropriate care. At this inspection we again found that documents staff would use to guide them in delivering care and treatment, had not been appropriately updated to make sure people received safe support. In failing to ensure instructions about people's care were up to date, the provider had not done everything reasonably practicable to minimise the risks to people.

Some people who required nil by mouth for safety reasons, had signs saying this on their wheelchairs, to alert staff that they should not have food or drinks orally, but by percutaneous endoscopic gastrostomy (PEG) only. It was not considerate of people's dignity to have signs about their health needs displayed for all to see, and more discreet methods could have been considered. However, staff said that the signs helped to ensure staff and visitors knew how important this instruction was to people's safety; as they could choke or inhale food or drink into their lungs if given them by mouth.

Despite these known dangers, one person who had been assessed as requiring 'Nil by mouth' in the weeks before our inspection, had no warning sign to that effect on the back of their wheelchair. This person was at high risk of inhaling food or fluid into their lungs if they had it by mouth. However, they had a communication passport attached to their wheelchair which contained instructions for staff to give pureed food and fluids by mouth. Although managers told us that this person's care file had been thoroughly reviewed to make sure all records showed that they could no longer eat or drink orally, two care plans referred to them having drinks of tea. Additionally, not all the entries on this person's medicines administration record (MAR) included the instruction that medicines should be given by PEG. This lack of accurate and consistent information about the person's needs placed them at risk of receiving unsafe care and treatment. Although staff on duty knew that this person should receive nil by mouth, the service regularly used agency staff who may not be as familiar with people's needs. It was therefore important to ensure that records were correct and up to date and we made the management team immediately aware of our concerns.

At our last inspection, most records about the frequency of bowel movements had been completed accurately, but we identified that further work was needed to make sure staff always recognised when to treat people with laxatives. At this inspection, care plans about bowel management continued to lack sufficient, personalised information to help staff know when people may be constipated. For example; the care plan about constipation had not been updated for a person who had been previously admitted to

hospital with a related condition. This continued to say that a GP should be contacted if the person had no bowel movements for three days. However, bowel charts completed before their admission to hospital recorded small or very small bowel movements on every day except one, for ten consecutive days. This showed that it was possible for the person to be severely constipated even though they had passed small amounts of faeces daily. They were at risk of becoming very constipated again because their care plan did not reflect this and alert staff to the potential for constipation to occur alongside small bowel movements. There were no records in any care plans or risk assessments reviewed about bowel management to define what 'small' or 'very small' bowel movements meant or to document the usual size and consistency of stools passed for individual people. An agency nurse was unable to say how this person would appear or behave if they were constipated.

Another person's care plan about bowel management recorded that increased laxative treatment should be given after four days without a bowel movement. However, this person often went home for one or two days and bowel charts had 'Home' noted on them at these times. While the care plan said that the person's family would make staff aware if the person opened their bowels when at home, there was no record of this on the charts. This gap in information meant that it was not always possible for staff to know how long the person had been without a bowel movement. There was one period of four days where there was no bowel movement documented but no record of increased laxative treatment being given as a result. This person's care plan said that constipation could trigger seizures; so, the monitoring and accurate documenting of bowel movements was especially important in keeping them safe and well.

The same person's care plan also noted that they should be encouraged to drink a minimum of 2,325 mls of fluid a day 'To assist with their bowel movements'. Fluid charts showed that they drunk less than this on at least five days in the previous two weeks; on one day having 960 mls. Staff instructions in the care plan were to contact the GP and request support if this person had reduced fluid intake for more than 24 hours. Staff said that the person had been recently seen by the GP specifically because they were drinking less than recommended for them. However, notes made by both the GP and nursing staff showed that the GP had been called for a different reason. There was nothing in either set of notes to indicate that the GP had been made aware of the decreased fluid intake; which may have been significant.

At our last inspection, records about one person's care in relation to preventing pressure damage to their skin were not consistent. At this inspection, we continued to find information about the same person's skin care needs showed it had not always been delivered in line with care plans. The person's care plan about their skin stated they should be supported to reposition every four hours in bed because they were at high risk of developing a pressure sore. The frequency of repositioning had not been transferred from the care plans onto these charts so that staff could easily see how often this should be happening. There were gaps on the charts where no timing of entries had been made, which made it impossible to know how long there had been between repositioning. On other occasions there was between five and six hours rather than four hours between repositioning and on one night there was no record at all. Although staff and managers assured us that the person had no current pressure wounds or skin problems, the lack of repositioning in line with care plan directions increased the risk of them developing them.

Care plans for a person who received their nutrition by PEG highlighted the risk of them inhaling food and drink into their lungs; which can lead to aspiration pneumonia. Another person had a history of chest infections. In both cases there was no guidance for staff about signs that people may have inhaled matter or were developing a chest infection. Physiotherapist staff employed by the provider, told us that a person needed to have their bed tilted to help prevent aspiration or chest infections happening, but this instruction was not included in their care plans about sleeping, positioning or chest infections. Repositioning charts had been completed by staff to show this person had been routinely sat up at 45 degrees as part of a regular

turning regime, which was not in line with physio directions. The physio staff told us they would ensure the care plans and repositioning charts were updated and that staff were made aware.
We had previously raised concerns about people's safety in relation to PEG, bowel, skin care and aspiration management at inspections of Orchard Lodge and some others of the provider's services. Despite this, we continued to find that these areas had not been fully or wholly improved at this inspection; exposing some people to the risk of receiving unsafe care and/or treatment. This showed that lessons had not been learned and information from inspections had not always been used effectively to ensure people received consistently safe support.

The failure to do all that is reasonably practicable to mitigate risks consistently, and to all service users, is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other care plans and risk assessments had been improved and included clear, detailed guidance for staff to follow; which helped to make sure people received appropriate care and treatment in those areas. Some, such as those about how to support people to move safely, had been written with input from physio staff. These were easy to follow and included photos to illustrate the actions staff should take. Risk assessments held information about all the equipment necessary to safely support people. Staff were observed following the guidance in practice and were knowledgeable about people's individual needs around moving and transferring.
Care plans now included details about people's individual baseline heart rates, blood pressure and other clinical measurements. This enabled staff to see at a glance if people's vital signs varied from what was normal for them. At our last inspection, weights records were difficult to follow but at this inspection they had improved, and the people we reviewed had no weight loss issues.

Systems and processes designed to protect people from abuse had not always been operated effectively. Accident and incident records had been completed and were audited by the management team. However, a minor physical incident between people using the service had not been referred to the local safeguarding authority as a manager told us it should. They said that this had probably happened during a period of change between managers, and made the safeguarding referral in retrospect during the inspection.

Untoward events forms were completed by managers to record incidents and document outcomes and actions. One of these referred to the deterioration in a person's health in August 2018. Although an internal investigation had been carried out and disciplinary action was taken as a result; the local safeguarding authority had not been contacted about the initial incident. Managers confirmed that this had not happened because an early decision had been made that this was an internal matter and that the person had not been placed at risk. A manager's report made at the time however, documented that there had been a risk to the person. As the matter was not discussed with the local safeguarding authority, they had not been given the opportunity to consider the circumstances and determine whether their involvement or independent overview was necessary to protect the person.

The failure to operate effective systems to protect people is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All staff we spoke with were able to correctly describe how to report any potential safeguarding concerns through the provider's internal processes. One staff however, did not know they could raise concerns outside the service to the local safeguarding authority or CQC if necessary. This staff member had recently completed safeguarding training.

Most people using the service were unable to verbally express how they felt about the safety of the service. However, people appeared relaxed and settled around staff. We spoke to relatives during and after the inspection to gain their views. All four relatives felt the service provided safe care to their loved one. One relative said, "I have no concerns at all. [Person's name] has exceptionally well-met needs. Another relative thought there had been improvements and told us, "I do feel [Person's name] is safe, there have been problems lately, they seem to be being addressed now". A further relative commented; I haven't ever felt badly or concerned about the way they treat [Person]".

Medicines were safely managed, were clearly labelled and dates of initial opening had been recorded. This is important to make sure medicines are used within safe timescales. People who required medicines through a PEG had individual containers for tubing, syringes and water. Each person's medicine administration record (MAR) had their details clearly printed on them including a photograph to help ensure the right person received the right medicine. The medication room was cool and the temperature of medicine storage facilities was recorded daily. This room was clean, tidy and well-organised.

The MAR showed no errors or missed medication in the month leading to our inspection. Any known allergies to medicines were clearly highlighted. Some people had medicines or creams prescribed on an 'As needed' basis. There were instructions in place for staff about why people might need the medicine, how much of it they could safely take and the length of time between doses. Information was in place about where topical creams and lotions should be applied.

We observed nursing staff giving people their medicines. People were spoken with before medication was offered to check they knew what was about to happen. The nurse waited and observed that medicines had been swallowed. Medicines about which there are specific legal requirements had been regularly audited and two staff signed to show the medicines and records had been checked before they were given to people.

Some medicines that were due for return to the pharmacy were stored in an open container rather than a sealed one inside the medicines room. These should be kept securely because they continue to be effective, even after they have reached their expiry date in some cases. The management team explained that this method of storage had been an interim arrangement while the service changed to a new pharmacy. During the inspection, these medicines were locked away until a sealed disposal unit could be sourced.

There were enough staff deployed throughout the inspection to meet people's needs. Staff rotas confirmed that sufficient staff were rostered on each shift and our observations showed that people received prompt support. During the inspection, some people were supported by two care staff to walk in the grounds or to ride adapted bicycles there. This still left enough staff within the service to attend other service users. At lunchtimes, many people received one to one support with their meals and this was carried out in an unhurried, relaxed way by staff who had the time to devote to assisting people. One relative told us, "Staff are with [Person's name] 24/7. I'm 100% confident in the care they receive and couldn't think of a better place for them to be". Another relative told us they had previously been concerned about staffing levels but thought they were now better. They said, "At the moment they seem to be doing something about staffing levels". Another relative echoed the former concerns but added, "There are enough staff now".

The provider used a dependency tool to work out how many staff were needed and managers told us that the service was staffed over and above this level to ensure there were enough staff to provide consistently attentive care. There was a nurse on each of the Orchard Lodge and Boldings sites all day and overnight, with five care staff in Orchard Lodge and three in the Boldings during the day and three to four care staff overnight across the sites. In addition to care staff, activities coordinators and physios worked with people

throughout the day; with some people going to a day care centre several times a week and others regularly spending time at home with their families.

Recruitment of staff had been carried out safely to check as far as possible, that applicants were suitable to work with people living in the service. There were robust processes in place to ensure pre-employment information was received and satisfactory before staff started work for the provider. This included, references from previous employers, identity information and a background check by the Disclosure and Barring Service (DBS). Nursing staff had provided PIN numbers which were verified by the provider. PIN numbers validate that a nurse is properly registered with the Nursing and Midwifery Council (NMC).

Environmental risks had been appropriately managed overall. However, the carpet in one person's bedroom was extremely worn and damaged; creating a trip hazard to staff and visitors. The management team gave assurances that replacement carpet had been ordered and would be replaced as soon as possible. Aside from this, the service was clean, fresh, well-decorated and spacious. Gloves, aprons and anti-bacterial hand gel were available for staff use, along with shoe protectors to wear when entering spa and pool areas. These measures helped to prevent the risk of the spread of infection.

Fire safety checks to doors, emergency lighting and extinguishers had been routinely completed and fire alarms were regularly tested. External professional contractors carried out servicing and safety checks to electrical and gas supplies and equipment. Water from hydrotherapy and spa pools was routinely analysed to ensure it remained safe for people to use and all water systems in the service had been subject to testing for Legionella bacteria. Hoists, special baths and wheelchairs were serviced and maintained so that people were supported with appropriate and safe equipment.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, people did not always receive person-centred care which met their individually assessed needs; which was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, people did not always receive effective care and treatment in response to their known health care needs. Care plans for five of the people we reviewed documented that they should have weekly hydrotherapy sessions. The reason for this therapy was described as, 'to provide free active movements, walking, exercises and relaxation in the water'. People's mobility was impaired and some had physical conditions which caused painful joints so activity in water could be beneficial in enabling limbs to be supported while exercise programmes were carried out. One person's care plan documented that they enjoyed spending time in the hydro pool and a relative told us staff had phoned them in the past to tell them how much their loved one liked the pool sessions.

However, on the first day of our inspection neither the large hydrotherapy pool on site nor the two smaller spa pools were working. Managers said there were maintenance or bacterial problems with all these facilities. We spoke with maintenance and physio staff about the closures and were then informed that any issues with two of the pools had been resolved almost two weeks before the inspection and they could therefore have been in use since that time. The third spa pool needed a large replacement part, which would take longer to fix.

Records about hydrotherapy showed that people had not received any since June 2018, despite their care plans stating they should. Physio staff confirmed that people had not had hydrotherapy "For some months" but said the provider had a hydro pool at another of its services which could have been used by people from Orchard Lodge and Boldings. Our further checks showed that this facility had not been utilised and people had missed their sessions in the water. A relative told us, "In the past, I pushed and pushed for [Person] to have physio. But now they are saying, 'Oh no the pool, the water is not good, they can't use it.' He went in a couple of times and enjoyed it and now not anymore".

Physio staff said that people had been provided with extra physiotherapy "to make up for the missed hydrotherapy" but this had not happened consistently, and in any event, did not have the same therapeutic effect as exercising in water. One person's physio records showed they had not received any physiotherapy for two weeks while physio staff were on leave. The person had a history of painful joints and the lack of physio and hydro input may have been detrimental to their comfort and well-being. Two of the pools were re-opened during the inspection and hydrotherapy rescheduled to start in the same week.

Other health care needs had not been followed up until highlighted by inspectors. Two people needed bespoke limb supports but appointments for these to be assessed, made and fitted had not been made even though one person's existing supports broke in July 2018, and a hospital recommendation was made in August 2018 for the other person. Care plans and risk assessments had not been updated to include advice provided by a GP in August 2018 about the management of a person's constipation and staff were

not aware of the latest directions. People had been placed at risk of deterioration in their health or conditions because their needs had not been fully met.

The failure to consistently meet people's assessed needs is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people required staff to provide them with suctioning of excess saliva and fluids from their mouth. There were detailed care plans in place to give staff clear guidance about how to do this, which referred to best practice guidelines. However, there was no information about how suctioning should be managed when people went outside the service on outings and activities. This is an area for improvement.

Care plans about PEG management gave step by step descriptions for staff, but some lacked detail about how to clean the PEG site effectively. Staff said that PEG sites were cleaned daily but there were no separate records to evidence this or show how it had been carried out. This is a further area for improvement. People had individual care plans about their teeth and mouth care. These listed the equipment needed to support each person and when we checked, people had the correct brushes, toothpaste and other items in place. Records were made daily to show that people had received oral care and we observed that people's teeth appeared clean.

Relatives said they were happy with the health care arrangements. One relative said, "The GP comes regularly and they are also on call, and if necessary in the evenings they use 111. Any concerns that I have are always sorted out with his care and personal care". Another relative commented "Carers do a wonderful job in recognising subtle changes and escalating them if necessary". A further relative told us," [Person's name] can't communicate in any way and the regular carers know what to look for if he is in discomfort. At the moment he is in discomfort and they got the doctor in straight away to help". People had hospital passports which contained important information about their care and communication needs. This was designed to help hospital staff understand how to provide safe care and treatment and to make sure the person's preferred methods of communication were known. Details about how people showed that they may be in pain or distress were included so that hospital staff could recognise these and take necessary action, such as providing pain relief or reassurance.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and DoLS and whether any conditions on authorisations to deprive a person of their liberty were being met. Most care files contained decision-specific MCA assessments and records of best interest discussions, to show that other professionals and relatives had been involved in deciding what was best for people. However, one person's file had MCA assessments but no information about best interest decisions taken on their behalf. This is an area requiring improvement.

Staff were observed asking people if it was ok to give them support with various tasks and giving choice about where to be in the service for example, or what to drink or do. One relative told us "[Person] is offered choices whenever that's possible". Staff described how they would provide people with choice. One said, "I

give them options, do you want to wear this today?" Another member of staff added, "With arts and crafts we put colours in front of people so they can be involved in choosing". DoLS authorisations had been received and a system was in place to reapply for these before they reached their expiry dates.

People were supported with eating and drinking. A choice of meals was offered and these were served at the correct consistency for individuals. Care plans documented how much support people needed and staff were observed following this guidance in practice by mashing a person's meal once they became tired or ensuring a non-slip mat or plate guard were in place, for example. Staff described what was on the plate and engaged in eye contact and conversation while supporting people with their meals. One person told us, "I like the food" and grinned to show they were enjoying it. All but one person we reviewed (please see 'Safe') received the recommended daily amount of fluids according to their charts, and drinks were offered throughout the day. People who received their nutrition and fluids by PEG had charts and records to detail intake and feeding regimes. Nursing staff were knowledgeable about how PEG feeding should be managed.

The environment was suitably adapted to meet the needs of people living there. A nursing station had been removed from one area since our last inspection, which opened up the space and created a less formal feel to people's home. Corridors and doorways were wide, enabling easy access for wheelchairs and equipment and ceiling tracks were in place in bedrooms to facilitate hoisting. Picture signs were in use in some areas to support people to identify their own bedrooms or communal places and toilets.

At our last inspection we raised concerns about the lack of staff training in some areas. At this inspection the situation had improved and almost all care staff, including agency staff, had received training about learning disabilities. Three newer staff had yet to complete the training but this had been scheduled. We spoke to newer staff; who were able to describe how they supported people with learning disabilities and were knowledgeable about people's needs.

Nursing staff, including agency were trained in PEG management, and epilepsy training had been carried out by all care staff; which equipped them to be able to meet people's health and support needs effectively. All care staff completed mandatory training sessions in areas such as fire safety, first aid, moving and handling, MCA and infection prevention and control.

Requires Improvement

Is the service caring?

Our findings

At our last inspection we highlighted that people were not always treated with dignity and respect in the way some staff spoke with them. This was a breach of Regulation 10 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection improvements were seen in explanations and descriptions given to people by care staff. These were observed to be clearer and delivered with kindness and reassurance.

However, the language used by one staff was child-like when speaking with adults who live with learning disabilities. The staff member repeatedly told a person he was "A good boy" and asked, "Where is your chin chin?" and "Was your lunch yummy?" Although the staff member was gentle with people and not being intentionally unkind, their approach was misguided and did not show the person the respect they deserved.

Another staff member was seen removing a person's headphones because they wanted them to engage in an activity. The person replaced the headphones and made it clear they wanted to listen to their music instead, but the staff was quite persistent in pushing them up to the activities table in their wheelchair. The person appeared frustrated that the staff member was not 'listening' to them. On another occasion staff pushed the same person towards inspectors who were trying to engage the person. However, their body language showed they did not want to see the inspector and they covered their face. Instead of taking their cue from this and moving the person away, the staff member continued to push them forward, so the inspector distanced themselves to avoid causing the person any distress.

Our observations showed that not all people received the same level and quality of interaction from staff. There were occasions during both days of our inspection when one or two people received most attention from staff while others were largely left without conversation or involvement at those times. One relative told us "Last time I went, there seemed to be awful lot of staff, but they were just sitting there writing their notes. There wasn't any interaction between [person's name] or anyone else. They just kept offering me tea". This was not considerate of people's dignity. There were enough staff to engage with everyone, and this was seen at mealtimes, when people all received individual attention. Minutes of a staff meeting in August 2018 recorded that this issue had been raised. The minutes read 'Activity room-please make sure you're always interacting with everyone even if you have your break in there you must interact with all in there'. This was still not consistently happening, despite the reminder at the staff meeting. Staff could have divided their time more equally between the people in communal areas to ensure they were not left without meaningful interaction for long.

This is a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were discreet when discussing people's care or treatment and ensured that personal care was delivered in private. People who received food or medicine by PEG tube were either taken to their bedrooms or the sensory room to allow for privacy and dignity; as locating the feeding tubes required people's stomach area to be exposed.

People were encouraged to be independent in some ways and by some staff, but more could be done to ensure everyone had the same experience. Staff told us about a person who was able to wash parts of their body themselves and how it was important to enable them to be involved in their own care. We also observed people being enabled to eat and drink independently, with staff stepping in to support as needed. However, during activity sessions only one staff was observed supporting a person to hold a paintbrush and become involved in the session. Other staff did the painting on people's behalf, while they watched and then staff held up the finished item to say, "Look what we did". As a result, one person told us, "I'm bored, there's nothing to do". More people could have been engaged by supporting them to do as much of the craft as possible themselves. This is an area for improvement.

People were able to attend meetings as a way of being involved in their care. These were held bi-monthly and provided an opportunity for people to express their views where possible, about activities, birthdays and outings for example. Key workers were assigned to each person and staff said they helped people to be included and involved in as many care decisions as they could.

Feedback we received from four relatives was generally positive about staff but some comments showed people were concerned about the management of the service. One relative said, "The overall picture here is a very caring, well-run home. [Person] is happier, calmer and more content than at any point in his life". Another relative told us, "I am 100% happy with the care on the shop floor and the carers but I really want to keep an eye on what comes through from head office. My complaints were always about management who refused absolutely to talk. I've never had a problem with the care [person]receives from the carers and nurses: it is exemplary, they have so much empathy for [person] and for me. I just can't fault the actual care".

On the first day of our inspection, a fish tank in the activities room at Orchard Lodge contained filthy, black water. We spoke to staff about this, who said that all the fish had been found dead in the tank the day before. They said that people had enjoyed watching the fish previously and staff meeting minutes also made reference to this. We spoke with care and maintenance staff about whose responsibility it was to maintain the tank and look after the fish. Neither was able to say who should have been doing so, the fish tank did not feature on any maintenance checklist and its upkeep had therefore been overlooked. The fish were clearly important to some people and more could have been done to make sure this facility was available to them.

Our observations showed that staff were compassionate and kind overall, spoke positively and praised people's efforts. Staff on duty during the inspection knew people well and treated them as individuals; understanding what to do to make a person laugh for example, or encouraging other people to talk about their Mum or their birthday; because they knew they were important to them. A person was warmly welcomed back after having spent some time with their parents, and relatives all said they felt welcome to visit the service at any time.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, people's needs were not consistently being met in relation to communication; which was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, there had been some improvement but there were still missed opportunities in this area. Care plans about people's communication were detailed, however we did not observe any staff using alternative or assisted communication techniques with anyone. People living at Orchard Lodge have complex needs and therefore it is important to find effective ways to support people to communicate. The interim manager told us that no assistive technology was in use in the service which may have enabled some people to express themselves with greater independence. Staff told us that two or three people use a type of sign language called Makaton. Although staff said they had been trained to use this, we did not see any examples of this happening during either day of the inspection. We did however hear about plans to make improvements in this area.

The CQC policy 'Registering the Right Support' states that providers must demonstrate they can provide appropriate, person-centred care if people are supported in larger services. Some aspects of people's care did not show that choice, inclusion and promoting independence had been properly considered or met.

Care plans and minutes of resident meetings had been typed up but were not in an accessible format for people. This was not in line with the requirements of the Accessible Information Standard (AIS) which places a duty on NHS and adult social care services to ensure that people with a disability or sensory loss are given information in a way they can understand. This had been raised at our last inspection but had not been addressed by this inspection.

At our last inspection, inconsistencies between care plan information were found. At this inspection, care planning had improved in some respects, such as more detailed information about how staff should support people with particular aspects of their care and treatment. However, we continued to find some care plans where information about people's needs was confusing or out of date. For example; individual care plans about epilepsy included detailed information about the type, frequency and duration of seizures. Action to take in an emergency was clearly set out along with information about any prescribed epilepsy medicines or rescue medicines for seizures. Although care plans about epilepsy specifically had improved, and staff knew what action to take in event of seizures, other related medical care plans had not always been updated to record most recent seizure activity. Another person's care file contained three different documents about their PEG feeding regime and a further person's documented that they wore items of support clothing which staff said were no longer in use. These confusing records created the risk that people may not receive care that met their assessed needs.

The failure to ensure that people's assessed needs are met is continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's likes and dislikes had been documented in a way which was person-centred and demonstrated

they had been written by staff who knew the person well. Bedrooms had all been individually decorated and had colourful nameplates to identify them. People had personal items around them in their rooms and photos of family and friends. All staff we spoke with were able to tell us about people's distinct personalities and support needs. A relative told us, "The regular staff absolutely know [person]. I have great peace of mind when they are working; they treat him and us with kindness all the time".

Spiritual and religious beliefs had been considered in care planning and people were supported to attend places of worship to meet those needs. At the time of the inspection, there was no one who was being supported at the end of their life. However, procedures were in place with the GP so that people would experience as comfortable, dignified and pain free death as possible.

Action had not always been taken in response to complaints. A relative had raised concerns on 23 October 2018 about the lack of hydrotherapy available to their loved one. Although an initial response was sent to the complainant the following day, hydro pools and spas within the service were not open and working when we inspected almost three weeks later. Our findings showed that two out of three hydro facilities had been fit for use since the beginning of November 2018, but managers had not ensured they were reopened in a timely way. The relative's letter should have prompted managers to check the situation with the hydro facilities but this had not happened until inspectors queried it.

A relative told us that an issue they had repeatedly raised about their loved one's property had not been resolved satisfactorily. They said, "I asked them to store [Property item] properly but nothing happens, I take a new one in and then wonder how long it will last". Another relative said that they had experienced difficulties in receiving a management response to concerns and commented, "I just kept coming up against a brick wall, no one was listening to me".

The failure to act on complaints is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, activities outside the service were limited and people were not always engaged in those on offer in the service. At this inspection improvements were seen in the activities planned and provided, but there was still work to do to engage all people who wished to be involved when activities were taking place. We observed activities such as baking and crafts taking place on both sites. Some people were fully supported to take part while others sat and watched without interaction from staff. A relative told us, "What I've seen of activities, I don't think much of. There was a man painting but [person's name] does need a bit more stimulation". This is an area identified for improvement.

During the inspection we heard about planned improvements to activities, and following the inspection the provider sent us further information about this. Plans include working collaboratively with an external company to provide a more individualised and meaningful activity programme for people. We will be checking progress against this plan at our next inspection.

Other relatives gave positive feedback about activities. One said "[Person's name] sits with everybody else, someone will do the card making with him. The activities are very good". There was evidence of more outings taking place including discos, bowling, fishing and a garden party earlier in the year. Photos were displayed showing people taking part and a relative had complimented the service on improved opportunities for their loved one to go out. During the inspection, Christmas shopping trips and a pantomime visit were being scheduled.

Some people's individual interests had been considered and equipment provided for them to engage in

activity of their choice. One person was excited about an activity they had recently taken up and were enjoying. Other people were supported by staff to either walk in the grounds or ride adapted bicycles there. This was clearly appreciated by people who were laughing and smiling throughout. Activity records showed that the sensory room at Orchard Lodge was used to provide people with stimulation, and external entertainers such as singers and guitar players visited regularly to provide variety.

Inadequate

Is the service well-led?

Our findings

At our last inspection, the provider had failed to make the necessary improvements to ensure they were not in breach of Regulations. At this inspection, although improvements had been made to some aspects of the service and people's experiences, the provider continued to be in breach of Regulations relating to safe care and treatment, person-centred care, dignity and respect and the governance of the service. In addition, we found new breaches of Regulation about safeguarding people and action taken in response to complaints. This is the fifth time that the provider has failed to meet Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, about providing people with safe care.

Similar themes and risks had been raised as concerns at our last inspection of Orchard Lodge and at several others of the provider's services. Even though our feedback and reports had highlighted repeated failings around, for example; constipation management, repositioning and choking/aspiration risks, the provider's own checking and audit processes were still not picking up on these and putting them right to ensure people's safety. This showed that information about risk was not being appropriately used or shared between services for the purpose of driving improvement. Risks are further increased where there is no registered manager in place to lead a service. The provider had not recognised their responsibility to make sure that services were appropriately and effectively led despite the lack of registered managers in some cases.

There had not been sufficient oversight by the provider to identify the failings before this inspection and to put them right; which had left people exposed to risk. Auditing took place both internally and by an external contractor, but these systems were not focussed in the right areas or were not detailed enough to give an accurate picture. For example; none of the audits we reviewed demonstrated that managers had scrutinised bowel charts to ensure staff were following care plan guidance in practice. This was despite concerns being raised in previous inspections about bowel management and the possible risks to people if this was not closely monitored. A Manager's daily walk around audit did include random checks of fluid and repositioning records but had last been carried out at the beginning of October 2018, due to the previous manager leaving the service. This had created an opportunity for emerging issues to be overlooked. Although medicines had been safely managed, weekly audits of them had also ceased in early October.

None of the auditing or provider and manager checks had highlighted that the spa pools in the service could have been re-opened and in use for some weeks. Neither had manager reviews of a person's care file picked up that information in it about taking oral fluids went against the current nil by mouth instruction. These checks had not gone far enough because documents and information in other places aside from the care file had not been updated to reflect this person's needs and to protect them from potential harm.

The provider's monthly audit had last been completed in September 2018 which meant that opportunities were missed to review the safety and quality of the service in October 2018 and take prompt action to remedy any failings. An external audit looked mainly at environmental matters and had highlighted in July 2018 that 'Worn and damaged flooring' needed to be replaced. However, this had not happened at the time of our inspection more than three months later. The care and maintenance of the fish tank and fish did not

feature in any audit or checklist and as a result had not been properly looked after. People's enjoyment of the facility and pets was spoiled because the fish all died in extremely dirty water.

The failure to assess, monitor and improve the quality and safety of the service and to mitigate risks to people is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

There had been no registered manager at Orchard Lodge since April 2017. The manager who was in post at the time of our last inspection had left by this inspection. There had been four managers in post since April 2017; who had submitted but later withdrawn their applications to register with the CQC. A new manager had been recruited and was expected to start work in the service in the coming weeks. An interim manager started work on the first day of our inspection. The departure of the last manager meant that some of the regular checks they would have carried out had not been completed for over a month. Some relatives expressed concern at the turnover of managers. One said "We've had a series of managers who haven't stayed. Hopefully this new one will be someone who will". Another remarked, "My concern is the rapid turnover of the manager. They come in very enthusiastic and then they disappear, it must be disturbing for the carers".
There had been no staff meetings since August 2018. A review of the minutes of the most recent meeting showed that the previous manager and staff had recognised and discussed some of the issues which we found during this inspection. For example, the need to accurately complete fluid charts, interact fully with people, and 'keep an eye' and escalate any bowel issues. However, the absence of robust management arrangements meant they had not been effectively followed up to make sure there had been consistent action by staff.

There had been improvements in a number of areas since our last inspection. Training had been audited effectively and records about this were structured and useful in identifying where staff needed to complete refreshers. Staff training had improved since our last inspection and meant that staff were better equipped to carry out their roles effectively. DoLS authorisations were documented so that expiry dates were flagged up to managers in time for reapplications to be made. Managers made returns to the provider which recorded the numbers of incidents and accidents, weight losses or pressure wounds for example, occurring in the previous month. This helped the provider to monitor themes and identify outliers in information being submitted.

The management team told us that all care plans and associated documentation were being reviewed, but acknowledged that there was more to do in this area. There was an improving picture overall in care planning, with greater detail and clearer guidance for staff. New records about people's baseline clinical observations had been introduced and were crucial in ensuring staff had information to help them recognise any changes which might indicate deteriorating health. Work had started to make positive changes to people's experiences of activities, and improvements were observed and acknowledged during this inspection.

Staff told us they were happy and had felt supported by senior managers in the absence of a manager at Orchard Lodge. One member of staff said, "The [Provider's] chief executive came to speak with me and told me how much they appreciated me. The company is supportive". Another member of staff commented, "The managerial side do listen to us". Staff acted confidently during the inspection and the management team told us that a lot of work had been done to empower staff. One of the management team said, "Staff are asking questions more-we're being challenged more by staff who are passionate about people". A relative told us, "Things have improved and the home was exceptionally well-led under the last manager".

Staff worked effectively as a team during the inspection. They were enthusiastic and cooperative and one staff said, "We have got some good staff who want to always make it better for people". Another told us, "This is a really lovely home. Staff and service users are fantastic".

People and relatives' views about the service had been sought using a questionnaire. Most of the comments reviewed were positive, including one relative who wrote 'The care received is first class'. Meetings were planned for relatives to attend and give their feedback.

Statutory notifications had been received by the CQC from the provider about incidents and events they must report; and the provider had displayed their CQC rating in the service and on their website.