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?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
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 younger adults with learning disabilities or autistic spectrum disorder and physical disabilities.

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.

Orchard Lodge had been built and registered before the Care Quality Commission (CQC) policy for providers of learning disability or autism services 'Registering the Right Support' (RRS) had been published. The guidance and values included in the RRS policy advocate choice and promotion of independence and inclusion, so people using learning disability or autism services can live as ordinary a life as any other citizen. The service did not consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons; People did not always receive personalised care. People did not always plan, review or develop their individual support needs and wishes. People did not always have support with meaningful activities. People's communication needs were not always met. Staff did not always support people with dignity or to be as independent as they were able to be.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

The service was registered for the support of up to 33 people. At the time of the inspection 14 people in total were using the service. This is larger than current best practice guidance.

The service consisted of two separate bungalows, Orchard and Boldings Lodge, and was in private grounds in the countryside near a large town. Both bungalows were bigger than most domestic style properties. 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. Staff wore uniforms and name badges to say they were care staff when coming and going with people.

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

Risks to people were not always adequately assessed, monitored and managed, causing or exposing people to risk of harm. People were not protected from infection. Staff practice and reporting systems to safeguard people from abuse were not always effective. Lessons were not always learnt, and actions taken to investigate safety incidents and prevent them re-occurring.

Best practice guidance was not always considered when assessing people's needs, or what people wanted from their support. Staff did not always have the right skills, knowledge or experience to deliver effective care to people. People's complex eating and drinking needs were not always met effectively or safely. People's day to day health and well-being needs were not always met effectively.

People were not always treated with respect, kindness or compassion, or supported to express their views and be involved in their care. Care plans were not always updated when people's needs changed to ensure staff knew how to support people. People's care was not always planned in a manner that accounted for people's personal history, individual likes and dislikes, social interests and how this informed their support needs and choices.

People did not always have support to follow their interests and take part in appropriate social activities or access the community. The service was not always meeting the communication needs of people with a disability or sensory loss.

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 not ensured that staff at all levels understood their responsibilities and managed staff accountability effectively. The provider had not always shared information openly and honestly. Staff had not always displayed values consistent with the provider's vision of delivering high quality, person-centred care.

Medicines were being managed safely. There were safe recruitment practices. The premises had been designed to accommodate people's needs and was decorated in a personalised manner. We found some people's cultural support needs were met in a caring and responsive manner. One person told us they liked living at the service and the staff were kind. Several relatives told us they thought staff were caring and they were very happy with the care their family members were receiving.

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

Rating at last inspection

We last inspected this service in April and May 2019. The service was rated Inadequate (Published 4 July 2019). There were multiple breaches of regulations and the service remained placed in special measures.

Following this inspection, the service remained rated Inadequate, with multiple breaches of regulations and placed in special measures.

The service has now been rated Inadequate for three consecutive inspections. There have been multiple breaches of regulations identified at the previous six consecutive inspections.

Orchard Lodge has been placed in special measures since September 2017. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. Services in special measures will be kept under review and, if needed could be escalated to urgent enforcement action.

There had been no registered manager at Orchard Lodge since May 2018. The provider had failed comply with Section 33 of the Health and Social Care Act which stipulates that it is a condition of their registration to have a registered manager at the location.
Why we inspected

This was a planned comprehensive inspection based on the previous rating.

This inspection looked to see if the provider had acted to make significant improvements to achieve compliance with regulations.

Enforcement

At this inspection, we have identified four continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regulations 9, 10, 12, and 17. We identified breaches of regulation 11, 13 and 18 in relation to: person centred care, dignity and respect, safe care and treatment, consent, safeguarding people from abuse, good governance and staffing. We also identified a breach of CQC (Registration) Regulations 2009 regulation 18, regarding failing to notify CQC of incidents as required.

Following the inspection in April and May 2019, due to repeated concerns about people's safety we imposed conditions on the provider's registration. These conditions relate exclusively to this service. The conditions mean that the provider must ensure a registered nurse who is independent from the service carries out audits and sends to the CQC monthly information about choking risks, clinical decisions and medicines. We used this information to monitor and inspect this service and to understand the actions the provider has taken to improve.

We wrote to the provider on 9 June 2020 to inform them of our serious and on-going concerns prior and since the November 2019 inspection regarding unsafe care and treatment, failing to protect people from abuse and avoidable harm, governance and staffing at Orchard Lodge. We informed the provider in light of the COVID-19 pandemic and the additional pressures the provider and people using the service were currently facing, we have decided against undertaking further enforcement activity.

We have asked the provider to instead focus on driving improvement in the areas identified above. It is important to state that under normal circumstances our findings would have resulted in enforcement activity being undertaken. However, during the COVID-19 pandemic CQC's primary objective is to act proportionately and support Providers to keep people safe during a period of unprecedented pressure on the health and care system.

We shall continue to closely monitor the situation and keep matters under review, including through regular engagement with the provider and partnership agencies. If absolutely necessary CQC will give consideration to the use of inspection and enforcement powers including urgent powers where we have concerns of harm, such as allegations of abuse.

We have served a fixed penalty notice to the provider for failing to comply with a condition of registration at Orchard Lodge. Fines totalling £1250 have been paid as an alternative to prosecution.

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.

Follow up

The overall rating for this service is 'Inadequate' and the service therefore remains in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will act in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

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.

Inspection team

This inspection took place over two days on 20 and 21 November 2019.

On 20 November 2019 the inspection team consisted of two inspectors, a registered nurse 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.

On 21 November 2019 the inspection team consisted of two inspectors and a registered nurse specialist advisor.

Service and service type

Orchard Lodge is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided.

An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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.

Notice of inspection

This inspection was unannounced.

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 by the provider as well as the local authority, other agencies and health and social care professionals.

We looked at safeguarding alerts which had been made and notifications which had been submitted by the provider. A notification is information about important events the provider is required to tell us about by law. This is necessary so that, where needed, the Care Quality Commission (CQC) can take follow up action.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all this information to plan our inspection.

During the inspection

During the inspection we spoke with four care staff, one registered nurse, the clinical lead, the manager, the provider's clinical quality lead and the provider's nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with the provider's chief executive officer.

We 'pathway tracked' four people using the service. This is where we looked at people's care documentation in depth and obtained their views on how they found the service where possible. This allowed us to capture information about a sample of people receiving care.

We spoke with one person using the service and observed people's support across all areas of the service.

We spoke with four relatives of people who were visiting the service.

We reviewed staff training and supervision records, staff recruitment records, medicines records, care plans, risk assessments, and accidents and incident records.

We also reviewed quality audits, policies and procedures, staff rotas and information about activities people were supported with and provided by the service.

After the inspection –

We asked the provider to send us information to help validate evidence found.

We spoke with two relatives 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, manage medicines safely and learn lessons and make improvements when things go wrong.

We found specific concerns about people's safety regarding risks associated with choking and aspiration, complex eating and drinking needs, epilepsy, constipation, skin integrity and failure to monitor and escalate healthcare concerns. This was a breach of regulation 12 (Safe Care and 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 12.

Assessing risk, safety monitoring and management:

● Risks to people living with epilepsy were not always being monitored, assessed or managed safely, exposing them to risk of harm. Some people did not have epilepsy risk assessments, so staff did not always know the safest way to support them with their epilepsy needs.

●There were inconsistencies in seizure monitoring documents and information in people's epilepsy care plans and epilepsy rescue medicine protocols. This increased the risk that staff may not know how often people were experiencing seizures and check they were getting the right support when they did. Different advice in care plans and protocols increased the risk of people receiving inconsistent support that may not meet their needs safely.

●There had been a recent incident where staff had not followed one person's protocol for administering emergency rescue medicine whilst experiencing a prolonged seizure. Staff did not contact the emergency services as required, which led to a significant delay in an ambulance arriving. This placed the person at increased risk of harm as they had not received further medical support when required.

●Some people were at risk of chronic constipation due to their health and physical conditions. Actions that had been identified to help keep people safe if they became constipated were not always taken by staff. Monitoring records of people's bowel movements were not always completed consistently or with the correct information. This increased the risk staff would not know if someone was constipated and needed support to manage the risk of acute constipation.

●A person had been assessed as needing support to have medicines for constipation and to seek further medical advice if they had not had a bowel movement for three or more days. We found there had been three separate occasions in the last three months where the person had not had a bowel movement for three or more days. On all three occasions, staff had not recognised action needed to be taken and the person had not been given medicines or been supported to get further medical advice.

● Risks relating to people's physical and non-physical challenging behaviours were not always assessed, monitored or managed safely, increasing the risk of harm to people. The functions behind people's challenging behaviours had not always been assessed. Other people had only basic behaviour support plans. These contained little guidance about how to support them to prevent their behaviours that may challenge from occurring or escalating.

●For example, one person displayed self-harming behaviour that regularly caused them minor injuries. This person had not been supported to assess the known reasons for this and there was no care plan for staff to follow to minimise this risk. This increased the chances these incidents would re-occur, and the person would continue to come to harm. Incidents where other people had displayed behaviours that may challenge were not always adequately monitored. This meant there was not always enough information to be able to check people were being supported safely.

● Risks of aspiration (breathing in liquids, food or saliva) and choking for people were not always assessed, monitored or managed safely. There had been two recent incidents where guidelines from Speech and Language therapists recommending specific textured food and drink for people with difficulty swallowing had been mixed up by staff. This meant people who required thickened fluids and chopped or pureed food had not received these, increasing the risk of them choking or aspirating.

● There were inconsistencies in guidance about how to support people to manage risks of aspiration and choking. One person had an information booklet that did not contain all relevant information about their eating and drinking needs and choking risks. This increased the chance that staff would not know how to safely manage these risks.

●One person required suctioning to remove excess salvia, which could cause aspiration leading to infection. The person was known to experience recurrent chest infections. The person's care plan directed staff to perform suctioning every day. The person's daily notes did not show that this was taking place. Staff told us they were not regularly performing suctioning and the person only required this on an 'when required' (PRN) basis. However, the person's care plan had not been updated to reflect this. There was no PRN suctioning protocol or guidelines to ensure all staff would know when suctioning might be necessary. This increased the risk of the person coming to harm.

● Risks of 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.

●One person who was fed via a PEG tube was required to be sat up, or elevated at a specific angle, whilst receiving their food and fluids, to reduce the risk of aspiration. There were inconsistencies about the correct angle this person should be elevated 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.

●Throughout the day, this person also required support to move from one surface to another where they

would no longer be elevated. There was no record the person's food and fluids had been paused when they were being moved into positions where they were not elevated in a safe position and could be at risk of aspiration. Staff told us they thought all staff always elevated the person during the night to a safe position and paused their food and fluids when moving them. However, as these tasks were not recorded, it was not able to be confirmed they had been supported safely.

● Risks for people with complex hydration needs were not always monitored or managed safely. One person required full support to drink a recommended daily allowance (RDA) of fluids each day, to help reduce the risk of dehydration. The person's care plan advised staff to contact the GP if the person had not drunk enough. There had been three recent days where the person had not received their RDA and staff had not contacted their GP, placing the person at risk of harm.

●Some people with complex eating and drinking needs had been assessed as being at risk of harm caused by malnutrition. One person had identified as requiring weekly monitoring of the percentage of their weight loss and gain. This information then had to be compared to information about their body mass index (BMI) and healthcare needs to create a score that showed if they were at high risk of malnutrition.

●Staff were not completing this monitoring weekly, as recommended, and did not know how to add up the information to correctly identify the level of risk. This had resulted in the person experiencing unplanned weight loss for several months, that had not been recognised by staff. There had been no action from staff to prevent this or reduce the risk of harm. Two other people had also recently experienced unplanned weight loss, but staff had not acted to re-assess the risk of harm and implement care plans that identify actions to help prevent this re-occurring.

● Actions that had been identified to manage risks to people with postural support and skin integrity needs were not always being carried out. Staff had been advised not to use one person's wheelchair cushion, as this was not providing appropriate support and was increasing discomfort and aggravating the person's skin condition. However, we observed the person being supported in their wheelchair using the faulty cushion throughout the first day of the inspection. When we spoke with the staff about this, they were not aware that this equipment should not have been used.

● One-person experienced regular soreness of skin. The person's care plan recommended to change their continence pad frequently, monitor this and to use barrier cream. However, staff were not monitoring their pad changes and their care notes showed they regularly received only one pad change per 8-hour shift and only up to 3 pad changes in 24 hours. This increased the chance of the person continuing to have sore skin and experience pain and discomfort.

●Nurses used a standardised system for recording and assessing baseline observations of people's health indicators called National Early Warning Score (NEWS). NEWS was designed to ensure people could be supported to receive or access healthcare support and services quickly. Nurses at the service had not always monitored people's healthcare needs or used NEWS correctly. This increased the risk there would be an avoidable delay in people receiving further medical support as quickly as possible.

Preventing and controlling infection

●There were not always arrangements so that people were protected from infections that could affect both staff and people using the service. One person at the service was known to be carrying an infectious anti-biotic resistant bacterium. If the bacteria spreads, it could increase the risk of all people who encounter it

developing serious infections.

●There were no care plans or assessments to inform staff about how to safely manage the risk of contamination and cross-infection. When we spoke with registered nurses, they could not tell us how to safely manage this risk and staff were not actively taking any action to prevent the spread of infection. This exposed people to risk of harm.

●Staff did not always understand their roles and responsibilities in relation to infection control and hygiene. We observed one staff member using their bare hands to place food onto a spoon they then used to feed a person, increasing the risk of contaminating the food with bacteria and causing illness. One person required daily percutaneous endoscopic gastrostomy (PEG) site cleaning. Staff were not always recording they were carrying out this task to confirm the person had been supported to reduce the risks of harm due to their PEG site becoming infected.

Learning lessons when things go wrong

● Systems in place for staff and management to report, review, investigate safety incidents and act to prevent them re-occurring were not always effective. Staff were not always identifying or completing accident and incident forms as required or reporting incidents internally or externally for further review. 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 acted on. For example, staff had either not been aware or not reported instances where people had not achieved their fluid RDA. Staff had not monitored and managed people's healthcare or malnutrition risks adequately. This had resulted in people being exposed to on-going risk of avoidable harm and lack of action to review assessment, monitoring and management procedures to help prevent these incidents occurring again.

●Risks associated with PEG care, choking and aspiration, epilepsy, constipation and failure to use NEWS correctly/escalate healthcare concerns were found at the previous inspection in April 2019. We also found concerns regarding failing to learn and make improvements when things had gone wrong.

●In response to our concerns raised the previous inspection, we imposed conditions specific to this service on the provider's registration. The conditions told the provider they must designate an independent registered nurse to carry out specific monthly audits to check that choking risks and clinical support decisions, including escalating healthcare concerns, were being assessed, monitored and managed safely. Since the conditions have been imposed, the provider has been carrying out audits and sending CQC reports as required each month. However, at this inspection, we had found the same risks and safety concerns were continuing and the provider had failed to learn and act upon these known areas of concern to improve safety for people.

●The themes of risks and concerns found at this inspection relating to PEG care, choking, aspiration, skin integrity, epilepsy, behaviours that may challenge constipation and failure to use NEWS correctly and escalate healthcare concerns 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, prevent and control infection 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 was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●On the second day of the inspection we received assurances from the manager and clinical lead that the correct wheelchair cushion had been ordered for the person who required this, which would help reduce the risks associated with their meet their postural support and skin integrity needs safely. The manager sent us information following the inspection about how they were assessing and managing infection control risks for people known to be carrying infectious bacterium.

●The provider continues to send us monthly information via their imposed condition report regarding how they are assessing, monitoring and managing risks to people from aspiration and choking, PEG care and the use of NEWS. This information is reviewed on an on-going basis and discussed with the provider as necessary to help ensure people are being kept as safe as possible.

Systems and processes to safeguard people from the risk of abuse

●Systems in place for staff and management to report, review and investigate safety and safeguarding incidents were not always effective. Since the last inspection in April 2019 there had been several safeguarding concerns raised concerning people using the service. These safeguarding concerns had been raised by other staff from within the provider's organisation, relatives or partnership agencies after visiting the service. The concerns included allegations of physical and psychological abuse and neglect against people using the service by staff.

●These allegations had not always been reported or acted on by the provider, to ensure people were protected and improve systems to keep people as safe as possible. Since this inspection, CQC have continued to receive intelligence from partnership agencies and the provider concerning further allegations of this nature.

●People had been placed at risk of harm due to staff not providing their constipation, epilepsy, eating and drinking and behaviour support safely. There had been multiple recording issues and concerns that appropriate healthcare monitoring had not taken place when further medical intervention may have been necessary.

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

● We spoke with the manager and the nominated individual at the end of the first day of the inspection to raise our concerns regarding incidents and safeguarding concerns that had not been reported or acted on. They offered assurances they would act to review, report and implement necessary changes in relation to all previously unidentified and outstanding safeguarding concerns. This included concerns in relation to people's epilepsy, weight loss, constipation, unexplained bruising, self-harming, behaviours that may challenge and ensuring the correct eating and drinking guidelines were available and being followed by staff. Following the inspection, we received confirmation via notifications and information from the provider and partnership agencies these processes had begun.

●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 was not confident systems and processes at the service kept their relative safe from abuse. Other relatives we spoke with had never had any concerns about people's safety.

●There was information about how people using the service could raise safeguarding concerns on communal noticeboards. One person who could verbally communicate told us they felt safe around staff and knew which staff they could speak with if they did not feel safe.

Staffing and recruitment

● The service currently employed a high percentage of agency nurses and healthcare assistants. Wherever possible, the same agency staff were booked for continuity and the provider was in the process of introducing a revised comprehensive induction and competency checks for agency staff nurses. However, we have raised concerns about the skills and competencies of staff deployed in other sections of this report.

●Rotas had been written to allocate staff, based on the provider's calculations of the levels of support people needed. People and staff did not raise any concerns about staffing levels. Relatives acknowledged the high use of agency staff by told us they thought there were enough staff to keep people safe.

● All staff working at the service had undertaken a satisfactory Disclosure and Barring Service (DBS) check. DBS checks help employers make safe recruitment decisions and help prevent unsuitable staff from working in a care setting. Permanent staff submitted applications, references and passed a competency-based interview prior to being offered a position.

● All nurses working at the service had a valid registration pin number with the Nursing and Midwifery Council (NMC). The NMC regulates nurses and midwives in the UK against their set standards of education, training, conduct and performance. A valid NMC registration helps ensure nurses have mandatory nursing knowledge, training and skills and uphold expected professional standards.

Using medicines safely

● Following issues with medicines found at the last inspection in April 2019, we imposed a condition on the provider's registration to ask that an independent registered nurse complete monthly medicine audits at the service. This purpose of this condition was to support the service to check that specific areas of practice including ordering, storing, disposing and administration of medicines were being carried out safely and support staff to address any issues.

●We checked these areas of practice and found these areas of practice were operating safely. Medicines were ordered, stored and disposed of safely. People had Medication Administration Records (MAR) and included information about the medicines they needed, how their medicines should be taken or used and how often. Staff signed MAR charts to show that people had received their medicines as intended. We observed staff supporting people with medicines in a hygienic manner and in line with the directions on their MAR chart.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

At our last inspection we found the provider was not always meeting people's assessed needs. At this inspection the provider was still in breach of Regulation 9.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

●Best practice guidance was not always considered when assessing people's needs, or what people wanted from their support. We have commented more on inadequate assessment processes in relation to people's behaviours that may challenge, nutritional, suctioning, mobility and healthcare support needs in the 'Safe' section of this report.

●Assessments of some people's sexuality and mental health needs had not considered appropriate, evidence-based practical social support, advice and guidance. This increased the risk that they might not receive effective support to meet their needs in these areas of their lives. For example, one person told us they were in a relationship with another service user. Their social and sexuality needs regarding this relationship had not been assessed in line with best practice guidance. The person had not received person-centred support to understand and explore this relationship appropriately, in line with their needs and preferences.

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

Staff support: induction, training, skills and experience

●Staff did not always have the right skills, knowledge or experience to deliver effective care to people. Agency nurses had not yet all received competency assessments or on-going support to ensure they were competent to use NEWS systems and meet people's clinical healthcare needs. Failure to ensure agency nurses had the appropriate knowledge and competencies had been highlighted at our last inspection in April 2019 as requiring improvement but had not improved.

●Agency and permanent staff had not always received training in subjects relevant to supporting people at Orchard Lodge. This included: positive behaviour support, de-choking devices, and learning disabilities. Some agency nurse training profiles showed they required updates for training in specialist areas of people's care needs such as tracheostomy care.

● We spoke with the service clinical lead, who told us there were on-going issues with agency nurses not meeting people's needs effectively in relation to PEG care, NEWS, and nutrition and hydration. The clinical lead explained the issues were on-going as there was a lack of formal supervision for agency staff to help clearly identify how best to support them to address the gaps in their skills and knowledge. The clinical lead had raised this issue with the previous manager, but no action had been taken.

●The service clinical lead was the only permanent registered nurse staff member located at the service. They told us all agency nursing and healthcare assistant staff relied on solely on their clinical knowledge and experience if needing information and advice. When clinical issues arose as the result of agency nurse lack of skills or knowledge, they were expected to resolve these without other support in addition to their other tasks. This created pressure and distraction that impacted on their own ability to deliver and oversee the provision of effective clinical care throughout the service.

●A health and social care professional and two relatives we spoke with raised concerns that agency nurses and healthcare assistants did not have relevant skills, knowledge and experience to be able to meet people's needs. We have commented on our findings during this inspection including specific examples of where agency and permanent staff had not meet people's needs in relation to PEG, epilepsy, NEWS, nutrition, choking and aspiration, social, activity and communication in the 'Safe' and 'Responsive' sections of this report.

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

●The clinical lead showed us a new format for agency nurse competency assessment that had been developed to include key areas of practice. This had very recently been delivered to two of the agency nurses and there were plans for all nurses to be assessed in the coming months. The provider had recently created an organisational head of clinical quality support position. This would provide on-going support for this service to address clinical practice issues, including supervising agency nurses and helping to arrange and deliver training specific to people's needs.

Ensuring consent to care and treatment in line with law and guidance

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

●People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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 whether any conditions on authorizations to deprive a person of their liberty had the appropriate legal authority and were being met.

● People's consent to care and treatment had not always been sought in line with the MCA. Where people might lack mental capacity to be able to make certain decisions, this had been assessed. However, for some people who lacked capacity, there was not always a record that a person with authority to act in their best interests had been identified and involved in making these specific decisions about their care. For example, the person's regular carers, or health and social care professionals such as GPs and social workers. This meant it could not be evidenced that decisions that had been made, and actions taken on behalf of people who lacked capacity, were in their best interests.

●For example, one person had been assessed as lacking capacity to consent to an audio monitor in their room to help staff identify if they needed support during the night. The monitor was currently in use. However, there was no record regarding who had been consulted with to make the final decision to use the monitor, and that it had been agreed this was the most effective and least restrictive way to support the person.

●Where people had authorised DoLS with relevant conditions in place, these conditions were not always being met. A person had a DoLS condition to ensure they had set goals to achieve when receiving their 1:1 and activity support, but this had not been done. Another person had a DoLS condition that their medicines should only be administered at a specific time in the morning. However, the person's medicine records showed they were being given their medicines at an earlier time.

The provider had failed to ensure service users' consent to care and treatment had been sought in accordance with legislation. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support, staff working with other agencies to provide consistent, effective, timely care

● People's day to day health and wellbeing needs were not always met effectively. We have commented more on people's healthcare needs not being met in relation to constipation, epilepsy, PEG care, NEWS, nutrition, skin integrity and fluid intake in the 'Safe' section of this report.

●We found issues during this inspection where staff had not followed guidance and information from other health and social care agencies to meet people's skin integrity, nutrition and hydration needs. We have commented more on these in the 'Safe' section of the report.

●A health and social care professional told us staff did not always work well with their service to ensure people received consistent care. They said, "An area for development continues to be communication about details and instructions being followed throughout the staff with equipment".

● We received mixed feedback from relatives about whether their family members healthcare needs were met effectively. Some relatives told us they had no concerns. One relative told us they were not always confident staff would support their family member to access appropriate healthcare services if necessary.

The failure to work effectively with other agencies and to ensure the health, safety and welfare of service users was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● Risks to people with complex needs in relation to their eating and drinking were not always monitored or managed safely. We have commented on this in the 'Safe' section of this report.

● Staff had sought advice from speech and language therapists (SaLT) to help advise them about the people's specific dietary needs and develop eating and drinking guidelines. People were involved in developing menus, which changed regularly. People were offered different meal choices daily. The service could cater for any religious or cultural food preferences, if these were requested. Meals were appropriately spaced throughout the day and mealtimes could be flexible to meet people's needs.

Adapting service, design, decoration to meet people's needs

● The premises had been designed to accommodate people with physical disability support needs. There were wide doorways and corridors to allow for wheelchair access. Equipment, such as ceiling track hoists, had been installed in individual bathrooms and bedrooms to support people with transferring from one place to another.

●There was a large communal space and smaller communal areas in both bungalows, where people could eat and spend time taking part in activities or socialising. There were outside gardens and people could access the wider grounds in which the service was set, if they wanted to spend time outside.

●There was appropriate signage on doors to toilets and other communal rooms and facilities, to help people find their way around the building. Communal areas were decorated with pictures created by and photographs of people. People had personalised their bedrooms with their own furniture and decorations.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

At the last inspection, the provider was not ensuring that people were always well treated and supported.

We had found staff moved people without asking their permission, did not interact in a caring and inclusive manner with people and people were often left unsupported without explanation for periods.

This was a breach of Regulation 10 (Dignity and respect) 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 10.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

●People were not always treated with kindness or compassion, which impacted negatively on people's quality of life and emotional wellbeing. We observed an agency nurse push a person's hand away abruptly and without explanation when the person reached towards them. We observed some people that were ignored and not responded to in a timely manner when showing signs of impatience and distress.

●There had been instances since the last inspection in April 2019 where relatives and other external staff had raised concerns that staff did not speak or treat people in a kind or caring manner. We observed another agency nurse becoming impatient and speaking in a disrespectful tone of voice when a person was slow to respond to their questions when they were supporting them with their medicines.

● People were not always involved in making decisions about their care or supported to express their views, which impacted negatively on their quality of life and emotional wellbeing. We observed several instances over the course of the inspection where staff moved people in their wheelchairs without asking permission or explaining what was happening. We observed staff asking a person what they wanted to watch on TV. Staff switched on a fashion programme and the person indicated they did not want to watch this. However, staff did not respect this choice and left the TV on this channel.

●We observed an instance where a person had been waiting to go out for 15 minutes after being supported to get ready. The person appeared agitated and staff moved them to another room with no explanation. The person was left alone for approximately one hour of unstructured time, without interaction or stimulation. Staff did not attempt to spend time to communicate with the person, provide them with information about what was happening or involve them in this decision.

The provider had failed to ensure people were well treated and supported to express their views and be involved in their care. This was a continued a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●A person we spoke with told us they thought staff were caring. They told us staff had involved them in creating a 'Communication Book' which contained information about their likes and dislikes and important things in their life, including accessible ways staff could communicate with them.

●We observed some positive interactions between staff and people, with staff engaging and involving people in their support, offering them choices and speaking with them in a kind and caring manner. We observed staff encouraging people to be as independent as possible, giving people prompts and helping them to eat without assistance as much as they were able.

●People's preferences, including their cultural and spiritual needs were respected when deploying staff and supporting them. Female staff adjusted their dress when supporting a person of a religious faith, to respect their beliefs. People were supported by staff of their preferred gender.

●Staff supported people to practice their chosen faith. For example, by playing religious music and reading religious texts to people in the service and supporting them to attend their chosen place of religious worship in the community.

● Relatives told us thought their family members' privacy and dignity was respected. One relative told us staff always made sure they closed curtains at night when supporting their family member with their personal care. Another relative told us staff were always respectful and treated their family member with dignity if needing to perform personal care. There were data protection and record keeping polices in place to make sure that people's personal information was correctly stored, used and shared.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At the last inspection, the provider was not providing person-centred care. This was a breach of Regulation 9 (Person-centred care) 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 9.

● People's care plans did not reflect people's strengths, levels of independence and preferences in all areas of their lives. Care plans were written exclusively by the clinical lead, manager and some of the agency nurses. There was limited information about people's mental, emotional and social needs.

● People's care was not always planned in a manner that accounted for people's personal history, individual likes and dislikes, social interests and how this informed their support needs and choices. Staff we spoke with were not always aware of this information or able to tell us how they supported people in a person-centred way. People had not always been supported to identify, or review, on-going individual aspirations and life goals. This increased the risk that people may not receive personalised support they needed and wanted.

● Planning and reviews of people's care by staff were not scheduled in advance, did not always involve people or relevant representatives and were not always formally recorded to ensure that any changes were followed. Care plans were not always updated when people's needs changed, to ensure staff would respond to provide the care people wanted and needed.

●During this inspection we found changes to people's mobility equipment, suctioning, epilepsy, behaviour and DoLS support needs had not been updated in the guidance available for staff. This had resulted in unsafe, ineffective and unresponsive care being delivered to people, as staff had not been aware or known how to deliver the support people needed. The risk of this issue re-occurring was increased due to high numbers of agency staff working at the service who did not know people well.

Support to follow interests and to take part in activities that are socially and culturally relevant to them; Supporting people to develop and maintain relationships to avoid social isolation

● People did not always have support to follow their interests and take part in appropriate social and cultural activities. People received group-based support and two people received specific 1:1 support throughout the week. People's 1:1 and group-based activity support did not always reflect their individual needs and choices, according to their care plan information. People had activity records in place. However, the activity co-ordinator told us they did not use this information to monitor people's engagement. There was no formal review to check what the purpose of the activity was and if this was being achieved.

● We observed an arts and craft activity taking place. People were unable to reach the table and not encouraged to join in, with staff doing the activity for all but one person whilst they watched. A relative told us they repeatedly observed their relative being supported with activities that were not stimulating or meaningful for them. They said, "They do have an individual activity time-table, but it is meaningless, none of the activities ever take place. They are often sat staring onto space while an irrelevant activity goes on around them".

● People were not always able to access the wider community, to take part in meaningful activities and avoid social isolation. A person using the service and staff told us there were issues with arranging transport for people to leave the service. A relative told us their family member did not go out often.

●We sampled four people's activity records. These showed since the last inspection, they were leaving the service on average once a month. When people had gone out, this was often as part of a group-based activity to maximise the available transport and did not reflect their preferred individual activity choices.

●People did not always have support to maintain or develop meaningful relationships. One person who required full support in all areas of their life, was in a relationship with another service user. The person had social interaction, expressing sexuality and what matters to me care plans and support documents. None of these mentioned the person was in a relationship or identified the personalised support they required.

●The person had not been supported to formally assess, plan or review any support they may require or want to maintain or develop this relationship. This increased the risk their social and emotional needs may not be met safely or responsively. For example, the person's sexuality care plan identified the person may want to understand and explore their sexuality but did not explain what this meant for the person or what support they needed to be able to do this. This meant it was not possible for staff to understand what the persons' needs were or regularly review how well their support with developing their relationship was working.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers'.

● The service was not always meeting the communication needs of people with a disability or sensory loss. Two people's care plan stated that they needed information about their care explained using easy read symbols, or pictures. However, they did not have easy read format care plans available or in use.

●There was incorrect information and inconsistencies about how to meet people's communication needs in their care plans and associated documents. For example, one person who was blind had an accessible

information document that stated they needed written information.

●We received feedback from a health and social care professional about work their team had been doing with staff to help improve communication between staff and people. They said this area of staff practice required on-going improvement, including the use of equipment. They told us, "The quality of interaction with the service users and staff knowledge and skill in using people's preferred non-verbal communication techniques needs attention."

The provider was not ensuring people received person-centred care. This was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people were receiving personalised care that was responsive to their needs. Staff used picture cards and computer technology to communicate with one person. This allowed the person as much choice and control as possible when planning their support. The person was supported with social activities of their choice each work, including trips into the community.

● Some people were supported to take part in activities that were socially and culturally relevant to them. People of different religious faiths were supported to visit and have visitors to be able to worship their beliefs. Staff played prayer music and allowed people time to engage in religious ceremony independently in their rooms as they chose.

●We observed an external music therapist visit the service during one of the afternoons of the inspection. People were interested in the instruments and the music being played. They engaged and responded well, and the session appeared to have a positive relevance to all that attended.

●Some relatives told us they had been involved in planning and reviewing their family members' care. Relatives told us staff were approaching them for their input more often than in the past. The nominated individual told us there were plans for a newly introduced keyworker role to take the lead from the clinical lead and the manager in assessing, planning and reviewing people's care. This would help ensure these processes would be more personalised.

Improving care quality in response to complaints or concerns

●The provider had a complaints policy that was available for people in an accessible form. One person we spoke with told us they knew they could talk to staff if they had a complaint. We saw the previous manager had responded to complaints in line with the provider's policy.

●We received mixed feedback from relatives regarding the management of complaints. Several relatives told us if they had ever had to raise an issue, this had been dealt with to their satisfaction. One relative raised concern over the response they had received from both managers and senior managers when making a complaint. We have commented more on this in the well-led section of this report.

End of life care and support

●No one was receiving end of life care at the service at the time of the inspection. People did not have detailed end of life plans. The manager was aware of this and there were planned arrangements to re-assess and comprehensively plan all people's end of life care needs was taking place. The review was identifying

people's end of life care wishes, spiritual and cultural and emotional support needs.

●Work was also underway to ensure each person had information about if they wanted to receive emergency resuscitation in the event of a medical emergency and how to help arrange access to necessary medical resources and equipment if this should become necessary.

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

At the last inspection, the provider was failing to assess, monitor and improve the quality and safety of the service and to mitigate risks to people.

This was a continued breach of Regulation 17 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 17.

● People remained at risk of receiving unsafe, poor quality or inadequate support. At this inspection we found the provider continued to be in breach of four Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; 9, 10, 12, and 17. We identified further breaches of Health and Social care Act regulations 11, 13, and 18 and a breach of CQC Registration Regulations 2009 regulation 18.

●The provider was therefore in breach of eight regulations in total in relation to; person centred care, dignity and respect, consent, safe care and treatment, safeguarding people from abuse, good governance, staffing and failing to notify CQC of incidents as required. Orchard Lodge has been in breach of legal requirements since our July 2017 inspection. Orchard Lodge has been rated 'inadequate' for six of the last seven inspections.

●The risks and concerns found at this inspection, including inadequate risk management in relation to people's epilepsy, constipation, PEG, aspiration and choking, skin integrity, complex eating and drinking needs, people not being supported in a kind and caring manner and lack of person-centred care and meaningful activity support 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 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.

●Systems and processes to assess, monitor and improve the quality and safety of the service were not operating effectively. We were told by the manager on the first day of the inspection that internal quality audit tools, including service development plan had been recently completely re-written at their request. The manager explained they could not use the SIP when they came into post, as it was inadequate in its current format for their purposes of assessing, monitoring and improving the quality and safety of the service. The manager explained they had raised this with internal colleagues, who had recognised this and provided support to re-write the format and information of the SIP to address this significant issue.

●Service management and the provider's wider governance systems had not always ensured actions were taken to address any issues and risks in a timely manner. We were provided with an updated service development plan on the second day of the inspection, however, this continued to show actions identified since the last inspection in April 2019 that had significantly overrun their timeframes for completion.

● 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, caring, responsive or effective care.

●Internal communication at service and wider organisational level was found to be poor at this inspection, and this had contributed to the staff and management's inability to identify and resolve issues. There was ineffective communication between the clinical lead and previous manager, meaning there had been no oversight of how actions were progressing relating to the service level conditions or where there were on-going issues with agency nurse practice.

●Where there had been actions recommended following a safety incident, these had not been completed as required by the out-going manager. When we enquired about the progress of the investigation outcome, there was confusion amongst management and senior management about the status of the investigation, what actions had been achieved to date and which actions were still required to be completed.

●The provider had not assessed, monitored and reduced risks relating to the health and safety of service users. Failure to manage epilepsy risks had caused a person harm. Failure to manage on-going constipation, choking and aspiration, skin integrity, mobility, PEG and behaviours that may challenge risks had exposed people to a consistently high risk of harm.

● People's care plans and risk assessments regarding DoLS, PEG, epilepsy, behaviours that may challenge, activities, end of life and social support needs were not always accurate, complete or up to date.

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; Working in partnership with others

● A relative told us the provider had not always acted openly and given serious consideration something had gone wrong regarding a continued pattern of unexplained bruising they had observed occurring for their family member. They told us they were concerned there was a culture within the service and wider organisation of failing to be open and honest when things had gone wrong.

●They gave an example of where they had raised concerns to the management about a large unexplained bruise. They had not been satisfied when told this incident would not be investigated. When they requested to see the incident reports that had been made about their concern, they were told they could not. After

several months they were eventually shown the reports, and these contained pictures of a much smaller bruise. We were shown copies of both the relative's and the service documents in relation to this incident and they confirmed the relative's account.

●The provider had not always informed relevant partnership agencies, such as the local authority safeguarding team or CQC, about notable safety incidents, as per their statutory and contractual responsibilities. For example, following the provider's previous clinical lead reporting witnessing an incident of alleged staff physical and psychological abuse of a person using the service, this was not reported externally, on the advice from the provider's nominated individual and safeguarding lead.

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

● Leadership at all levels at the service did not always inspire staff to provide a quality service. The service had not had a permanent registered manager in post since May 2018. There had been a high turnover of managers during this period. Since the last inspection there had been a manager in post from January 2019 who had also recently left in October 2019 and had not applied during this period to become a registered manager.

●The service was currently being managed by the provider's Engagement and Involvement lead until a new manager could be recruited. The manager told us they found stepping outside of their normal job role to manage the service created some challenges for them. They said they had been asked to fulfil the role on an interim basis and were hopeful this would not be a long-term arrangement as interviews were underway to recruit a permanent registered manager.

●Some staff told us the repeated changes in management had affected their morale and created uncertainty. One staff member said, "Staff would like a manager to stay longer than 6 months. The staff get upset. I think lack of manager is the main problem here." Another staff told us, "The main thing is not knowing what is going on".

● Staff had not always displayed values consistent with the provider's vision of service delivery. The provider's vision was that the highest quality care, based on the needs of the individual, was delivered by highly skilled professional teams. Following this inspection, the service has been in breach of multiple Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 over seven consecutive inspections between July 2017 and November 2019.

●This includes consecutive repeated breaches of regulation 12 and 17 and other repeated breaches over this 28 month-period in relation to; failing to manage risks and ensure good governance, seeking people's consent in line with legislation, treat people with dignity and respect, failing to provide skilled, knowledgeable and trained staff, keep people safe from abuse and improper treatment and ensure good governance.

●The provider and the service have received specific directions from CQC via imposed conditions to undertake monthly audits of the quality and safety of their support and act to manage any risks to people. This includes conditions to identify and resolve issues relating to clinical decisions, NEWS, medicines and choking risks at Orchard Lodge, and for the provider to review incidents and accidents, unplanned hospital admissions and staffing at all their services and act on any concerns. Despite this, the provider has not made necessary improvements and has not prevented 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 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 had not always worked in partnership effectively with other agencies and was not always open and transparent with service users and other relevant persons. This was a continued breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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.

● The service has been without a registered manager since 21 May 2018. This means the registered person has failed to comply with a condition of their registration and ensure there was a manager registered with CQC to manage the regulated activities being provided at the service. This is a breach of Section 33 of the Health and Social care Act 2008.

●The provider's chief operating officer and nominated individual told us about a new governance and quality assurance framework that was being developed to help ensure quality and safety issues would be identified and addressed effectively. There were plans to implement improved IT and technology resources for staff and management, to enable timely information sharing and good quality care delivery. Work was currently underway to invest in recruiting and retaining staff.

●The manager told us they hoped to be able to change the existing culture and support staff to move towards delivering more personalised support for people. They said, "The support has historically been designed and delivered from a clinical and health-based perspective and hasn't been focused on social side of people's lives. I want to make sure person is heard, has a say in how their life is planned, and their voice is heard around what they want and how they live. Staff are task orientated, so I want to support them on their learning curve towards realising these values".

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

● People's views and experiences were gathered to help improve the service. People and relatives were sent questionnaires to ask for their views on what was and was not working at the service. Questionnaires were available in an accessible format. One relative told us changes to the rota had been made due to their feedback, meaning their family member now did not miss as many appointments as they had been. There were meetings for people who used the service each month to gain their ideas and choices about their activities and menu options.

●The previous manager had recently arranged more regular relative meetings to discuss and gain their feedback about service performance issues. The provider had also arranged relative forums, which had been attended by senior management including the Chief Executive Officer. Relatives told us they appreciated this level of engagement. One relative said this had made them feel "very positive".

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	Statutory notifications had not been submitted to CQC as required.

The enforcement action we took:

We have served a fixed penalty notice to the provider for failing to comply with a condition of registration at Orchard Lodge. Fines totalling £1250 have been paid as an alternative to prosecution.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider was not ensuring people received person-centred care.

The enforcement action we took:

In light of the COVID-19 pandemic and the additional pressures the provider and people using the service were currently facing, we have decided against undertaking further enforcement activity. We have asked the provider to instead focus on driving improvement in the areas identified above. It is important to state that under normal circumstances our findings would have resulted in enforcement activity being undertaken.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The provider had failed to ensure people were well treated and supported to express their views and be involved in their care.

The enforcement action we took:

In light of the COVID-19 pandemic and the additional pressures the provider and people using the service were currently facing, we have decided against undertaking further enforcement activity. We have asked the provider to instead focus on driving improvement in the areas identified above. It is important to state that under normal circumstances our findings would have resulted in enforcement activity being undertaken.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 11 HSCA RA Regulations 2014 Need for

personal care Treatment of disease, disorder or injury	consent The provider had failed to ensure service users consent to care and treatment had been sought in accordance with legislation.

The enforcement action we took:

In light of the COVID-19 pandemic and the additional pressures the provider and people using the service were currently facing, we have decided against undertaking further enforcement activity. We have asked the provider to instead focus on driving improvement in the areas identified above. It is important to state that under normal circumstances our findings would have resulted in enforcement activity being undertaken.

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, prevent and control infection 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:

In light of the COVID-19 pandemic and the additional pressures the provider and people using the service were currently facing, we have decided against undertaking further enforcement activity. We have asked the provider to instead focus on driving improvement in the areas identified above. It is important to state that under normal circumstances our findings would have resulted in enforcement activity being undertaken.

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:

In light of the COVID-19 pandemic and the additional pressures the provider and people using the service were currently facing, we have decided against undertaking further enforcement activity. We have asked the provider to instead focus on driving improvement in the areas identified above. It is important to state that under normal circumstances our findings would have resulted in enforcement activity being undertaken.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

Treatment of disease, disorder or injury	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 had not always worked in partnership effectively with other agencies and was not always open and transparent with service users and other relevant persons.

The enforcement action we took:

In light of the COVID-19 pandemic and the additional pressures the provider and people using the service were currently facing, we have decided against undertaking further enforcement activity. We have asked the provider to instead focus on driving improvement in the areas identified above. It is important to state that under normal circumstances our findings would have resulted in enforcement activity being undertaken.

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

The enforcement action we took:

In light of the COVID-19 pandemic and the additional pressures the provider and people using the service were currently facing, we have decided against undertaking further enforcement activity. We have asked the provider to instead focus on driving improvement in the areas identified above. It is important to state that under normal circumstances our findings would have resulted in enforcement activity being undertaken.