SHC Clemsfold Group Limited

Orchard Lodge

Inspection report

Tylden House Dorking Road
Warnham
Horsham
West Sussex
RH12 3RZ

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

Date of inspection visit:
06 July 2017
07 July 2017

Date of publication:
08 August 2019

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

Summary of findings

Overall summary

The inspection took place on 6 and 7 July 2017 and was unannounced.

The inspection was bought forward as we had been made aware that following the identification of risks relating to people's care, the service had been subject to a period of increased monitoring and support by commissioners. The service has been the subject of 8 safeguarding investigations by the local authority and partner agencies. As a result of concerns raised, the provider is currently subject to a police investigation. West Sussex Safeguarding Adults Board have also published information on their website regarding safeguarding concerns about Orchard Lodge. Our inspection did not examine specific incidents and safeguarding allegations which have formed part of these investigations. However, we used the information of concern raised by partner agencies to plan what areas we would inspect and to judge the safety and quality of the service at the time of the inspection. Between May and August 2017, we have inspected a number of Sussex Health Care locations in relation to concerns about variation in quality and safety across their services and will report on what we find.

Orchard Lodge provides accommodation in three units called Boldings, Orchard East and Orchard West, which are all on one site. Orchard Lodge provides nursing and personal care for up to 33 people who may have learning disabilities, physical disabilities and sensory impairments. Most people had complex mobility and communication needs. At the time of our inspection there were 28 people living at Orchard Lodge.

People living at the service had their own bedroom and en-suite bathroom. In each unit, there was a communal lounge and separate dining room where people could socialise and eat their meals if they wish. The units shared transport for access to the community and offered 24-hour nurse support and a social and recreational activities programme. The home environment is spacious throughout and adapted to meet the needs of people who use wheelchairs. The home was decorated with pictures and photographs of people living at the home. Orchard Lodge also offers a spa and hydrotherapy facilities however they were not fit for use at the time of our inspection.

A home manager started working at Orchard Lodge in April 2017 and had submitted an application to register with the commission. The service is required by a condition of its registration to have a registered manager. A registered manager is a person who 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. Although the home manager was new to Orchard Lodge they had been working for the provider for 15 years.

At the last inspection in November 2016 the service was found to be complying with legal requirements and was given a rating of 'Good'. However, at this inspection we found that the quality of safety and care had deteriorated and we identified three breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The information of concern shared with the CQC about specific incidents and safeguarding concerns indicated potential concerns about the management of risk related to complex health conditions (Epilepsy, Asthma and dysphagia (difficulty swallowing), deployment of suitably qualified and skilled staff and care of percutaneous endoscopic gastrostomy (PEG) feeding tubes for people who were not able to take food and drink by mouth. Therefore we examined those risks in detail as part of this inspection.

We found concerns regarding how staff were deployed particularly in Orchard West. There were not enough staff readily available to meet people's needs and to ensure the safety of people at all times, therefore placing people at risk from harm. You can see what action we told the provider to take at the back of the full version of the report.

All staff were trained in safeguarding adults yet the training was not always implemented in practice whilst supporting people. Staff members told us about five separate incidents which had not been raised or brought to the attention of the current management team. Staff had also not raised the concerns with external agencies such as the West Sussex Safeguarding team for their review. Therefore people may have been exposed to further unnecessary risks which may have had a negative impact on their physical and emotional well-being. You can see what action we told the provider to take at the back of the full version of the report.

We identified gaps in training provided to staff. All people living at the home had a learning disability yet not all staff had received specific training on the subject. A significant amount of people lived with epilepsy however, some staff had never completed epilepsy training and others required an updated course.

We spoke with many staff during our inspection that were unhappy in their work and didn't feel valued and supported. This was mostly dominated with comments about low staffing levels and the impact this had on people they supported. We found opportunities had been missed to provide all staff with face to face supervision sessions to discuss these issues and concerns. You can see what action we told the provider to take at the back of the full version of the report.

The home used four different nursing agencies to supply nurses to cover gaps within shifts. However, no routine checks were carried out to assess whether each nurse attending the home had current training in key subjects such as epilepsy, learning disabilities and PEG management.

Individual risk assessments had been completed by nurses relating to people's care to minimise risks associated with their needs. However, we found a lack of specific guidance available for nurses surrounding PEG management. Nurses provided care for ten people who used PEG systems for nutrition, hydration and medicines. This had an associated increased level of risk due to the amount of agency nurses working at the home and the lack of monitoring of their skills and abilities by the management team.

Systems to assess and monitor the service were in place but these were not sufficiently robust as they had not ensured a delivery of consistent high care across the service or pro-actively identified all the issues we found during the inspection. The area manager offered assurances during and after the inspection all concerns and issues identified would be addressed to minimise impact on the people living at the home. You can see what action we told the provider to take at the back of the full version of the report.

Policies and procedures were in place and medicines were managed, stored, given to people as prescribed and disposed of safely. Environmental risks such as hoist equipment, wheelchairs and legionella checks were managed effectively through prompt and regular servicing. Staff employed by the home underwent a thorough safe recruitment process.

Mental capacity assessments carried out by the provider were in line with current legislation. Staff understood how people's capacity should be considered and had taken steps to ensure that people's rights were protected in line with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

There was enough food and drink available and offered to people throughout our inspection at mealtimes and also in-between. The menu offered flexibility to meet the needs of people and their specific dietary requirements. People had access to external health care professionals including GP's who visited the home weekly. The provider had recently employed a dietician. A physiotherapist was employed by the provider to facilitate sessions to people assessed as needing support with this. They told us they were not able to achieve all planned sessions due to staffing levels we shared this with the provider.

Staff presented as kind and caring and offered supportive interactions with people living at the home. We observed staff responded to personal care needs as they arose and involved them with their own care as much as they were able by offering choices and gaining consent prior to providing support. Staff knew people well, their preferences and people who were important to them. Care plans were personalised and pertinent to the person being written about and reviewed monthly by registered nurses.

People were encouraged to be involved in activities including preparing for a garden party soon to be held at the home. Formal complaints were recorded and actions carried out in line with the provider's complaints policy.

The provider asked people and their relatives views on the care they received using various methods including satisfaction surveys. Relatives shared mostly positive views on the care their family members received. People were able to receive visits from their relatives and friends whenever they wished at the home.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There was a lack of recording and reporting incidents which may have placed people at risk from harm.

There were insufficient staff deployed to meet people's needs safely. This was with particular reference to Orchard West.

Risks to people were identified and assessments drawn up so that care staff knew how to care for people safely and mitigate any risks and medicines were managed safely.

There were aspects of unsafe care and treatment which had been highlighted to the provider in the months prior to our inspection by external agencies and in some instances we found that suitable action had not been taken to respond to these known risks.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always receive and complete training in key subjects and receive consistent supervision to enable them to carry out their role effectively.

Consent to care and treatment was sought in line with legislation under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were supported to have sufficient to eat and drink and received 24 hour nursing care with access to external health professionals when needed.

Is the service caring?

Requires Improvement

The service was not always caring as the deployment of staff and staff response to safeguarding concerns did not always ensure people were treated with respect and dignity.

People were supported by kind, friendly and caring staff who

knew them well.

People were given opportunities to be involved and supported to express their views on how they wished to be cared for as much as they were able.

Staff promoted people's dignity and respected their privacy.

Is the service responsive?

Good

The service was responsive.

Care records were personalised and pertinent to the person being written about.

There were various activities and stimulation offered to people throughout the week.

People and their relatives knew how to raise a concern and felt able to do so.

Is the service well-led?

Inadequate

The service was not well led.

A positive and empowering culture was not always promoted to enable staff to carry out their role and responsibilities and there was a lack of governance regarding the training completed by agency nurses.

Care records were incomplete regarding specific written guidance available for nurses on PEG management.

There was a lack of effective auditing systems in place to identify and measure the quality of the service delivered to people.

People and their relatives were routinely asked their views on the care and support they received.

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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection of Orchard Lodge was undertaken on 6 and 7 July 2017 and was unannounced.

The inspection was prompted, in part, by notification of four historical service user deaths from 2016, the circumstances of which were raised as a concern in April 2017. There have also been five subsequent safeguarding and quality concerns raised by partner agencies. These incidents and safeguarding concerns are the subject of a police investigation and as a result this inspection did not examine the circumstances of specific incidents.

However, the information of concern shared with the CQC about specific incidents and safeguarding concerns indicated potential concerns about the management of risk related to complex health conditions (Epilepsy, Asthma and dysphagia (difficulty swallowing), deployment of suitably qualified and skilled staff and care of percutaneous endoscopic gastrostomy (PEG) feeding tubes for people who were not able to take food and drink by mouth. Therefore we examined those risks in detail as part of this inspection.

The inspection was undertaken by two inspectors, two specialist nurses 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. The expert-by-experience at this inspection had experience of adults with learning disabilities and other caring settings.

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 provider 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. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This 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.

During the visit we spoke with one person who lived at the home. Due to the nature of people's complex needs, we were not always able to ask direct questions. However, we did chat with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with an activity coordinator who also provided care support, one registered nurse, five care assistants, two senior care staff, one agency nurse, the clinical nurse tutor and a physiotherapist who was directly employed by the provider. We also spoke with the registered manager and area manager throughout the inspection. The nominated individual who represents the provider introduced themselves to the inspection team during the first day of our inspection.

We also spoke with five relatives by telephone and face to face to gain their views of the care provided to their family members. We spent time observing the care and support that people received in the lounges and communal areas of the home during the morning, at lunchtime and during the afternoon. We also observed medicines being administered to people.

We reviewed a range of records about people's care which included five people's care plans. We also looked at six staff records which included information about their training, support and recruitment record. We read audits, minutes of meetings with people and staff, menus, policies and procedures and accident and incident reports and other documents relating the management of the home.

Inadequate

Is the service safe?

Our findings

People's relatives told us the home provided a safe service. However, we found shortfalls within the home which held potential risks for people living there.

All staff working at the home told us they felt the home needed more staff to meet people's needs safely. One staff member said, "We are struggling, we are short staffed". Another staff member told us, "There is not enough staff", they added, "How can it be safe?" A third member of staff told us, "The service users aren't getting their care needs met, we don't have enough time to spend with them".

The home was split into three sections, Orchard East, Orchard West and the Boldings. There were three separate care staff teams supporting each section of the home throughout the day and night. There were two registered nurses on duty at any time. One of the registered nurses 'floated' between Orchard East and Orchard West. The other nurse was based in the Boldings section of the home. The new manager was also a registered nurse whose role was to provide support and supervision to clinical staff and oversee the day to day operations of the service.

During our inspection we did not observe staffing levels having a negative impact on people in Orchard East and the Boldings as staff were able to attend to their needs in a timely manner. However, we became increasingly concerned about the support people received in Orchard West. At the time of our inspection seven people with learning and physical disabilities and other complex needs lived in Orchard West. People we met had limited speech, lacked capacity to make specific decisions about their care and were completely reliant on staff to meet all their needs. All people were wheelchair users and required two staff members to support them to move safely. For example, all people living there needed two staff members to help them to wash themselves. We were told and rotas confirmed there were only two care staff allocated to support Orchard West throughout the day and night. This meant there were periods of time when the other six people would have very little or no support from the allocated staff team when the two available staff members were supporting a person with their moving and handling or personal care. The registered nurse covering both East and West would attend in this time if a person required their medicines or support with the use of their PEG (percutaneous endoscopic gastrostomy) system. This is an endoscopic medical procedure in which a PEG tube is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding. An agency registered nurse told us this practice was not safe as having one nurse to support both sections meant there was a risk the nurse could be easily distracted whilst carrying out more clinical tasks such as administering medicines. We were told two out of the seven people used a PEG system for their nutrition, fluids and medicine intake and most people living there had a diagnosis of epilepsy. A further three people used a PEG system in Orchard East. This meant the nurse supporting both sections of the home would be supporting five people with this care need along with people's medicines and other clinical needs. This may impact on the nurse's ability to manage several people's clinical health needs in a timely and responsive way. This is of particular concern because these risks had already been identified by external agencies in the months prior to our inspection and are currently under investigation. Insufficient action had been taken by the provider in response to these concerns about timely support of people's clinical needs.

On the second day of our inspection we observed how support was given to people in Orchard West. At 9.55am we found six people were sat alone in the communal lounge without staff support whilst one person was supported by both staff in the bathroom. The inspectors called out to gain the attention of the two staff yet as they were in the bathroom they were unable to hear our calls. Staff told us how the low staffing levels had impacted people's health and well-being in the past. This included how they had been unable to monitor the length of one person's epileptic seizure as no staff member had been supporting in the communal area of the home where they were at the time. This meant at the time of our inspection, the way staff were deployed increased the potential risk of harm for people living at Orchard West. Although we did not observe any service users in distress, having an acute health crisis or in harm's way at the time of our inspection, there was not sufficient staff to monitor service users in Orchard West who were known to have complex health conditions such as Epilepsy. This was of concern as allegations had been raised in the months prior to our inspection about timely assessment and response to people's health deterioration and clarity of epilepsy protocols for people. Therefore the provider had taken insufficient action to review their staff deployment across Orchard Lodge to ensure there were enough staff to monitor people's health conditions.

The area manager agreed this was not a safe way to deploy staff and told us they would increase staffing levels from two care staff to three care staff at times when people required more support. As we received numerous comments from staff including registered nurses and the home's physiotherapist regarding insufficient staffing levels we highlighted the concerns to the area manager and manager. Although the provider told us that their staffing numbers were determined by an assessment of people's dependency, we found that the staff deployment, particularly in Orchard West, had not been sufficiently planned in line with the assessed needs of people living there.

The above evidence showed that there was not always sufficient numbers of staff deployed to meet peoples assessed needs, therefore posing a risk to people's safety. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the area manager confirmed in writing that the increase of care staff in Orchard West would continue to ensure people living in that part of the service had sufficient support and supervision to keep them safe. However this is a gap in the provider and manager's quality monitoring as they failed to identify this concern about staff deployment until it was raised by the inspection team.

The provider had safeguarding adults at risk policy and procedure. They also provided staff with safeguarding adults at risk training. Staff covered the subject within their induction period and continued to receive updated training usually on an annual basis. Staff could describe to us what signs and symptoms they would look for and named various types of abuse such as physical and psychological. However, the procedures and processes in place aimed at protecting people were not robust and had failed to embed a culture where staff felt confident to take the proper action to ensure further risks were minimised and people were kept safe. Some staff we spoke with expressed their frustrations with what they considered as a lack of current support in their role. This seemed to influence why they had not taken steps to raise concerns regarding people and their care to their manager. Some staff we spoke with had knowledge gaps about their own role and responsibilities and duty of care to alert others more senior to them with anything they were concerned about which impacted people. For example, some staff were able to share incidents and situations of alleged neglect with the inspectors verbally yet had failed to fully record what had happened at the time or discuss it with their line manager.

Prior to our inspection some staff had not taken their concerns externally outside the organisation to agencies such as the West Sussex safeguarding team and/or the CQC to ensure all people at all times were

protected. One staff member told us about an incident which they had highlighted to their manager in January 2017 yet were not aware of any action taken after they had. They told us they did not escalate the incident to an outside agency such as the West Sussex safeguarding team or the CQC yet they remained concerned about what had happened. There were a total of five allegations shared by different staff members during our inspection which required further review. The allegations described to the inspectors were all involving different people living at the home. For example, one incident involved how a person's continence needs were not managed appropriately and in a timely manner. Another allegation described how a person displayed self-injurious behaviour due to a lack of staff supervision at the time. All of the allegations may have had a detrimental impact on the health or well-being of the people involved. Allegations described to the inspectors were shared with the manager and/or area manager with a request to refer them all to the West Sussex safeguarding team for their review. Since our inspection the area manager confirmed this action had been completed and the local authority confirmed receipt of these concerns.

The above evidence showed that people were not always protected from potential abuse and improper treatment. Some staff were not all aware of their individual responsibilities to prevent, identify and report abuse when providing care and treatment. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Shortly after our inspection the area manager wrote to us and told us they were holding a staff meeting they said, 'An agenda item will be to encourage and remind staff of the appropriate way to raise any concerns they may have'. However we had serious concerns about what this indicated about the leadership and culture of the service that staff either did not know how or did not feel able to raise serious concerns they had about neglect of people's needs.

Medicines were mostly managed safely by the home using an effective medicine administration system. We spoke with nurses who confidently discussed how they administered medicines to people. Nurses were knowledgeable as to the reasons why people had medicines prescribed to them, any known side effects and what to do in the event of any concerns. The recording system included a photograph of the person and information that was pertinent to them, this included any known allergies. Tablets were dispensed from blister packs and medicines administered from bottles or boxes were stored and labelled correctly. Some medicines had to be stored in a refrigerator. Staff were vigilant at recording the temperature of the refrigerator daily. We observed that the Medication Administration Record (MAR) was completed on behalf of each person by the registered nurse on duty each time someone was supported to take their medicine. This evidenced that people received their medicines as prescribed. Guidance was provided for staff when administering "When required" (PRN) medicines. A health and social care professional raised with us concerns about one person's medicines in relation to their swallowing difficulties and PRN protocols. This has been followed up with the manager of the home and actions agreed to resolve these concerns with external professional input.

There were ten people living at the home who could not manage to eat and drink and take medicines orally and had feeding tubes either (PEG) or a balloon gastrostomy tube or low profile devices. Nurses we spoke with were knowledgeable about the management of supporting people using PEG and we observed them carry out their support safely. However, on one occasion the registered nurse did not wear gloves to complete administering medicines through a PEG tube. Wearing gloves is best practice to avoid the risk of spreading infection. We fed this back to the area manager for their review. We also identified gaps within written guidance available for the nursing team to support them with PEG management. As the home regularly used agency nurses we have discussed this and the associated risks in the Well-Led section of this report.

Other aspects of risk management were being managed appropriately. This included risks associated with choking, skin integrity and malnutrition. One person required a tracheostomy and their care plan stated how often equipment should be changed, by whom and what the indications are for this to happen. There were instructions for how to raise concerns and seek support in an emergency and step by step guidance for care of the site. Tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help the person breathe. Moving and handling risk assessments were reviewed regularly and changes implemented where necessary. These risk assessments described the number of staff needed and what equipment was needed for each movement and we saw that this was being followed. These were clearly written and contained step by step instructions with photographs to aid understanding of precisely how the person needed to be supported.

We also found examples of risks being managed appropriately relating to the premises and equipment; these were monitored and checked to promote safety. For example, equipment and utilities were serviced in accordance with manufacturers' guidance to ensure they were safe to use. Gas and electric safety was reviewed by contractors to ensure any risks were identified and addressed promptly. Fire equipment such as emergency lighting, extinguishers and alarms, were tested regularly by the provider's maintenance engineer to ensure they were in good working order. Records confirmed that maintenance staff attended immediately when contacted by staff to repair damage, which may cause harm to people and others visiting the service. People were protected from environmental risks within the service such as hoist equipment, wheelchairs and legionella checks were managed effectively through prompt and regular servicing. One relative told us, "It's very safe, it's all on one level, they make sure the service users are safe".

Staff recruitment practices were robust and thorough. Staff were only able to commence employment upon the provider obtaining suitable recruitment checks which included; two satisfactory reference checks with previous employers and a current Disclosure and Barring Service (DBS) check. Staff record checks showed validation pin number for all qualified nursing staff. The pin number is a requirement which verifies a nurse's registration with the Nursing and Midwifery Council (NMC). Recruitment checks helped to ensure that suitable staff were employed.

Requires Improvement

Is the service effective?

Our findings

Relatives told us the staff team were effective and received the necessary training to enable them to carry out their role. However, during our inspection we identified gaps in training and support provided to staff. This included gaps within learning disability awareness, epilepsy and missed opportunities to provide a recent supervision session. A system of supervision and appraisal is important in monitoring staff skills and knowledge. The manager kept a list of staff who required supervision. We also checked training records. There were a significant amount of people with epilepsy living at Orchard Lodge. Epilepsy is a condition that affects the brain and causes a person to have repeated seizures. However, some staff had never completed epilepsy training and others required an updated course. We were told 79% of people living at the home had some form of epilepsy. The training plan we read did not include epilepsy training as part of the core mandatory training alongside the other ten subjects such as health & safety, fire training and safeguarding adults. We checked the list of epilepsy training completed by staff. The last course named, 'understanding epilepsy' took place in December 2015. Out of twenty-five care staff employed by the home there were twenty staff names on the attendance list. However, we were told seven of those staff were no longer employed by the service. This meant a possible twelve staff had not been trained to gain a general understanding of the subject. Eight staff had attended training on the use of emergency epilepsy medicine 'midazolam' on 20 April 2016 yet this was not a general understanding on the subject and how to support people with this health condition.

We talked with staff about the support and training they received. All staff employed by the home we spoke with held negative views due to what they considered a lack of support and low staffing levels. We have discussed our concerns with how staff were deployed in the Safe section of this report. One staff member who had been working at the home for six months had never attended epilepsy training and had not received a supervision session from their line manager since they had started. They described difficulties attending a recent health appointment with a person as they lacked knowledge about their type of epileptic seizures. They expressed their frustrations with the lack of support they had received and informed us they were leaving their employment because of this. They said, "The support here is not good, especially if you are doing care for the first time. We do a 12 hour shift I am always second guessing". Supervision records demonstrated that staff had received supervision and/or appraisals between 2016 and 2017 and that the manager was working on ensuring this was being kept up to date. However, the staff we spoke with consistently told us that they felt unsupported and did not always receive the training and support they required to deliver care to people. One member of staff told us that they felt they had not received effective face to face supervision at regular intervals to support them in their role and added, "All staff are unhappy". The provider also had no mechanisms in place to check the training histories of agency nurses who worked at the home. We have discussed the lack of governance when accessing agency nurse support further in the Well-led section of the report.

We fed back staff's views on training and the lack of support to the area manager and manager. They told us about workbooks and on line additional training opportunities on subjects such as epilepsy and learning disability which had been offered to the staff team. Yet they told us workbooks remained blank in the office and we were given no records available to state which staff may have attended online courses.

The above evidence showed that staff had not always received appropriate support and training to enable them to carry out their duties they are employed to perform. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After our inspection the clinical nurse tutor provided us with training course dates booked between July and December 2017. There was an extensive list of courses covering many topics available for care staff and nurses. This included mental health awareness, HIV, Tracheostomy, Person Centred Care Planning and moving and handling. We also noted three epilepsy courses were going to be taking place in August, October and November 2017 and were available to care staff and nurses. We read staff meeting minutes from meetings carried out in May and June 2017. They discussed topics relating to people living at the home, the introduction of the new manager and recent safeguarding concerns raised by the local authority. This meant staff had been given opportunities to come together as a team.

Consent to care and treatment was sought in line with legislation 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked that the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Care records showed how consent from people had been captured and capacity assessed thoroughly and where deemed necessary a DoLS application completed. After our inspection, the area manager confirmed 19 people had an authorised DoLS in place. They also told us any DoLS which were due to expire were reviewed accordingly and if needed an extension applied for. Training records confirmed staff had attended training in both MCA and DoLS. Staff were able to share some knowledge on the topic and provided assurances they were aware of its importance.

People were supported to have sufficient to eat, drink and maintain a balanced diet taking into account individual needs. There were allocated kitchen and domestic staff employed to prepare meals on behalf of people. Meal times were a busy period in the home and we observed staff support people to eat using a sensitive and discrete approach. All staff were aware of any specialist diets including any allergies people had and adjusted the menu accordingly. There were ten people living at the home who could not manage to eat and drink orally and had feeding tubes either (PEG) (percutaneous endoscopic gastrostomy) or a balloon gastrostomy tube or low profile devices. We observed nurses support people who received food and fluid this way with competence. A relative told us, "The food is very good". They told us a list of choices of meals were always displayed for people to see and said, "If my [named person] doesn't like it they offer an alternative. [Named person] is non-verbal but staff do understand her hand gestures". Another relative said, "The food is lovely here, I have a roast dinner on a Sunday". The manager and staff team confirmed relatives were able to join their family members at meal times for a small fee. However, a staff member told us there was a delay in people in Orchard West receiving their meals on time. They told us this was due to insufficient staffing levels and were concerned people had to wait whilst others were supported. We have written about staff deployment in the Safe section of this report.

Staff including the registered nurses completed food and fluid charts on behalf of people to monitor what people were eating and drinking. Weights were recorded and monitored on a monthly basis. Registered

nurses were able to explain what action they would take if they were concerned about a person's weight which included informing the GP and increasing their observations of the person and what they were eating. This ensured people's nutritional needs were regularly monitored for any changes.

The provider employed various health professionals to support people with specific complex needs. This included a dietician and physiotherapists. A dietician had recently visited the home and assessed people accordingly. A physiotherapist was employed by the provider to facilitate sessions to people assessed as needing support with this. They told us they were not able to achieve all planned sessions due to there being insufficient care staff to support them with this activity. They needed care staff to support them when people needed to move and transfer safely. For example, if a person was to use the hydrotherapy pool it required additional staff to use the hoists available. The physiotherapist and staff told us this meant staff would be removed from the main communal areas therefore it was safer for the sessions not to happen. We fed this back to the manager and area manager. The area manager told us the additional staff member they were introducing would be used to support the physiotherapist to enable them to operate safely and to meet people's needs.

Requires Improvement

Is the service caring?

Our findings

There were occasions where staff did not give due consideration to people's dignity and did not take all measures to protect people from risk of neglect. We observed and were told about examples where the provider had failed to deploy staff consistently or effectively to provide person-centred care to people and support their needs. This meant staff were not always able to spend the time they needed to ensure people's emotional and well-being needs were being met in a timely manner. For example, in Orchard West staff were so busy that whilst they knew people well they were not able to spend time engaging with them at key personal care times of the day. Therefore caring values were not always evident. We elaborated on these concerns in more detail in the Safe and Well-Led domains of this report.

Despite this we observed positive, caring relationships had been developed between people and staff. We observed that people looked at ease in the company of staff and were comfortable when anyone in the staff team approached them. One person told us, "It is nice living here". A relative told us, "It's a lovely home, every time I come and see [named person] the care is second to none". We asked another relative whether staff were kind and caring they responded, "Yes, absolutely". A third relative said, "Staff are very good, very caring, I don't think I've got anything bad to say".

We observed numerous occasions of positive support provided by staff to people. Staff bent down to address people who used wheelchairs so they were at their own eye level and maintained good eye contact throughout their conversation. Staff spoke with people calmly and warmly and ensured they had everything they needed. We observed how staff interacted with people during an activities craft session. People appeared engaged and enjoyed the interaction and conversation throughout. Staff also promoted a positive atmosphere throughout meal times, laughter and appropriate 'banter' was heard throughout lifting the mood for people living in the home.

People were encouraged to express their views and actively encouraged people to be involved in making decisions about their care as much as they were able. Resident meetings and care plan reviews gave people and their relative's opportunities to discuss what was important to them. Care plan reviews took place once a year or sooner if a person's need changed. The person, their family representative and the relevant health and social care professionals were invited and attended care reviews. One person told us they enjoyed the chance to speak at their review and said, "Yes I go to reviews. My mum and dad come". A relative told us, "[Named person] has a care plan; it is reviewed and discussed every six months". Another relative told us, "Haven't had a review this year, usually we have one each year".

People were encouraged to be as independent as possible by the staff. One relative told us, "We see staff give encouragement, they do the right things". Staff described how they would enable people to take part in their own personal care, enabled them to make choices and decisions about what they wore each day, how they wanted to spend their day, what time they wanted to get up and what time they wanted to go to bed.

People were treated with dignity and respect. Staff were observed knocking on people's bedroom doors. We observed one staff member knock on a person's door and say, "Can I come in?" and waited for a response

before they entered. Staff continually were overheard saying to people, "Would you like another drink?", "Are you ok?" and "Are you comfortable sat like that?" This meant staff considered people how people were feeling and intervened when they felt they may require additional support. On one occasion one staff member was called upon for support elsewhere. As they were in the middle of supporting a person with their meal they requested another staff member to take over from them. Before the second person started to provide support with the meal they checked with the person to see if they were happy with them supporting them. This meant they had realised the change may alarm the person and used a compassionate approach.

Staff talked to people whilst they were supporting them so they gained their consent and people knew what was happening. All staff members we spoke with told us how they would draw people's curtains before supporting them with personal care. A relative told us, "Definitely treat [named person] with dignity and respect". Another relative said, "The staff always close the curtains when they change [named person], it's done properly I would say, gives [named person] their privacy". They explained how their family member sometimes chose not to eat their meal and how sensitive the staff were with them and said, "They (staff) persevere with [named person]."

Good

Is the service responsive?

Our findings

People lived in a home where staff were responsive to their individual needs. We observed people receiving personalised care. A relative told us, "In seven years of my [named person] being at Orchard Lodge there has never been cause to complain". We observed people were happy with the care they received; care records demonstrated they were created to meet the needs of each individual. Bedrooms were personalised to suit people's preferences and photographs of people living at the home were displayed taking part in various activities throughout the communal areas. Signs outside people's bedrooms doors displayed a decorated name and photograph of the person. This promoted and added to a homely environment. Staff demonstrated they had a good understanding of people's personal histories and what they liked and disliked. One person told us, "My bedroom is a pinky colour, I chose the pinky colour and I have photos on my wall". A relative told us they were pleased with the care their family member received described how well staff knew them. They added, "My [named person] loves their room, we are able to take her out anytime".

Each person had a care record which included a care plan, risk assessments and other information relevant to the person they had been written about. Care plans were reviewed monthly by registered nurses and included information provided at the point of assessment to present day needs. Mostly, care plans provided staff with detailed guidance on how to manage people's physical health and/or emotional needs, their goals and their aspirations. This included guidance on areas such as communication needs, continence needs, mobility needs and specific health information such as if the person had a diagnosis of epilepsy. For example, one person had epilepsy and presented with behaviours which may, if you did not know the person, be identified as 'challenging'. Therefore, the care plan provided details on how the person presented whilst having an epileptic seizure and how staff should respond accordingly. Pictorial images were used throughout care plans to enable them to be more accessible for the individual they concerned. Care plans also wrote about significant people in their lives, places they liked to visit and whether the person may have a religious belief or another passion or hobby. They also included a 'how I like to look document' about how the person wanted to be seen by others such as how they liked their hair styled and what they liked to wear.

In addition, all people who required one had a communication passport attached to their wheelchair to ensure staff and other relevant persons were provided with a clear message about how the person communicated. Care staff told us they found care plans easy to read and follow and effective working tools. However, we identified some gaps surrounding specific clinical guidance for nurses to refer to in relation to PEG management which we have discussed further in the Well-led section of this report.

Daily records were also completed about people by care staff and nurses during and at the end of their shift. This included information on how a person had spent their day, what kind of mood they were in and any other health monitoring checks. These daily records were referred to when staff handed over information to other staff when changing shifts to ensure any changes were communicated.

People were provided with stimulation and were offered various group activities to be involved in at the home. This included arts and crafts, various games, music session, sensory sessions and various outings. Outings away from the building included trips to Longleat country park, horse-riding sessions, shopping and

lunches out. At the time of our inspection, we observed people throughout the home were encouraged to be engaged in various activities. At the time of our inspection the focus for all were preparations for the garden party which was going to be taking place on Sunday 16 July. Staff and relatives spoke with us about the annual garden party. One relative told us the food at the garden party was, "Excellent". Another relative described to us how their family member spent their time and said, "[Named person] goes out twice a week, day trips to a museum or garden centre. He is out daily on a trike and goes on an exercise bike; we encourage him to be active". Another relative told us, "[Named person] goes to day centre twice a week". A third relative told us, "They celebrate bonfire night, Halloween, Valentine's day and they do their rooms up around Christmas and Easter". Photographs displayed around the home showed people dressed up in various attire and fancy dress costumes.

Complaints were looked into and responded to in a good time. There was an accessible complaints policy in place available for both people living at the home and their relatives. There was a clear log of all complaints and the actions taken by the management team. There were no formal complaints open at the time of our inspection. One relative said, "I've had no reason to complain", they added, "If I had a reason to complain I would see the home manager".

Inadequate

Is the service well-led?

Our findings

At the time of our inspection a manager was in post who was also was a registered nurse. There were five registered nurses covering shifts within the home, two of the nurses were bank staff. Two nurses were on shift over a 24 hour period seven days a week. The provider was also in the process of recruiting a further two nurses to join the team. We were told the home used four different nursing agencies to supply nurses to cover gaps within shifts. The area manager and manager told us they aimed to have consistency and aimed to use the same nurses. However, no routine checks were carried out to assess whether each nurse attending the home had current training in key subjects such as epilepsy, learning disabilities and PEG management. Nurses were booked by the administrator, nurses and on occasions the manager. There was no monitoring carried out by management whether the nurses had the necessary skills and training prior to them attending the home. We were unable to confirm the exact amount of agency nurses used at Orchard Lodge. However, we were told and rotas confirmed agency nurses were used routinely throughout the week since May 2017. We sampled some training and experience profiles for agency nurses. For example, one profile of a nurse showed they had updated training in health & safety and safeguarding yet they had not completed epilepsy, learning disabilities and PEG management training. We spoke with one agency nurse who appeared confident in her work and told us they had received an induction from the home. However, they also told us they had not undertaken any epilepsy training. This lack of oversight from the provider meant there was a risk people may not have received care and support from nurses who have the correct experience and skills. People living at Orchard Lodge had complex physical health and learning needs who required nurses to have training and experience in key areas to ensure they receive the correct care and treatment.

Nurses provided care for ten people who used various PEG systems for receiving nutrition, hydration and medicines. However, we found a lack of specific written guidance available for nurses surrounding PEG management. For example, a nurse we spoke with told us one person received routine checks on their PEG tube and their care record provided a prompt to remind nurses to do so. However, the care plan did not give guidance on how PEG tubes need to be advanced and rotated. This practice is the pushing in and rotating of the tube to help prevent further health complications such as part of the tube, getting stuck. This can be carried out daily or weekly. In addition, some people used Balloon Gastrostomy tubes (BGT) for nutrition, hydration and medicines. These are enteral feeding tubes which are retained in the stomach with a balloon filled with a measured amount of water. When tubes are changed or fall out there is a procedure to be followed to ensure the safety for the person and effectiveness of the device. Care plans did not include step by step guidance of how to carry out the necessary checks prior to a new BGT being fitted. This lack of guidance within care plans, posed an increased level of risk due to the amount of agency nurses working at the home and the lack of monitoring of their skills and abilities by the management team. We also identified one person had no records in place to state they had their routine PEG care for a period of eight weeks in 2017. We checked to see if the person was absent from the home in this time, they were not. We fed back this information to the area manager for them to identify why this was. Although nurses confirmed care was provided routinely to them there was no documentation in place to confirm this. Therefore, it was not possible to confirm how and when this routine PEG care was provided to the person. The lack of records and monitoring of this necessary PEG care meant there was potential for risk to a person's health, relating to

their PEG management.

Since our inspection the provider has sent us a separate PEG policy document and recently developed best practice guidance on changing a BGT. However, at the time of our inspection specific personalised guidance was not available within people's care records we read. Therefore this has not addressed all of the gaps we identified at the time.

When BGT's are changed or fall out various checks are required to be made before another is fitted. This should be completed by a nurse who is trained and assessed as competent to undertake this procedure. Part of the checks made is to gain a PH level of gastric contents pre and post insertion of a new tube into the person. (PH is a figure expressing the acidity or alkalinity of a solution, in this case gastric contents). The manager showed us this was being carried out when required and a record of this was kept in the nurses notes. They also provided us with a new form which was about to be implemented within the home which would be easier to follow and monitor to ensure safe PH levels were maintained consistently over a period of time. However, there was no step by step written guidance readily available in people's care plans for nurses to refer to when carrying out this procedure. The gap in information we identified, may pose a potential risk for people's safety. This was a further increased risk as agency nurses were being used on a regular basis without their training in this area being checked by the management team.

During our inspection we spoke with many staff and received numerous negative comments about how they felt about their job role. This was mostly dominated by their dissatisfaction with staffing levels and the lack of support they received from the current manager. Whilst we observed only positive and caring interactions between staff and people they (staff) were dissatisfied in their work. They described a culture which lacked the support and resources to enable them to carry out their role and responsibilities. Most staff talked of looking elsewhere for employment or were already leaving. Staff told us they were concerned about the people living at the home due to staffing levels and the impact this had on people. Both the area manager and manager told us they were unaware staff held negative views regarding their work. After our inspection they told us they had booked a staff meeting for 17 July 2017 to discuss all the concerns highlighted.

Staff also told us they were frustrated the home's hydrotherapy pool had not been working for a significant period and they had not been told when it would be fixed. Some people living at the home regularly used the home's hydrotherapy pool. We were told by the manager the hydrotherapy pool had been unable to be used for three weeks. We were told this was due to a tiling issue. The manager or area manager could not tell us why it had been unfit for purpose for that length of time. There were no records available to state whether it had been explained to people or their representatives including relatives as to why they had not been able to access it. The area manager told us it was going to be fixed and ready to use by Monday 10 July 2017.

Systems to assess and monitor the service were in place but these were not sufficiently robust as they had not ensured a delivery of consistent high care across the service or pro-actively identified all the issues we found during the inspection. For example, the area manager visited the home on a regular basis throughout the month. During these visits they spoke with staff and people and sampled records relating to people's care and the management of the home. They would then complete a document accordingly of any areas which required improvement and present this to the manager of the home. This process had failed to highlight issues we found with staff deployment, gaps in training, monitoring of agency nurse skills and a lack of reporting potential safeguarding incidents. This lack of governance over the areas highlighted during and after our inspection potentially placed people living at the home at risk from harm and required improvement.

The above evidence shows that there were inadequate systems or processes in place that operated effectively to ensure compliance with requirements. There was a failure to assess and monitor and to improve the quality and safety of the services provided. There was a failure to assess, monitor and mitigate the risks relating to health, safety and welfare of service users. There was a failure to maintain securely an accurate and cotemporaneous record in respect of each service user. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with both the area manager and manager throughout our inspection who expressed their concern regarding the areas we identified as requiring improvement. They were aware of the importance of continuing to notify the Commission of certain events and incidents within the home such as potential safeguarding incidents, deaths and other important incidents to comply with the provider's registration requirements. This is important so we have an awareness and oversight of these to ensure that appropriate actions are being taken on behalf of people living at the home. They both explained that they had been under an increasing amount of pressure due to concerns raised by the local authority safeguarding and health teams yet were clear and confident they knew how to make these improvements. The area manager wrote to us after our inspection telling us about the immediate actions they had taken to reduce any further risks to people. This included the introduction of additional staffing, planned training in key topics and how they would be discussing with all staff safeguarding adult's procedures.

The feedback we received directly from relatives was mostly positive. One relative shared how open they found the management team and said, "There were some issues here and they took every parent aside to tell them what was happening and we got a letter". Another relative said, "They are brilliant, they (staff) really take pride in what they are doing". A third relative said, "The management is very good they are very approachable". However, one relative did say she had asked the manager, "To put the heart back into the place". They described how the service had changed and they didn't always feel like they were informed about what their family member was doing as much as they would have liked. We checked how the provider gained people and relatives views of the quality of care provided. These were routinely sent out from the providers head office on a monthly basis. The ones we read were all positive. One relative wrote, 'Sussex healthcare are second to none'.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from potential abuse and improper treatment. Some staff were not all aware of their individual responsibilities to prevent, identify and report abuse when providing care and treatment.

The enforcement action we took:

Impose a condition on the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There were inadequate systems or processes in place that operated effectively to ensure compliance with requirements. There was a failure to assess and monitor and to improve the quality and safety of the services provided. There was a failure to assess, monitor and mitigate the risks relating to health, safety and welfare of service users. There was a failure to maintain securely an accurate and cotemporaneous record in respect of each service user.

The enforcement action we took:

Impose a condition on the provider

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 There were not always sufficient numbers of staff deployed. Staff had not always received appropriate support and training to enable them to carry out their duties they are employed to perform

The enforcement action we took:

Impose a condition on the provider