Flightcare Limited

Orchard Residential

Inspection report

St. Mary's Road
Huyton
Liverpool
Merseyside
L36 5UY

Tel: 01514806056
Website: www.flightcare.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Orchard Residential is a 'care home' providing accommodation, nursing and / or personal care for up to 26 older adults; some of whom lived with dementia. At the time of the inspection 24 people were living at the home.

People's experience of using this service and what we found
People were not receiving a safe level of care and areas of risk were not robustly monitored, reviewed or safely managed. Care records did not always contain the most relevant information or guidance that staff needed to follow, and people were exposed to unnecessary risk. One staff member told us, "Residents are not provided with a good or safe level of care."

Unsafe medication practices were identified. Medicines were not safely stored as temperatures were not regularly monitored, controlled drugs were not always signed out by two members of staff and PRN (as and when required medicines) protocols were not in place for all residents living at the home.

Infection prevention and control (IPC) measures and arrangements were not embedded and we were not assured that people were protected from harm. Staff were not routinely engaged in a COVID-19 testing regime, enhanced cleaning regimes were not in place and regular COVID-19 symptom checks were not being carried out.

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

Sufficient numbers of suitably qualified, competent, skilled or experienced staff were not deployed across the home. There was no systematic approach to determine the numbers of staff needed in relation to the dependency needs of people living at the home. Staff were not supported with the necessary training, learning or development opportunities.

Recruitment of 'fit and proper' staff could not always be assured. There was evidence to suggest that the provider did not have robust recruitment procedures in place, or the relevant recruitment checks were being carried out.

Inadequate quality assurance and governance measures meant that the provision of care people received was compromised. Quality performance measures were not effectively in place, areas of risk were not safely managed, and regulatory requirements were not complied with.

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

Rating at last inspection and update
The last rating for this service was 'good' (published 20 December 2020).

Why we inspected
We carried out an unannounced inspection to follow up on concerns we had received in relation to the provision of care that was being delivered. The information The Care Quality Commission (CQC) received indicated that there were concerns around IPC, staffing, safe care and treatment and good governance. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We looked at IPC measures under the 'safe' key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

The overall rating for the service has deteriorated to 'inadequate'. This is based on the findings at this inspection. We found evidence that the provider needs to make improvements.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified breaches in relation to safe care and treatment, staffing, fit and proper persons employed and good governance. Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following the publication of this report to discuss how they will make changes to ensure they improve their rating to at least 'good', we will request an action plan to understand what they will do to improve the standards of quality and safety and we will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore 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 take action 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Orchard Residential

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection prevention and control measures in place. This was conducted so we could understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors, and one 'Expert by Experience'. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service did not have a manager registered with the Care Quality Commission at the time of the inspection. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. A manager had been recruited and a start date had been confirmed.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We also sought feedback from the local authority who work with the service. We used the information the provider sent us in

the provider information return prior to this inspection. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. We used all of the information we received to plan our inspection and formulate a 'planning tool'.

During the inspection
We spoke with the interim manager, one deputy manager, one regional manager, six members of staff and nine relatives about their experiences of care their loved ones received.

We reviewed a range of records including four people's care records, multiple medication administration records, and four staff personnel files in relation to recruitment. We also reviewed a variety of records relating to the management and governance of the service, including policies and procedures.

After the inspection
We continued to review evidence that was sent remotely as well as seeking clarification from the provider to validate evidence found. We looked at audit and governance data, as well as infection prevention and control policies and procedures. We also informed the local authority of the concerns and areas of risk we identified.

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 'good'. At this inspection this key question has deteriorated to 'inadequate'. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Inadequate safety monitoring measures and management of risk was identified; people were exposed to unnecessary risk and their safety was compromised.
- Care records contained inconsistent information and areas of risk were not monitored. For instance, one person who was at risk of falls did not have a falls risk assessment completed on the day of admission and monthly falls reviews were not taking place.
- There were systems and processes in place to manage and mitigate risk, but these were not being completed by staff. For instance, weight charts, repositioning charts and oxygen saturation checks were not being routinely completed.
- Environmental health and safety checks were not always being completed. For instance, water temperature checks, window restrictor checks and sensor checks were not being completed on a weekly basis.
- Regulatory compliance assessments and certificates were in place. However, the fire risk assessment which was completed in January 2021 identified a number of remedial actions; these remedial actions had still not been rectified at the time of the inspection. For instance, combustible materials found in a sluice room and fire doors were not always shut.

The provider failed to ensure safe care and treatment was delivered; people were exposed to harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- Inadequate IPC arrangements and procedures were in place
- The internal and external environment was poorly maintained. We found dirty vents and bathtubs, dusty shelving, cobwebs in communal toilet facilities and discarded cigarettes in the entrance walkway.
- Routine cleaning schedules and enhanced cleaning regimes were not being completed; there was no oversight in relation to the completion of these and routine IPC audits were not identifying concerns raised.
- Staff and agency staff were not completing weekly routine COVID-19 tests and signs and symptoms were not always being monitored. For instance, twice daily temperature checks were not being conducted on people living at the home.

The provider failed to ensure safe systems and measures were in place to protect them from harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed staff wearing the appropriate PPE and was also informed supplies of PPE were always sourced and stocked.

Using medicines safely
● Unsafe Medicine procedure and practices were identified at the service.
● People were not always receiving support with their medicines by trained members of staff and competency checks were not being conducted.
● Medication policies were not always complied with. For instance, medicine temperatures were not regularly monitored and when they were, they were not always in range, controlled drugs were not always countersigned by two members of staff and 'as and when' (PRN) protocols were not always in place.
● Medication administration records (MARs) did not always contain the medications that should have been administered and MAR stock balance checks were not always accurate.
● We found no evidence that routine medication audits were taking place as a way of establishing safe practice.

The provider failed to ensure safe medication practices were in place. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Unsafe recruitment procedures, high turnover of staff and high agency usage meant that the quality and safety of care was compromised.
● Staff were not always safely recruited into their positions. Suitable references were not always obtained, employment histories were not always provided, and application forms were not always thoroughly completed.
● Disclosure and Barring Service (DBS) checks were completed. However, the adults barred list was not always checked, and risk assessments were not always completed when convictions had been recorded.
● Staff expressed that there was a lot of agency staff supporting the service who are not familiar with people's care needs. Relatives also told us, "I think there are lots of agency staff" and "the atmosphere is cold now, staff are breaking down in tears and leaving."
● Staff also told us, "Staffing levels are poor", "It's been terrible and unsafe" and "The past five months (the home) has run on agency staff."

The provider failed to ensure robust recruitment procedures were in place. This was a breach of regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong.
● Systems and processes to safeguard people from the risk of abuse were in place. However, we identified that only 50% of staff had completed safeguarding training.
● We saw evidence of accident / incident reports as well as internal investigations taking place. However, it was not always clear if lessons were learnt or if improvements were taking place.
● Staff explained how they would raise their concerns and the importance of protecting people from harm.

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 'good.' 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.

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.

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 authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Principles of the MCA (2005) were not always complied with.
- The correct measures and procedures were not always put place to ensure people received the expected level of care in the least restrictive way possible.
- Care records did not always contain the relevant level of information in relation to people's capacity to consent or best interest decisions that had been agreed.

The provider failed to ensure they were complying with the MCA (2005) principles. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Staff were not effectively inducted into their roles; they did not receive the necessary training or development opportunities and were not supported on a day to day basis.
- The provider did not have a systematic approach to determine the number of staff or the range of skills required to meet the needs of people living at the home.
- Staff training statistics were poor; staff were not receiving the required level of training to equip them with the necessary skills. For example, one staff member who began working at the home towards the end of 2020, had completed 0% of their required training.
- Staff expressed that they felt unsupported, undervalued and never had their concerns or suggestions listened or responded to. One staff member said, "I've raised my concerns but I'm just not listened to."

● The provider utilised a high percentage of agency staff; agency staff were not familiar with people they were supporting or provided with the correct level of guidance when working at the home.

The provider failed to ensure suitable numbers of trained, competent or experienced member of staff were deployed. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs, and choices were not always assessed and delivered in line with standards, guidance and law.
● People did not always receive the tailored level of care that should have been centred around their assessed needs, choices and decisions.
● It was not clear if people were empowered to make decisions or encouraged to involve themselves in the day to day delivery of care.

Supporting people to eat and drink enough to maintain a balanced diet
● Nutrition and hydration support needs were assessed however it was not always clear from the records we reviewed if people received the required level of support.
● People's care records did not always contain relevant or up to date nutrition and hydration information and areas of risk were not always monitored. For example, clinical charts to establish nutrition / hydration risks were not always completed.
● People were not always supported to make decisions around their meal preferences. We received feedback to suggest that people's meal suggestions were not sought, and alternative options were not always accommodated when requested.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● We received minimal assurances that people received consistent, effective or timely care.
● Agency staff in particular were not familiar with people's support needs; we were not always assured that areas of concern or risk would be responded to in a timely manner.
● Care records did not always contain the most up to date or relevant guidance that staff needed to follow. It was not always clear if care was being provided in the manner that it should or if risks were being appropriately responded to.

Adapting service, design, decoration to meet people's needs
● Service design, adaptation and decoration did not always meet people's needs.
● Orchard residential was not inviting or welcoming; bedrooms were individually decorated to meet individual tastes. However, the communal and social areas looked tired, unkempt and not very well maintained.

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 'good'. At this inspection this key question has deteriorated to 'inadequate'. 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

- The home did not have a registered manager at the time of the inspection, staff were not clear about their roles and were not receiving any managerial support. Quality performance measures and management of risk was not effectively in place and regulatory compliance was not met.
- Inadequate governance and quality assurance measures meant that people were exposed to unnecessary risk and avoidable harm. The provider was not assessing, monitoring and / or mitigating risk relating to the health, and well-being of the people living at the home.
- Multiple breaches of regulation meant that the provider was not clear about their role and regulatory responsibilities and was unable to demonstrate their compliance with the fundamental standards.
- Governance and monitoring systems failed to identify shortfalls. The quality and safety of care was not effectively monitored, areas of improvement were not effectively identified, remedial actions were not responded to in a timely manner and it was unclear if lessons learnt were acknowledged.
- The lack of visible managerial presence and oversight within the home meant that the quality and safety of care was compromised, and the expected standard of care had deteriorated.

The provider failed to ensure there were effective governance and quality assurance measures in place. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the provider submitted a number of action plans to demonstrate how they were mitigating risk and protecting people from harm.

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

- We were not always assured that a positive, person-centred, inclusive approach to care was being achieved.
- Areas of risk were not being monitored and health and well-being of people living at the home was not routinely assessed.
- People were not always receiving a tailored level of care that was centred around their support needs; conflicting, inconsistent and misleading care record information meant that people were potentially receiving care that was no longer relevant.

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

● The home was not always including people, staff and the public in the quality and safety of care being delivered.

● Methods of communication between managers, staff, people and relatives was poor. Relatives told us, "Communication is the major issue" and "They [staff] don't communicate with us at all,"

● Staff told us they felt unsupported and under-valued by the provider and never had their concerns listened to. Staff told us, "We ask for help and support; we don't get any. It's an awful environment" and "Management and support is very, very poor."

● There was no routine process in place to capture feedback or suggestions about the provision of care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong.

● Relatives confirmed that there was correspondence from staff if their loved ones had been involved in an accident or incident.

Working in partnership with others

● The home worked in partnership with other external agencies and professionals.

● People received care and support from external professionals such as speech and language therapists, dieticians, district nurses and local GP's when requested.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure principles of the Mental Capacity Act 2005 were suitable followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure that robust recruitment procedures were in place; the appropriate pre-employment recruitment checks were not sufficiently being carried out.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff were appropriately trained, provided with development opportunities or appropriately supported in their roles. The provider failed to ensure they deployed enough suitably experienced staff across the home.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure people were receiving safe care and treatment. Risks were not effectively mitigated, unsafe medicine practices were found and IPC measures were not effectively embedded.

The enforcement action we took:

Warning Notice has been issues

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure there were effective quality assurance measures in place. There was a lack of oversight, lack of leadership and ineffective systems and processes to monitor and assess the provision of care being delivered.

The enforcement action we took:

Warning notice has been issued