Dharma Limited

Orchard Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

We undertook a focused inspection on 28 May, 03 and 04 June 2015 to assess whether the provider had made improvements to meet requirements of the regulations. The provider had sent the Care Quality Commission an action plan to say what they would do in order to meet the regulations the home was in breach of. We wanted to check if the provider had followed their plan and to confirm that they now met legal requirements.

We carried out an unannounced comprehensive inspection of this service on 27 November 2014. During this inspection, we found multiple breaches of legal requirements. As part of our findings we issued seven warning notices in relation to people's consent to care and treatment; their care and welfare; the assessment and monitoring of the quality of service provision; cleanliness and infection control; management of medicines; maintenance of safe and suitable premises; and the staffing levels the provider had in place. We additionally found concerns with how the provider safeguarded service users from abuse; met their nutritional needs; respected and involved service users; managed complaints; and supported staff.

Summary of findings

This report only covers our findings in relation to the latest inspection. You can read the report from our last inspection in November 2014, by selecting the 'all reports' link for Orchard Lodge Care Home on our website at: www.cqc.org.uk.

Orchard Lodge provides care and support for a maximum of 44 older people, some of whom may have physical disabilities or sensory impairment. At the time of our inspection in May and June 2015, there were 24 people who lived at the home. Orchard Lodge is situated in a residential area of Blackpool. It offers single and shared accommodation over two floors. Garden areas to the front and rear are accessible for wheelchair users via a ramp. Communal space is accommodated in three lounges and a dining room.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection in May and June 2015, we found that the provider had failed to meet the requirements of the warning notices. Additionally, the provider had not undertaken all of the actions on their plan, which they had told us would be completed by the 30 April 2015.

We observed poor practices in relation to the maintenance of people's safety when being supported. Individuals were not consistently given clear explanation of support that was provided and were supported by staff who were not always trained to do so.

We have made a recommendation about policies and procedures in relation to safeguarding people against abuse and whistleblowing.

We found multiple breaches of people's environmental safety. There was no indication as to how the provider had managed people's safety when accessing the main staircase. The provider had removed the stair gate without putting in place any protective alternative for people's safety. Not all window restrictors or door closures were present and they did not consistently offer ample protection for people's safety. The provider had continued to fail to ensure accidents and incidents were properly managed, analysed and monitored to ensure the risk of their reoccurrence was minimised.

Fire, kitchen and equipment safety was poorly maintained. For example, boiling pans in the kitchen were not being continuously monitored even though people who lived at the home entered this area. Health and safety risk assessments were poor and did not always protect individuals who lived at the home. The provider had failed to ensure risk assessments were in people's care records to manage the risk to them of receiving unsafe care.

We found multiple concerns with the maintenance of infection control and cleanliness at orchard Lodge. Staff had no awareness of the Code of practice in relation to Healthcare Associated Infection and the new infection control audit had not picked up concerns we found. Additionally, the medication audit had not been carried out monthly as indicated on records held by the home. Although we observed medication was administered safely there were periods during the week when there were no staff on duty who were appropriately trained in medicines. This meant the provider had continued to fail to ensure people who received medicines were continuously monitored or had support should they need it.

We noted there continued to be periods during the week when there were inadequate numbers and skill mixes of staff on duty to provide care. Comments received, our observations and checks of records confirmed staffing levels were not sufficient to meet people's needs in a timely manner.

We have made a recommendation about the provider seeking evidence-based, best practice guidance related to the assessment of staffing levels.

We noted staff did not promote lunchtime as a social occasion. We observed poor practices in relation to staff assistance to help people to eat their meal. For example, staff did not always engage with people, explain what they were doing or seek consent to carry out support. One staff member who provided support did not have training to do so. Associated care records were poor and

Summary of findings

had missing information. For example, there were no nutritional risk assessments. People who had lost weight were not always monitored or managed effectively to prevent the risks of malnutrition.

The provider had implemented a range of staff training and guidance since our last inspection in November 2014. However, we found domestic staff, who undertook care duties, had limited training and two other staff provided care without any training at all.

The provider continued to fail to work within the Mental Capacity Act. We observed incidences where people were deprived of their liberty without authorisation. There was no documentation that best interests, consent, risk assessment and mental capacity assessments had been undertaken in relation to deprivation of liberty or the continued use of bedrails. Recorded consent to care was not always evident.

We have made a recommendation about the effective provision of a dementia-friendly environment.

Throughout our observations, we observed poor practices from staff when they supported people. We noted staff interactions were poor and they did not demonstrate a caring attitude. Staff failed to promote people's dignity or show respect to individuals. People's recorded preferences were not always updated or were missing from care files. Care records did not always evidence that individuals or their representatives had been involved in their care planning and assessment.

The provider had ensured people's confidential information was stored securely following our last inspection in November 2014. However, we found people's privacy and their dignity was not always maintained. For example, the provider had failed to ensure a lock was in place on the first floor shower that was in use.

People were not protected against inappropriate care because the management team had failed to maintain up-to-date, suitable records that met people's planned needs. For example, care files were not always regularly reviewed, signed and dated by staff. Not all care plans were in-depth to ensure staff were given guidance that enabled them to respond to people's requirements.

The registered manager had continued to fail to provide up-to-date information to assist people to make a complaint if they chose to. Details on display for individuals who lived at the home and their representatives had not been changed following concerns we identified at our comprehensive inspection. There were three policies in place that were conflicting and did not adequately guide people and staff about the relevant procedures.

New policies had been introduced that followed national guidance and legislation. However, not all procedures were in-depth and there were two sets of policies in place. This meant the provider had not adequately and clearly guided staff in their roles and responsibilities.

Staff told us they felt management support had improved in the last two weeks since the introduction of a new management team. Quality audits had been introduced since our last inspection in November 2014. However, these did not pick up issues we identified with infection control, medication, environmental safety, nutrition, kitchen safety and care records.

Staff, visitors, people and their representatives had limited opportunity to feedback about the quality of the service. This included the opportunity to reflect upon improvements and the provider's action plan since our last inspection in November 2014.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of

Summary of findings

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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

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.

People told us they felt safe whilst living at the home. However, we observed poor practices in relation to the maintenance of people's safety when being supported. Care records did not contain risk assessments.

Staffing levels were insufficient to meet people's needs in a timely manner. Not all staff who provided care were trained to do so and skill mixes were not always safe. There were periods during the week when people who received medicines were not continuously monitored by appropriately trained staff.

There was a risk to people of harm or injury from a poorly maintained environment. Environmental risk assessments were deficient and accident/ incident management was inadequate. Infection control measures failed to protect people from the risk of infection and we found there were multiple areas of the home that were dirty.

Is the service effective?

Inadequate

The service was not effective.

We observed one staff member supported people with their nutritional needs without any training to do so. We further observed two untrained staff supported people with their care.

The provider had continued to fail to ensure the management team and staff worked, where appropriate, under the principals of the MCA. We saw incidences of people being deprived of their liberty without authorisation.

People were not always supported to maintain their nutritional needs and we observed poor practices in how staff assisted individuals with their meals. Associated care records were poorly maintained and had gaps in information. Where there were changes in individuals' weight, these were not always monitored and responded to effectively.

Is the service caring?

Inadequate

The service was not caring.

Throughout our observations, we observed poor practices from staff when they supported people. We noted staff interactions were poor and they did not demonstrate a caring attitude. Staff failed to promote people's dignity or show respect to individuals.

Staff did not always check how people wanted to be supported or explain the assistance they were carrying out. They did not always check if individuals agreed to support before undertaking personal care.

Summary of findings

Recorded preferences had not always been updated or were missing from care records. Not all care files evidenced that people or their representatives had been involved in their care planning.

People's privacy, dignity and confidential information was not maintained at all times.

Is the service responsive?

Requires improvement

The service was not always responsive.

Care records were not always regularly updated, signed and dated by staff. Care plans were limited and did not always adequately guide staff to enable them to respond to people's requirements.

There were three complaints policies in place that were conflicting and did not fully guide staff and people to make a complaint. The provider had failed to ensure information made available to people who lived at the home and their representatives was up-to-date.

Is the service well-led?

Requires improvement

The service was not always well-led.

Staff, visitors, people and their representatives had limited opportunity to feedback about the quality of the service.

Policies in place were not always in-depth and clear to assist staff in their roles. For example, there were two sets of policies in place.

New quality audits in place did not pick up issues we identified with infection control, medication, environmental safety, nutrition, kitchen safety and care records.

Orchard Lodge Care Home

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.

We undertook this inspection of Orchard Lodge Care Home on 28 May, 03 and 04 June 2015 to check that the provider had met the requirements of the warning notices we had issued at our last inspection on 27 November 2014. We additionally assessed that improvements to meet legal requirements planned by the provider after our last inspection in November 2014 had been made. We inspected the service against all of the five questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection team consisted of two adult social care inspectors; an inspection manager; and a specialist professional advisor. The special advisor was a social worker with experience of older people and people living with dementia.

Prior to this inspection in May and June 2015, we reviewed the information we held about Orchard Lodge. This included notifications we had received from the provider, about incidents that affect the health, safety and welfare of people who lived at the home. We checked safeguarding alerts, comments and concerns received about the home. At the time of our inspection, the provider was working with the Local Authority's investigation into ongoing safeguarding concerns.

We spoke with a range of people about this service to gain an overview of what people experienced whilst living at the home. They included the management team, seven staff members, three people who lived at the home, three relatives and two visiting healthcare professionals. We also spoke with the commissioning department at the local authority who told us they were closely monitoring the service to check improvements were being made to the safe care and welfare of people who lived at the home. The commissioning department had placed an embargo upon the home to prevent further admissions from within the local authority until improvements had been made and were sustained by the provider.

We also spent time observing staff interactions with people who lived at the home and looked at records. During our inspection we used a method called Short Observational Framework for Inspection (SOFI). This involved observing staff interactions with people in their care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We checked seven people's care records. We also reviewed documents about staff training and support, as well as those related to the management and safety of the home.

Inadequate

Is the service safe?

Our findings

At our last inspection in November 2014, we found that suitable arrangements were not in place to protect people against the risks of abuse and unsafe care. The registered manager had not always ensured care practices and associated records kept people safe. The registered manager had failed to protect people from excessive and unauthorised restraint.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We requested that the registered manager completed an action plan to address the concerns.

During the last inspection in November 2014, we further noted people were not being protected against the risks associated with unsafe or unsuitable premises. Accident and incident management was poor. We found multiple concerns with environmental health and safety, fire safety and premises security.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice in relation to our findings.

Additionally, at our last inspection in November 2014 we observed that people were not being protected against identifiable risks of acquiring an infection. We found infection control record-keeping was poor and cleaning schedules were not in place. Related staff training was poor. We found multiple areas of the home were dirty and observed poor hygiene and food safety practices.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice in relation to our findings.

Further findings at our last inspection in November 2014 included concerns that people were not safeguarded against the risks of receiving inappropriate or unsafe care. This was because there were limited or no risk assessment records in place.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice in relation to our findings.

During the last inspection in November 2014, we also noted there were not, at all times, sufficient numbers of staff to meet people's needs in a timely manner. People and staff told us staffing levels were insufficient. People who received medication were not continuously monitored because there were insufficient numbers of skilled staff.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice in relation to our findings.

Additionally, at our last inspection in November 2014 we found people were not being protected against the risks associated with the unsafe use and management of medicines. There were not enough staff trained to administer medication. Staff were not kept up-to-date with current information and did not always follow record-keeping guidelines. Staff did not always follow instructions to ensure people were safe and did not concentrate on one person at a time when administering medication.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice in relation to our findings.

We requested the provider send us an action plan to outline actions they would take to improve the service and ensure it met requirements of the regulations and the warning notices we issued. The provider sent us their action plan on 20 April 2015, which stated the service would meet requirements of the regulations by 30 April 2015. At our inspection in May and June 2015, we found that the provider had not completed their action plan to make improvements to meet requirements of the regulations, despite telling us they had. Nor had the provider met all the requirements of the warning notices we issued.

Inadequate

Is the service safe?

People and their relatives told us they felt safe whilst living at Orchard Lodge. One person said, "My life is here, I'm safe." On discussing people's safety a relative stated, "[My relative] has always got somebody with her. She's not left to walk on her own."

However, we observed poor practices in relation to the maintenance of people's safety when being supported. One staff member, who had no care or movement and handling training, supported an individual out of their chair whilst they were asleep. There was no communication from the staff member or explanation of the process being carried out. On standing, the individual woke up and was startled to find himself in this position. He walked away in an unsteady, disorientated manner and the staff member spoke to the individual for the first time, telling him he was going in the wrong direction.

Another person was supported by a care staff member out of their chair by being pulled by their arm. This was unsafe manual handling practice and was a potential risk of causing injury or pain to the individual. We observed the staff member pulling the person's extended arm and being led across the lounge to the dining room. The individual was unsteady and at risk of falling. At no time did the staff member talk with the individual or explain what they were doing.

This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff had failed to assess the risks to people of receiving unsafe care and provide proper explanation to mitigate those risks. Additionally, the provider had failed to ensure staff were adequately trained to provide safe care for people.

At our last inspection in November 2014, we found concerns with how the provider recorded, managed and addressed issues with accidents and incidents. A member of the management team told us a new policy and documents had been introduced since to improve people's safety and minimise the reoccurrence of accidents and incidents. However, we found that this system had not been introduced because events were still being recorded in the old logbook, which meant staff were not following the new policy. Management follow-up actions were poorly recorded. There was no evidence that accidents and incidents had been investigated and analysed to minimise their re-occurrence.

We looked at nine documented accidents, which included the details of what happened and immediate actions to treat the person involved. However, follow-up actions were minimal or not evidenced. For example, comments included '[Person's name] has his buzzer, please remind him to use it' on two separate logs. Another was recorded as 'encourage [person's name] to try and sit still when on the toilet.' These recorded responses did not adequately analyse and manage risks to people to reduce the potential of their reoccurrence.

There were no arrangements in place to analyse the causes of accidents to ensure people's ongoing safety was maintained. There was no system in place to record incidents, including the management of incidents to reduce the risk of these events reoccurring.

At our last inspection in November 2014, we found multiple concerns with how the provider had maintained people's environmental safety. During this inspection in May and June 2015, we noted some areas of the home required continued attention. For example, the ground floor bathroom hoist and toilet frame were rusted and wall tiles were missing. The first floor bathroom had no side panel on the bath and one of the metal pins holding the bath up was bent, which was a health and safety risk.

The management team told us they had taken action identified in their action plan to address health and safety risks we found at our last inspection in November 2014. However, we noted continued risks with door closures that were inadequate at protecting staff, visitors and people who lived at the home from the potential risk of injury. This was because the closures did not prevent doors from shutting too quickly. The fire door labelled '10' had no closure in place and the fire door next to the kitchen did not close fully into its fittings. Additionally, we saw continued risks with inadequate or missing window restrictors in three bedrooms and a bathroom.

The fire testing records did not show whether lighting tests had been carried out. Additionally, it had not been completed since February 2015. This meant the provider had no evidence that fire safety was being monitored properly. We additionally noticed a fire extinguisher positioned between rooms 101 and 102 had no servicing sticker to show it had been checked and was in working order.

Inadequate

Is the service safe?

At the last inspection in November 2014, we told the provider to take immediate action to address a stair gate that placed people at severe risk of injury from falling down the stairs. We observed the provider had removed the stair gate, but had not put in place any other measure to continue to protect people. The carpet at the top of the stairs was patterned, which did not promote a safe environment for people who lived with dementia. The landing was dimly lit and there was a large mirror on the stair well wall, which posed a further risk to people and visitors if they tripped or fell.

The provider was unable to demonstrate how they had come to make this decision and had no records to evidence this. The risk assessment in place did not address any of the environmental issues such as the patterned carpet, the large mirror and the impact this may have on someone who was disorientated. The lighting on the two smaller staircases was powered with single energy saving light bulbs. Consequently, the lighting in these areas was extremely poor and was liable to cause an individual to fall. We further observed room 106, which was occupied, the first floor shower room and the corridor between rooms 10 and 11 were dimly lit.

We found the home's gas and electrical safety certification, which was not up-to-date at our last inspection in November 2014, had been updated. The provider had introduced a checklist for the management team to monitor when building safety checks were due for renewal to reduce the risk of this reoccurring. We saw the electrical safety check identified seven points of action that the provider had invoices to show this work had been completed. However, the provider had not considered risk assessments to manage risks to people whilst this work required attention.

For long periods throughout this inspection in May and June 2015 the fire exit door next to the kitchen was wedged open when there were no staff present. We were told this was alarmed to alert staff to it being opened by people who lived at the home and visitors. A visitor told us their relative was moved to another bedroom because they had cut their leg on old furniture in their previous room.

Additionally, room 20, which was occupied, had no call bell in place. This meant the individual would be unable to contact staff in an emergency or to attend to their general needs. Another person told us, "My only complaint is my wardrobe. It's faulty and I've asked them to sort it, but they haven't." This showed the provider had not always acted upon people's requirements in relation to environmental maintenance.

Environmental risk assessments in place were poor and had limited information. For example, the smoking and external ramp risk assessments referred to other hazards being 'noise' and 'repetitive stress'. The documents had limited or no information about how the risks were being managed to minimise harm or injury to staff, visitors and people who lived at the home.

Kitchen safety was poorly maintained because we observed on two occasions that unattended pans were left boiling on the gas cooker. On another occasion one person was observed entering the kitchen to light a cigarette off the gas cooker when there were no staff present. We intervened and asked staff to support the individual safely. Additionally, one person told us they frequently accessed the kitchen to make hot drinks, but there were no associated risk assessments in place.

There were a number of mattresses in use in the home that were intended to reduce the risk of people developing pressure ulcers. These mattresses required regular top-up of air that had to be delivered manually by staff. We observed the majority of the equipment were deflated and requested the management team show us records of when they had been checked and inflated. However, they were unable to produce these records, which meant that the equipment was not monitored to ensure it was effective. We saw another mattress in use that still had the plastic manufacturer's cover in place, which did not promote the individual's well-being.

We made a recommendation following our last inspection in November 2014 that the provider sought guidance from Medicines and Healthcare Products Regulatory Agency guidance on the Safe Use of Bed Rails 2006 (Revised 2012). There was no evidence the provider had done so. We observed the continued use of bed levers as bedrails. A staff member and the person who had this equipment in place confirmed the bed levers were being used as bedrails to keep them safe at night. However, bed levers should only be used by an individual to assist with movement. This meant the provider had continued to place people at risk of harm or injury by the unsafe use of equipment.

Inadequate

Is the service safe?

We have informed the local authority environmental safety officer and the fire service about our ongoing concerns.

These are breaches of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to ensure premises and equipment were safely maintained, secure, cleaned, used and suitable for the provision of care for people.

When we discussed the principles of safeguarding people against abuse with staff, they demonstrated a good understanding of processes to follow. A staff member told us, "If I had any concerns I would go to the senior managers. I would also report to the safeguarding and CQC [Care Quality Commission]."

Training records we reviewed confirmed staff had received guidance about safeguarding procedures to underpin their understanding. This demonstrated the registered manager had enabled staff to develop their skills in protecting people against abuse.

We noted the safeguarding and whistleblowing policies were limited and brief. For example, they did not contain definitions and descriptions of different types of abuse and the whistleblowing procedures did not refer to CQC. This meant these policies did not reflect current national guidelines.

We found one person was seated in a chair with a lap belt in place. There was no evidence of associated records of best interest decisions, consent or mental capacity assessments. The individual was being illegally and excessively deprived of their liberty without legal authorisation. This person and another individual were deprived of their liberty, without proper authorisation, because bedrails were in place that would prevent their movement if they were in bed.

This is a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to ensure two people were not deprived of their liberty for the purpose of receiving care without lawful authority.

We asked the management team to verify if they had completed all the actions to meet the requirements of the regulations and warning notices we had issued. They stated they had and confirmed people had risk assessments in place related to potential risks of harm or injury and appropriate actions to manage risk.

However, when we reviewed seven people's care records we found there were no risk assessments in place. The care files showed people were at risk from, for example, falls, malnutrition and the development of pressure ulcers. Other risks included those related to the provision of support because people had limited or no independence, such as incontinence, medication, medical conditions and self-neglect. However, there was no information about how this could affect people or the assessment and management of risks. A member of the management team acknowledged on the second day of our inspection that these processes were not in place. This meant the provider continued to fail to provide guidance for staff about supporting people safely.

On day two of our focused inspection, one member of the management team showed us a form they said was a risk assessment for one person in relation to falls. This was a poor record as it was a flow-chart tool that did not include actions to manage risk and was not personalised. It was dated 08 May 2015, but had been placed in the individual's care records after 28 May 2015. We checked this out with the management team member, who gave us conflicting information and eventually told us they did not know why this had occurred.

Care files contained documents that were designed to measure people's level of risk whilst receiving care and support. We saw evidence that people had been identified as high risk with no further information to guide staff about how to assess and manage those risks. Staff had not always documented on falls management records important information about actions they had taken to manage risks. Other potential risks had not been identified, such as those associated with malnutrition, medication and medical conditions. There was no evidence that the provider had always identified, recorded and managed risks to people when receiving care and support.

This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to assess the risks to people of receiving care and to ensure processes were in place to manage and minimise those risks.

During our last inspection in November 2014, we found multiple concerns with how the provider monitored, managed and maintained infection control and cleanliness within the home. We noted the provider had since put in place cleaning schedules and auditing records in relation

Is the service safe?

to infection control. We observed infection control monitoring forms were in place in bathrooms and toilets for staff to sign on completion of tasks. However, we noted that not all records were up-to-date.

We found multiple concerns around the home in relation to infection control and cleanliness. Room eight smelt strongly of urine and there was a used continence pad on the radiator. Four people's beds had been made up, but we noted their bed sheets were soiled. Room four had faecal matter on the mattress, even though staff had made the bed up, and the toilet brush was dirty. Windowsills and a bath were dirty. A relative told us, "There's the odd occasion when there's a pad on the floor and the toilet is dirty."

Additionally, the kitchen wall tiles were grimy and the grouting was in need of replacement. The ceiling had grease stains that had not been attended to between the beginning of this inspection on 28 May and our final day on 04 June 2015. The fridge and freezer seals were split, which meant food hygiene could not be safely maintained. The ground floor bathroom had a rusted bath hoist and toilet frame that were an infection control risk.

The infection control policy did not refer to the Healthcare Associated Infection Code of Practice. These are standards services are required to meet under the Health and Social Care Act 2008. We referred to this in our warning notice following concerns we found during our last inspection in November 2014. A staff member told us, "I have not heard of the Code of Practice." This meant the provider had failed to follow the Code and ensure staff were guided about it in relation to infection control standards.

This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to effectively assess, monitor, manage and maintain infection control. Additionally, the provider had failed to ensure the management team and staff were guided about and followed the Code of Practice in relation to Healthcare Associated Infection.

We checked how the management team had assessed staffing levels and skill mixes following concerns we found at our last inspection in November 2014. We also discussed how this had been reviewed following the more recent drop in occupancy levels. We did this to confirm people's ongoing needs were being met safely by sufficient numbers of staff. A member of the management team told us, "I discussed with staff what their needs were and the needs of residents and restructured rotas around busy times. I introduced 'walkie-talkies' and reassigned workloads. I based the assessment of staffing levels on my experience. We don't use a model."

The management team stated there were always four care staff on duty in the morning, three in the evening and three at night. Orchard Lodge was a large, complexly designed building and we were informed three people required two staff to attend to their needs. Other people required constant monitoring due to risks associated with their health and well-being and we were told a staff member was always on duty in the lounge.

During our inspection in May and June 2015, we used a method called Short Observational Framework for Inspection (SOFI). This involved observing staff interactions with people in their care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. This enabled us to observe frequent periods during the SOFI and at other times throughout the inspection when there were no staff in the lounge to supervise and support people. We noticed staff who had no training in care provision or movement and handling practices supported individuals with personal care. This showed the provider had failed to ensure skill mixes were appropriate for people's care needs.

We noted incidences of staff not responding to people's required or requested needs in a timely manner. For example, until we intervened, it took staff 90 minutes to change one person who had wet stained clothes after spilling coffee over themselves. Another person requested they be transferred back to the lounge after lunch had finished because they were tired. We noted it took staff 30 minutes before they provided this support. This meant the provider had not always ensured there were adequate staffing levels to meet people's needs in a timely manner.

We observed people who lived with dementia were being monitored by other individuals who lived at the home, such as being told to sit down when they got up, because there were no staff present. A relative told us that they felt there were not always enough staff on duty. They described times when there were no staff in the lounge and they had supported people to go to the toilet. The relative said, "If someone is struggling to go to the toilet and no-one is there I will take them."

Inadequate

Is the service safe?

We reviewed staffing levels over a four week period and found there were multiple occasions when staffing levels did not match what the management team told us should be in place. For example, there were 15 night shifts when there were only two staff on duty. Additionally, we found domestic staff had been utilised to cover 12 shifts, even though only one domestic had adequate and appropriate training. This was difficult to assess because where domestic staff had undertaken care duties this was not always identified on the rota.

We received mixed comments from staff about staffing levels at Orchard Lodge. A staff member told us, "We will get extra staff if we know we have a busy day, such as appointments. Staffing has improved, but when our occupancy dropped, our staffing did as well. Now, I think we could do with more staff." This staff member added, "We have a number of residents who require two carers to assist them and it means some people still have to wait for help." Another staff member said, "Staffing levels are good and manageable. We could always do with more, but we could always say that." However, a relative told us, "Sometimes there are not enough staff. If someone is struggling to go to the toilet and no-one is there I will take them." This relative added, "They are always busy, but always there in an emergency."

This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to ensure sufficient numbers of suitably qualified, competent and experienced staff were deployed to meet people's requirements.

We observed staff used a safe approach when administering medication to people who lived at the home. The staff member concentrated on one person at a time and ensured the medication trolley was locked whenever they were away from it. The staff member was discreet when dispensing medicines and monitored individuals to ensure they had taken their tablets. During this inspection, we noted the provider had made available up-to-date guidance for staff to develop their knowledge about medicines. One staff member said, "We also ring the pharmacy. Patient information leaflets are in place."

We checked the medication audits the management team had introduced following concerns we found at our last inspection in November 2014. The first document was dated on 27 February 2015, which identified a room thermometer and drug disposal pot was required. The next audit was dated 24 April 2015, which meant medication processes were not being completed monthly as stated on the audit form. We found no recorded evidence that the earlier identified issues had been addressed. This was poor practice and failed to meet the purpose of undertaking auditing systems.

We discussed medication with staff to assess their knowledge and understanding. One staff member told us, "If someone refuses we respect their decision, but we explain what this is and try again. If they continue to refuse we document this. We would seek advice from the GP or pharmacy." A staff member told us, "I've been doing medicines for a few weeks now and I've had the training. The medication has got a lot better now." The provider had updated staff training for those who had medication responsibility since our last inspection in November 2014. One staff member told us, "Medication processes have improved. For example, I have a do not disturb tabard to help me concentrate."

In February and March 2015, the provider had introduced competency tests for all staff administering medication. These assessed staff ability to perform all tasks related to medication processes to ensure people's medicines were managed by using a safe approach. The provider intended the assessments to measure competencies over three assessments. However, we found large sections of the documents had not been completed and not all staff had completed their second or third assessments.

We checked if the provider had ensured there were enough staff on duty to ensure people who had received medicines were continuously monitored. One staff member told us, "There are 10 staff trained in medication, six are night staff. There are still occasions when there are no staff trained on duty." Another staff member said, "There are still times when there are no trained staff on duty, such as when staff are on leave."

We reviewed the staff rotas for the current week of our inspection and the three weeks prior to this. We noted there were 11 occasions when there were no staff on duty trained in medication. On two occasions, proficient staff worked split shifts in order to return to work to administer medicines to people. However, this meant there were 11 periods during four weeks when there were no trained staff to monitor people or provide support with their medicines should they need it.

Inadequate

Is the service safe?

We found prescribed creams that were in use were left in two people's unlocked bedrooms. This was a risk of harm to people with limited or no capacity, who could enter these rooms and unwittingly use the creams inappropriately. This meant the provider had failed to protect people against the safe use and storage of medicines.

This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to deploy enough appropriately trained staff to ensure the safe management of people's medicines. Additionally, the provider had failed to ensure medicines were securely stored.

We recommend that the registered manager seeks guidance about writing and introducing policies and procedures in relation to whistleblowing and safeguarding people against abuse.

We recommend that the provider seeks evidence-based, best practice guidance about the assessment of safe staffing levels that adequately meet people's needs.

Inadequate

Is the service effective?

Our findings

At our last inspection in November 2014, we found that staff were not adequately trained to effectively meet people's needs. Training records were inconsistent and certificates indicated staff had minimal training. Training was provided by other staff who had no training to do so.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We requested that the registered manager completed an action plan to address the concerns.

We further noted at last inspection in November 2014 that suitable arrangements were not in place to ensure people's consent in relation to their care had been sought and acted in accordance with. Where people's freedom was restricted, the registered manager had failed to evidence their consent and best interest decisions.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice in relation to our findings. We additionally made a recommendation in our inspection report that the registered manager checked and ensured the management team and care staff followed the Medicines and Healthcare Products Regulatory Agency guidance on the Safe Use of Bed Rails 2006 (Revised 2012). This was because the provider had in place inappropriate and unsafe equipment.

At our last inspection in November 2014, we also observed people were not always protected against the risks of inadequate nutrition and hydration. An identified risk associated with malnutrition was not responded to in a timely manner. People did not receive meals quickly enough to maintain their health and well-being. The kitchen was dirty and there were no cleaning records. Food hygiene was not always effectively managed and staff had limited training.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We requested that the registered manager completed an action plan to address the concerns.

We requested the provider send us an action to outline actions they would take to improve the service and ensure it met requirements of the regulations and the warning notices we issued. The provider sent us their action plan on 20 April 2015, which stated the service would meet requirements of the regulations by 30 April 2015. At our inspection in May and June 2015, we found that the provider had not completed their action plan to make improvements to meet requirements of the regulations, despite telling us they had. Nor had the provider met all the requirements of the warning notices we issued.

People's representatives told us their relatives enjoyed the meals provided at Orchard Lodge. A relative stated, "[My relative] loves the food." Another relative said, "It's good food and I also eat meals here." A third relative told us, "[My relative] lost weight and they kept a food diary. [My relative] has now put weight on."

We noted the home had been awarded a five star rating by the Food Standards Agency following our last inspection in November 2014. There was a four week programme of menus and a variety of options to give people choice. We were told the menus had recently been changed following a residents' meeting where people highlighted what they did and did not want. Records, such as cleaning schedules and appliance temperature checks, were in place to ensure people were protected against the risks of poor food safety.

However, we found concerns with the cleanliness and infection control risks of the kitchen. The wall tiles were greasy and the ceiling had ingrained grease stains. The fridge and freezer door seals were split, which were a risk to food hygiene. We noted the dry storage area contained food along with other inappropriate equipment. This included open cans of beer, screwdrivers, knives, sanitizer liquid and oven cleaning fluids. Some of these items were dirty and posed further food hygiene contamination risks.

On arrival, we noted three people were eating breakfast, but throughout the breakfast there was little or no staff supervision or nutritional support for people. We observed people were sitting in wheelchairs at lunchtime. There was

no indication in people's records that this was their preference. Those people who were seated in these devices were observed to be in uncomfortable positions that did not promote good nutritional support.

We observed poor practice during the lunchtime meal and found concerns with how people were supported. It was not a social occasion and people were not supported to enjoy their meal or engage with each other or the staff. Staff stood over people and placed food in their mouth, which was neither discrete or encouraging of good communication through eye-level contact. When staff provided support, they did not check for people's consent to do so or explain what they were going to do. Engagement was fleeting and offered little meaning to the interaction given.

We observed one person, who was not eating their meal, being asked if they were 'ok' by a staff member. Without waiting for a response, giving an explanation or checking for consent, the staff member, who was not trained, started placing food in the individual's mouth. She started coughing food up and the staff member offered them a drink before asking another staff member to continue to support the individual. The second staff member took the drink away from the person and continued to put food in their mouth for ten minutes without any interaction or explanation. The individual's plate was then taken away without the staff member checking if they had finished or had enough to eat. Two other people were observed pushing their food around the plate because they were unable to cut it up or place it on their cutlery. It was ten to 15 minutes before staff offered to cut their food up or provided support, which meant their meal would have gone cold.

At our last inspection in November 2014 we found concerns with how the management team acted upon people's weight loss to prevent malnutrition and observed fluid and food charts were poorly maintained. We were told that all care records had been updated prior to our inspection in May and June 2015. A staff member said, "We check people's food allergies, likes and dislikes. These are updated monthly. I talk with the residents if I am able to do so." However, we found that care files did not contain nutritional risk assessments to minimise the risks of malnutrition. We checked how four people's weight loss had been managed and addressed. Two people's weight reduction was managed effectively. A member of the management team told us, "People are referred to the dietitian."

However, we noted two other people were not and all care records did not fully highlight concerns and actions. For example, care plans had not always been updated and monitoring charts had missing information or had not always been regularly reviewed. This meant people's nutritional and hydration needs were not being effectively monitored. One person's Malnutrition Universal Screening Tool (MUST) form, which measured if people were at risk from malnutrition, stated there had been no weight loss. However, we found this individual had lost 4.9 kilograms in six months. A fifth person had not been weighed for seven of the past 12 months, which meant it was difficult to assess if they had lost or gained weight.

We were unable to fully check the provider's response to one person's weight loss because staff were unable to locate their daily records prior to 11 April 2015. This meant people continued to be at risk of malnutrition because the provider had failed to ensure they were effectively assessed and monitored.

We noted all the kitchen staff had received food hygiene training. We raised concerns about limited food hygiene training for staff at our last inspection in November 2014. We checked the training matrix and saw that only 50% of none-kitchen staff had received this training. We observed an untrained staff member supporting people with their nutritional needs. We further noted that people were not supported to wash their hands before or after meals.

These are breaches of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to ensure nutritional support was effectively provided by staff who were trained to do so. Additionally, care records did not effectively demonstrate how people were protected against the risks of malnutrition.

Staff told us they had completed a lot of training since our last inspection in November 2014. This included moving and handling, infection control and medication. A staff member said, "I have completed my B-Tech [Bachelor of Technology] level two in Health and Social Care and I'm doing my level 3 QCF [Qualifications and Credit Framework]." Another staff member stated, "I feel

supported to get training and have had supervision. It has helped me to come out of my shell and interact much more easily with the residents." Supervision was a one-to-one support meeting between individual staff and a senior staff member to review their role and responsibilities. A member of the management team told us, "Some supervisions have been done and some still to do. It's on the agenda." This meant not all staff had been provided with supervision since our comprehensive inspection.

We found it difficult to assess staff training and qualifications during our last inspection in November 2014 because the training matrix and staff files were not up-to-date. We checked the training matrix again and found it had not been updated. For example, we were told 10 staff had completed medication training and we were shown their certificates to confirm this. However, staff training files evidenced only four staff had completed this training. This meant it would be difficult for the registered manager to monitor effectively when staff required refresher training.

We observed two staff provided care without appropriate training. Other staff were covering shifts as care staff with minimal training to do so. For example, all four domestic staff undertook care duties, but only one was in the process of completing a care qualification. Of the other three only one had received safeguarding guidance and none had completed moving and handling, nutrition, mental capacity or end of life training.

This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to ensure all staff who provided care were effectively trained and supported to undertake their duties.

The provider had admitted people who lived with dementia. However, we observed the home lacked a dementia-friendly environment. Not all communal areas had pictures to identify their purpose and carpets were patterned, which could be confusing to people and affect their mobility. Orchard lodge was a large, complex building, but there were no signs to direct people to bedrooms, toilets and other areas of the home.

Care records contained consent forms designed around decision specific agreement. A relative told us, "I am involved in making decisions." However, not all files held evidence that consent had been sought. Some documents stated the individual was unable to give consent, without further evidence of why or mental capacity assessments. One person's care records stated they had capacity to make decisions and had requested bedrails be put in place. However, the individual's consent form was signed by their relative.

Other people's forms stated they had been signed on behalf of the individual's relatives. Staff had recorded on one consent form 'signed on behalf of daughter who lives away'. This was an inadequate way of recording consent because it did not evidence this was in place. We saw two different signatures from one relative in relation to consent for a second person's care and support. This meant we could not confirm whether consent was in place.

Policies and procedures were in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). CQC is required by law to monitor the operation of DoLS. We discussed the requirements of the MCA and the associated DoLS with the management team staff. The MCA is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. DoLS are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

The MCA and DoLS policies in place were in-depth and followed the Code of Practice in relation to the act. The Code is a set of processes for services who care for people who cannot make decisions for themselves. It outlines what providers must do when they act or make decisions on behalf of people who cannot act or make those decisions for themselves under the MCA. When we checked staff understanding of the MCA, one staff member told us, "The MCA is basically about helping people to make decisions. As an example, I'll do this by offering a choice of clothes. I don't go and give them a coffee because that's what I think they want. I offer a choice."

We checked with the management team about how they worked under their policy and assessed people's capacity to make decisions. The management team stated consent, best interest decisions, risk assessments and mental capacity assessments were in place. However, we observed care files and applications for DoLS authorisation did not contain an assessment of the individual's mental capacity. A management team member stated, "We know the residents and if they had dementia they did not have

capacity. You only have to look at [resident's name], for example, to know she doesn't have capacity." This was poor practice in relation to the Code and demonstrated the management team had not worked under the MCA to assess people's capacity and support them in their decision-making.

Initially we were told there were two DoLS applications being processed in relation to the use of bedrails. Between day one and day two of the focused inspection, we noted further information had been added to one urgent authorisation document. The date the authorisation was intended to end on this form had been entered as 18/05/2015. The documentation had been completed by the service administrator who had no care responsibilities. The forms included a section to record who was the registered person under the regulations, but the person's name that had been entered was incorrect.

Both DoLS applications had been commenced in May 2015, which was three months after the need to install bedrails for people's safety had been identified. The management team were unable to explain why there had been a delay in these important processes. Additionally, they could not clarify why the individuals had been deprived of their liberty without proper authorisation throughout this time.

Following our last inspection in November 2014 the provider sent us an action plan that stated all unauthorised bedrails had been removed. We were further informed by the management team that best interest meetings/decisions and consent for people with bedrails had been evidenced and put in place.

However, we found six bedrails in use in people's bedrooms without recorded consent or risk assessment documentation. One person's records stated that consent for the use of bedrails had been agreed by a relative. Another individual's relative told us that they had asked for bedrails to be put in place. There was no evidence that this individual's best interests had been taken into account or that their mental capacity had been assessed.

Care files contained a document called 'Bedrail Usage Decision Tool'. This was a brief form that assessed whether an individual required a bedrail to keep them safe whilst in bed. These had been reviewed monthly, without any indication as to how staff had come to make decisions about ongoing use of equipment. There was no evidence that individuals or their families had been involved or that best interest meetings had taken place. One person's form stated 'to speak to daughter again', in relation to decisions about bedrail use, that had been ticked with no other details.

We were shown two people's best interest records that the management team told us related to the use of bedrails. However, these documents were dated 2013 and made no reference to the use of this equipment. The forms referred to not being admitted to hospital or be resuscitated should these needs arise. Additionally, one had a record that stated the document should be reviewed monthly, whilst the other required annual review. We saw no evidence that evaluations had taken place.

We observed one person had a lap belt in place that prevented them from getting out of their chair if they chose to. There were no records to evidence this had been authorised, such as DoLS applications, best interest decisions, risk assessment or mental capacity assessment. This meant the individual was being illegally and excessively deprived of their liberty without proper authorisation.

These are breaches of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to ensure care was always delivered with the consent of people who lived at the home. Additionally, the provider had failed to act in accordance with the MCA where this was applicable.

We recommend that the provider seeks evidence-based, best practice guidance about effectively supporting people in a dementia-friendly environment.

Inadequate

Is the service caring?

Our findings

At our last inspection in November 2014, we found that people were not safeguarded against the risks of receiving inappropriate or unsafe care. The ground floor toilet did not have a lock on it, failing to protect people's welfare. People's recorded preferences were not always followed. Staff did not effectively engage with people with limited capacity in a way that aided their understanding.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice in relation to our findings.

We further observed at our last inspection in November 2014 that people were not always involved in the planning of their care and did not have their privacy maintained. One person told us they did not know if they had a care plan. Care records did not always indicate people or their representatives were involved in care planning and reviews. People's recorded preferences were not always followed. People's privacy was not maintained because their confidential information was not stored securely.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulations 9 and 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We requested that the registered manager completed an action plan to address the concerns.

We requested the provider send us an action plan to outline actions they would take to improve the service and ensure it met requirements of the regulations and the warning notices we issued. The provider sent us their action plan on 20 April 2015, which stated the service would meet requirements of the regulations by 30 April 2015. At our inspection in May and June 2015, we found that the provider had not completed their action plan to make improvements to meet requirements of the regulations, despite telling us they had. Nor had the provider met all the requirements of the warning notices we issued.

People and their representatives told us staff were caring. One person stated, "Staff are very friendly, very helpful and very kind." A relative said, "[My relative's] ecstatic. She can't praise staff enough. They are lovely and talk to her." Another relative told us, "The hairdresser cuts [my relative's] hair and he has clean clothes every day."

One staff member was kind and engaged people in social conversation. She explained clearly to individuals what she was going to do before providing support and checked if people agreed to this. Another staff member told us, "I love working here. I love having a laugh with the residents." However, throughout our observations, we observed poor practices from staff when they supported people. We noted staff interactions were poor and they did not demonstrate a caring attitude. Staff failed to promote people's dignity or show respect to individuals.

We saw two people that were supported with their mobility without any communication from staff. Staff supported people to eat their lunchtime meal with minimal contact that did not promote socialising or well-being. Staff did not promote social interaction or explain what they were doing. We observed the chef and hairdresser support people with their care, even though neither had any relevant care qualifications or training. We saw no evidence that individuals were being supported in a manner that met their preferences in relation to support provision.

At our last inspection in November 2014, we raised concerns that staff had not followed people's recorded preferences. People who lived at the home had had their care plans updated within the last month. However, this did not include a review of their preferences about how they wished to be supported. Files contained a document entitled 'Resident Lifestyle Choices' that required monthly review. We saw no evidence this had occurred and two documents had not been reviewed since 2011. Where statements recorded that this document had been updated, there were no further details or entries had not been signed or dated.

People's preferences around end of life care were not always updated or regularly reviewed. One document stated it had been reviewed without any further details, whilst another person's form had updated entries that were not signed or dated. A staff member told us people had allocated days when they had a bath and we saw a bath chart that reflected this. However, staff were unable to confirm how this enabled people to have a choice of when they bathed. We checked seven people's records and found

Is the service caring?

no evidence to confirm when people could choose to have a bath. One person told us, "I have a wash every day because the bathrooms are too far away and I have to go through the corridor."

A staff member told us that night staff got eight people up prior to the commencement of the day shift. We checked with this member of staff who these individuals were and how their related preferences had been sought and recorded. The staff member was unable to answer our questions and said, "They would get some up." We were unable to confirm people had agreed to this and not all records in relation to choice about times to get up had been updated.

We checked how people or their representatives were involved in the assessment and planning of their care. A relative told us, "[A staff member] went through the forms and I helped out as best as I could."

However, one person's care records stated the individual was 'unable to give input into her care planning', but there was no other information to indicate why. Their care plan was brief and contained limited information personalised to the individual's needs. Another person's goal was recorded as ensure 'she remains comfortable, smart and tidy', but there was no inclusion of the individual or their representative's input around this.

This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to ensure care was carried out in collaboration with people and in a way that enabled them to understand options available to them. People's preferences were not always recorded or updated and they or their representatives were not always involved in their care planning.

One person was offered a coffee in the lounge along with other people who lived at the home. Left alone, the individual spilt their coffee over themselves and their clothes. A staff member noted this and offered them a fresh coffee. No staff offered to change the individual's wet, stained clothes until we intervened and requested a staff member attended to their needs. 90 minutes after the incident, we noticed staff supporting the individual to their room. This demonstrated staff had failed to promote the individual's dignity in a caring manner.

On checking if a fire exit door was alarmed, a member of staff stated, "There are no 'wanderers' at the moment. The door is not alarmed." The use of 'wanderers' to describe people with limited or no capacity was a derogatory term and did not promote people's dignity or individualism.

We checked how people's diverse needs were monitored and maintained to ensure, where applicable, staff had regard to their protected characteristics, as defined in the Equality Act 2010. We found the policy entitled 'sexuality' was limited and used inappropriate language. For example, it stated staff should be non-judgemental and not stereotype people. However, there was no further guidance to assist staff understanding. Additionally, it referred to 'transsexual' people, an inappropriate term for a transgender person.

We observed a curtain was in use in a bedroom to protect the dignity of the two people who shared the room. However, another bedroom, which was occupied, had a glass panel in the door with no screen to protect the individual's privacy.

Following our last inspection in November 2014, we observed a toilet lock had been put in place on the ground floor communal toilet to protect people's dignity and maintain their well-being whilst accessing the facility. However, during our inspection in May and June 2015 we noted the upstairs shower room had no lock on it and staff confirmed this was used to support people with their personal care. This meant the registered manager continued to fail to protect people's dignity and well-being whilst having a shower in this room.

Care records had been moved and stored more securely in the medication room following concerns we raised at our last inspection in November 2014. Both this area and the main office were locked when no staff were present, which meant people's confidential information was protected. However, we observed one person during lunch asking a staff member why they had not been given apple crumble as per their request. The staff member said loudly in front of other people in the dining room, "You're diabetic, there's sugar in the crumble." This meant the staff member had failed to protect the individual's confidential medical information.

Inadequate

Is the service caring?

This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had continued to fail to ensure people were always treated with dignity and respect.

Requires improvement

Is the service responsive?

Our findings

At our last inspection in November 2014, we found that people were not safeguarded against the risks of receiving inappropriate or unsafe care. Care records were poorly maintained, had missing/conflicting information, gaps in documents and were not always signed, dated and reviewed by staff.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice in relation to our findings.

We further observed at our last inspection in November 2014 that there was no effective system in place to handle and manage complaints in order to reduce or prevent the impact of unsafe or inappropriate care. There was no system in place to review and follow-up on complaints. The registered manager had failed to ensure procedures were effective and up-to-date in order to enable people to complain.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulations 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We requested that the registered manager completed an action plan to address the concerns.

We requested the provider send us an action plan to outline actions they would take to improve the service and ensure it met requirements of the regulations and the warning notices we issued. The provider sent us their action plan on 20 April 2015, which stated the service would meet requirements of the regulations by 30 April 2015. At our inspection in May and June 2015, we found that the provider had not completed their action plan to make improvements to meet requirements of the regulations, despite telling us they had. Nor had the provider met all the requirements of the warning notices we issued.

People and their relatives gave us mixed comments about the entertainment and activities programme the provider had in place to respond to their social needs. One person told us, “I spend some time downstairs, but it’s not very amicable. People are not very friendly. I’m bored to tears. I go out.” However, a relative said, “[My relative] can’t be bothered to watch TV or do a ‘wordsearch’. She’s happy to sit with a carer or watch what’s going on.” Another relative said, “They have parties for birthdays, lovely entertainment and music. [My relative] even dances and has a bit of fun.”

Care documents were not always signed, dated, regularly reviewed and updated and had missing information. A member of the management team told us, “The care plans are ok, but not at a standard I would like.” Documents designed to measure people’s level of risk whilst receiving care and support were not always up-to-date. There were no risk assessments in place to ensure risks to people who received care were safely managed and documented. Where records required a review the registered manager had documented ‘review monthly or PRN [when required]’. This did not properly guide staff or give a clear indication about which instruction to follow. Another person’s ‘client handling’ form had not been reviewed since 24/08/2011, despite a statement that this was to be reviewed monthly. This meant the provider had not regularly checked for changes in people’s health to ensure care provision was designed around their ongoing needs.

Care planning documentation was inconsistent. Some sections of care records were in-depth and individualised to the person’s needs, whilst other sections lacked detail. Care plans contained limited and brief information to guide staff about their support requirements. For example, one individual’s personal care section stated ‘to support [person’s name] with her personal hygiene’, but there were no details about how staff could best assist the individual. The person’s mobility care plan outcome stated ‘to ensure [resident’s name] was comfortable’. There was only limited information to guide staff about how to ensure this. The person was diagnosed with arthritis, but there was no mention of how this would affect their independence, mobility and personal care needs.

Another care plan stated ‘one carer to assist with meals’, but did not guide staff as to what assistance this person required. A third file held a ‘Do Not Resuscitate’ form in place, but it was a photocopy and did not contain the second page. This was an inadequate record and did not follow national guidelines. A relative told us, “[My relative] was assessed at the nurse-led unit by [the registered manager].” However, two care files had no admission or pre-admission assessment forms to show what the

Requires improvement

Is the service responsive?

individuals' initial requirements were. One person's care records stated 'monitor for signs of aspiration', but did not include information about how to monitor or what these signs were.

Another person had a moving and handling risk assessment that stated the individual should be hoisted for all transfers, but staff used a stand aid when supporting them in the toilet. The person had a medical condition that contra-indicated the equipment utilised. This meant people were not protected against inappropriate care because the management team had failed to maintain up-to-date, suitable records that met people's planned needs.

These are breaches of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to ensure people's requirements were continuously met through care records that reflected their assessed, monitored and updated needs.

A visiting professional told us, "They are very open to working with us. I will offer the support and tools and support the manager to choose those that will work best for the home. The staff do listen and seem to retain the information we give them." Another visiting professional said, "Key indicators for falls, UTIs [urinary tract infections], ambulance call outs and hospital admissions are showing the care home is improving in all these areas."

We found the complaints policy had not been updated since we raised concerns about this at our last inspection in November 2014. Information displayed in the lobby to advise visitors, people who lived at the home and their relatives about how to make a complaint had additionally not been updated. This meant the provider continued to fail to ensure people had current information to help them to comment about the service they received.

The management team stated this had been updated and initially showed us the same policy that was in place at the last inspection in November 2014. New documents had been introduced that were intended to improve how complaints were managed and acted upon. However, we were told there had only been one complaint received since our comprehensive inspection, which was still ongoing. Therefore, we were unable to assess whether this system was effective.

On day two of the inspection in May and June 2015 a member of the management team showed us two more policies. One was dated 2008, with a recorded review date of 2011, along with a complaints policy from a new suite of policies the management team member told us had been introduced. It was unclear which policy the provider had in place and all three policies contained information that conflicted with each other. Having three policies in place and out-of-date information on display for people and relatives was not good practice in responding to an individual's concerns.

This is a breach of Regulation 16 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had continued to fail to ensure people were given up-to-date information about making a complaint if they chose to.

Requires improvement

Is the service well-led?

Our findings

At our last inspection in November 2014, we found that people were not protected against the risk of receiving inappropriate or unsafe care by the means of an effective quality assurance system. The registered manager did not have effective systems in place to check the quality of the support people received. There was no evidence that the registered manager acted upon identified issues from staff and service user satisfaction surveys. The management team did not have a clear picture of quality assurance and individual responsibility.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice in relation to our findings.

We requested the provider send us an action plan to outline actions they would take to improve the service and ensure it met requirements of the regulations and the warning notices we issued. The provider sent us their action plan on 20 April 2015, which stated the service would meet requirements of the regulations by 30 April 2015. At our inspection in May and June 2015, we found that the provider had not completed their action plan to make improvements to meet requirements of the regulations, despite telling us they had. Nor had the provider met all the requirements of the warning notices we issued.

We found a copy of the report of our last inspection in November 2014 was kept in the entrance lobby for people and visitors to read. The management team explained they did this to keep people informed. We checked records, spoke with people and observed practices to assess how the provider had completed the action plan they had submitted to CQC and made improvements to the service people received.

We discussed the action plan the provider had completed in relation to actions taken to meet the requirements of the regulations with the management team. A member of the management team told us, “Some things have been done and some things to do.” A visiting professional told us, “Things have improved a lot, but it’s been very slow and there is a lot of work still to do.”

The provider sent an action plan following our last inspection in November 2014 that stated the service would meet the requirements of the regulations and the warning notices we issued by 30 April 2015. However, we found that not all of the identified breaches had been addressed. For example, information made available to people about how to complain had not been updated; not all health and safety risks had been attended to; and care records continued to have gaps in information and were not always reviewed, signed and dated.

Additionally, we found ongoing concerns with the deprivation of people’s liberty and associated records; there was continued use of bedrails without recorded consent or best interest decisions; and people’s preferences were not always recorded or followed. There were continuing breaches in how people’s nutritional needs were monitored and met; the maintenance of people’s dignity and privacy; staffing levels and training; and infection control and medication management. This meant the provider had failed to achieve all required improvements to ensure people received safe and appropriate care.

We saw new quality assurance audits had been introduced and completed in the last two weeks prior to our inspection in May and June 2015. These included medication, kitchen environment/food safety, nutrition and infection control. One of the management team told us, “I have completed and updated most of the audits, policies and supervisions in the last two weeks since I have been in post.” However, these did not pick issues we identified with infection control, medication, environmental safety, nutrition, kitchen safety and care records. There was limited evidence to show the provider had monitored quality assurance in the six months since our last inspection in November 2014 up to the recent introduction of new audits.

We asked a member of the management team about how staff had been included in taking action to meet the requirements of the regulations and the warning notices we issued. We were told, “Not all staff have had their supervision, but we have had two staff meetings.” This meant not all staff had been given the opportunity of discussing improvements following our last inspection in

Requires improvement

Is the service well-led?

November 2014. One staff member told us, "[The management team] have involved me and other staff in the ongoing improvements. So we have felt part of the drive. But this has only been recently."

Staff told us they felt management support had improved in the two weeks prior to our inspection in May and June 2015 since the introduction of a new management team. One of the management team said, "Staff are much more relaxed and less stressed recently. They feel they are being managed now." A staff member confirmed, "I feel managed and supported well. The managers are always there." Another staff member stated, "I feel things have improved and, although we need to continue to do so, it is much better working here. The new managers are much more supportive."

We reviewed the policies and procedures the provider had in place. We were shown those that had been updated by one of the management team and were informed these had been completed in the last two weeks. We noted some policies were in-depth and referred to legislation and national guidance.

However, we noted these were not dated and signed. This meant we were unable to assess and confirm how the registered manager monitored when policies required updating and review. Some policies were brief and used inappropriate language. For example, the policy entitled 'sexuality' used terms that were insensitive. The infection control, safeguarding and whistleblowing policies were also limited, brief and did not contain definitions to properly guide staff.

There were two sets of policies in place, which included those that had been developed by one of the management team. Additionally, an external set of procedures had been purchased by the provider and introduced at Orchard Lodge. This meant the provider did not always ensure staff had clear, detailed and up-to-date information to guide them in their work.

There was a suggestion box placed in the entrance lobby, which we checked for any comments made. We found one was dated 22 April 2015. There was no evidence to demonstrate the management team had seen, considered, acknowledged or actioned the comments made in the 36 days since it had been placed in the box. This meant people's comments about the service may not always be acted upon in a timely manner because the provider had no arrangements for checking the system in place.

We were told a service user survey had been undertaken recently and were shown two returned questionnaires. The surveys were poor because they were a simple tick box form that offered no opportunity to comment about specific areas. They still referred to the home as a nursing home, which was no longer the case. We were told staff surveys had been completed, but the management team were unable to provide us with these. This showed limited opportunities had been provided for people and staff to feedback about the quality of the service provided. Additionally, individuals had not been fully enabled to comment about any improvements or requirements following our findings at the last inspection in November 2014.

We asked to see minutes from resident meetings and the management team were only able to show us one dated from 29 January 2015. Areas discussed included activities, outings and checks of any problems people had. However, there was no reference to the findings at our last inspection in November 2014. There was no opportunity for people to discuss improvements or any further concerns.

These are breaches of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to effectively monitor and assess the quality of care people received. Staff, visitors, individuals and their representatives had limited opportunity to comment about the service provided.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People's recorded preferences were not regularly reviewed or were missing. Staff did not always assist people in ways that enabled them to have a choice and to meet their needs. We observed staff supported individuals with their nutritional needs in ways that did not always promote their well-being. Staff did not always explain processes to people, offer choice or gain their consent when they supported them, including people with limited capacity. Staff communication with individuals was poor. People's end of life preferences were poorly recorded and not always regularly reviewed. Individuals or their representatives were not always involved in their care planning. Regulation 9 (1) [a, b, c], (3) [a, b, c, d, f, i], (4), (5)

Regulated activity	Regulation
	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Staff did not always maintain people's dignity. Staff did not always provide care that demonstrated respect and kindness to individuals they supported. Terms used by staff and contained in policies were not always appropriate or respectful. People's privacy was poorly maintained and we found a used shower room had no lock on it. Staff did not always maintain people's confidential information. Regulation 10 (1), (2) [a, c]

Regulated activity	Regulation
	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Not all care files contained evidence of people's consent to care. We saw the continued use of bedrails without

Enforcement actions

recorded consent. Where people lacked capacity, the provider failed to have in place best interest decisions, consent and mental capacity assessments to provide support. The provider failed to work within the requirements of the Mental Capacity Act, the associated Code of Practice and within the remit of their policies.

Regulation 11 (1), (2), (3), (5)

Regulated activity	Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

People were supported by staff who did not assess potential risks to them or give clear explanation of the risks involved. People were supported by staff who were not trained to do so. The provider had failed to ensure the premises and equipment were safe for people to live in and use. There were no risk assessments in place to protect people against unsafe care. We found areas of the home were dirty and food hygiene was poorly maintained. Medication was not always stored safely and related audits were not carried out regularly. There were not always enough trained staff on duty to continuously monitor people who received medicines.

Regulation 12 (1), (2) [a, b, c, d, e, g, h]

Regulated activity	Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Two people's movement was restricted because one individual had a lap belt in place and both had bedrails on their beds. They had been deprived of their liberty without legal authorisation.

Regulation 13 (2), (5), (7) [b]

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

We found concerns with the management of food hygiene. We observed poor practices in relation to how staff supported people with their nutritional needs. The provider had not always monitored and responded to people who lost weight in order to protect them from the risks of malnutrition. There were no nutritional risk assessments in place. Not all staff had received food hygiene training.

Regulation 14 (1), (2) [a (i), b], (4) [d]

Regulated activity

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Accident and incidents were not always properly recorded, analysed and managed to minimise the risk of their reoccurrence. We found multiple concerns with environmental health and safety, fire safety and associated risk assessments.

Regulation 15 (1) [a, b, c, d, e], (2)

Regulated activity

Regulation

Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

The provider continued to fail to ensure procedures were effective and up-to-date in order to enable people to complain. There were three policies in place that contained conflicting and incorrect information. This did not clearly inform staff, people or visitors about making a complaint.

Regulation 16 (2)

Regulated activity

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

People were not always protected against the risks of inappropriate care because care records were poorly maintained and had missing information. Staff did not always regularly update, sign and date care documentation. Staff were not always given clear guidance about how best to support people or when their records should be updated. There were no risk assessments in place and care plans did not reflect all the needs of the people who lived at the home. The provider had sent a written report to CQC of actions they had completed to meet the requirements of the regulations. Our findings demonstrated not all concerns had been addressed. Audits in place did not pick up issues we identified. There were two sets of policies that contained conflicting information, which did not clearly guide staff in their roles. Staff, people and visitors had limited opportunity to comment about the service provided. Staff training records were not up-to-date.

Regulation 17 (1), (2) [a, b, c, d (i, ii), e, f], (3) [a, b]

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing Comments from people and relatives and our observations evidenced staffing levels did not always meet individuals' requirements in a timely manner. We observed people were left unsupervised for long periods in the lounge. Staff rotas showed shifts were not always adequately staffed. Skill mixes were not always safe because untrained staff provided personal care. People who received medication were not continuously monitored by appropriately trained staff. Staff who had no movement and handling training provided personal care. Domestic staff who had care responsibilities provided care when they were not always effectively trained. The training matrix was not up-to-date and not all staff had completed relevant training. Regulation 18 (1), (2) [a]