Mrs Tersaim Khaira

Orchard Cottage

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Orchard Cottage is a residential care home providing personal to up to 10 people. The service provides support to older people who had varying care needs including, dementia, diabetes and mental health needs. At the time of our inspection there were 10 people using the service.

People's experience of using this service and what we found
Individual risks were not effectively identified and managed to keep people safe. Lessons were not learnt from accidents and incidents to prevent future occurrences. People were not always protected from the risk of abuse as staff did not have a good knowledge of what action to take. Peoples medicines were not managed well or in a safe way. There were not sufficient staff on duty to effectively meet people's needs and keep them safe.

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

People did not have a full assessment of their needs in order to develop care plans that were individual and reflected their health and care needs. People did not always have access to advice and treatment from the appropriate healthcare professional. The environment was not suitable for some people living at Orchard Cottage, such as people living with dementia.

Staff training was insufficient to meet staff needs. There were gaps in staff skills and knowledge which meant people did not always receive the help they needed.

The provider and registered manager did not have sufficient oversight of the service. Records did not reflect the changing needs of people. There was no process to monitor the quality and safety of the care provided to people to identify areas for improvement or take action when needed.

People received sufficient food and snacks and had a choice. People could request certain meals and their requests were acted upon.

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

Rating at last inspection
The last rating for this service was good (published 5 May 2022).

Why we inspected
We undertook a targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted due to concerns received about fire risks, staffing, response to

incidents and access to healthcare. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with the assessment of individual risk and care needs, staff understanding of the Mental Capacity Act and the management and oversight of the service. We widened the scope of the inspection to become a focused inspection which included the key questions of safe, effective and well-led.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

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

We have identified breaches in relation to safe care and treatment, medicines management, capacity and consent and monitoring and oversight of quality and safety at this inspection.

Please see the enforcement action at the end of this report.

Follow up
The provider told us during the inspection the service was no longer financially viable and made the decision to close the service. They worked with the local authority to find suitable alternative accommodation for all the people who were living at Orchard Cottage at the time of the inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Orchard Cottage

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Orchard Cottage is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Orchard Cottage is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We contacted Healthwatch to provide feedback. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with two people who used the service about their experience of the care provided. We observed the care provided within the communal areas. We spoke with three members of staff including the registered manager and two senior care workers.

We reviewed a range of records. This included three people's care records and three medication records. We looked at a variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
The provider told us during the inspection the service was no longer financially viable and made the decision to close the service. They worked with the local authority to find suitable alternative accommodation for all the people who were living at Orchard Cottage at the time of the inspection.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not protected from the risk of abuse. Staff had received safeguarding vulnerable adults training. However, they were not aware when to raise concerns and who to. A person returned from hospital following a fall at the service. The hospital staff confirmed they were fit to return. However, they were not. We asked staff if they had raised a safeguarding alert and they told us they were not aware they could.
- There were altercations between people, where people were frustrated with each other but care plans had not been developed, or updated, to ensure staff had guidance to provide consistency when offering support. When we reviewed one person's daily records, we found an incident that described a member of staff as 'restraining' the person when they tried to leave the service. A care plan was not in place to provide guidance around the person's agitation and how staff should support them if they were feeling challenged by their environment. The risks associated with the person's agitation had not been identified and mitigation in place to prevent unplanned restraint. The incident was not raised as safeguarding concern with the local authority to keep the person safe.

The failure to safeguard people from abuse was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- The assessment and management of risk was poor. Sufficient information and guidance was not provided to ensure staff knew how to reduce risks when providing people's care. There was a lack of knowledge by the staff and the registered manager in how to identify, assess and mitigate individual risks.
- One person had a diagnosis of diabetes. A blood sugar monitoring form was in place stating the person's blood sugar should be monitored twice a day. It was unclear who advised this as there was no record in the care file of healthcare professional involvement. However, the person's blood sugar had not been checked since April 2022. Staff told us the person often refuses intervention, the staff member said this may be the reason why but said they were unsure. No records had been made to show why the record had not been completed or what staff were doing about it. This meant the person was at risk of ill health due to uncontrolled blood sugar.
- It was difficult to ascertain if the most up to date information was recorded in people's care records. Risk assessments were basic and not regularly reviewed. One person's risk assessment, dated 2020, stated they walked with the support of a walking aid and one member of staff. Staff told us this was not current information as they no longer used a walking aid. Staff did know people well, but as their level of skill and knowledge was not up to date, we could not be assured they recognised concerns or signs of deterioration in people's health and care needs and take appropriate action.

● The management and oversight of incidents and accidents was poor and had not been used as an opportunity for learning lessons to mitigate future risks. Staff had not completed an incident form to report and record when incidents occurred. Body maps were used to record when an accident or incident happened. The body map only showed where an injury was located on the body following an incident but did not give a description of how the incident happened and action taken such as seeking medical advice.
● A body map for one person recorded they had a witnessed fall, where they banged their head. No further information was recorded such as the reason for the fall and if healthcare advice had been sought. We asked staff about the person's falls and they said they didn't think the person had any falls. The person had four falls recorded on the body map. Incidents and accidents were not regularly monitored to check for similarities and trends to reduce further incidents.
● Fire safety checks had not been undertaken to make sure risks to people were mitigated. A fire risk assessment had not been reviewed and updated since 2009.
● People were at risk of not receiving the support they required to evacuate the service safely in the event of a fire or emergency situation. The fire evacuation plan was basic and did not provide sufficient guidance for staff to support people to evacuate the premises safely. People did not have a personal emergency evacuation plan (PEEP) in place to provide guidance about each individual person and how staff should support them to evacuate. This would include if the person had specific mobility needs or a visual or hearing impairment and how many staff were needed to help them to evacuate. Staff were not aware individual PEEP's were required and did not have knowledge of them.

Using medicines safely
● Medicines were not managed safely. People's prescribed medicines were not stored in a safe way as advised in current National Institute for Health and Care Excellence (NICE) guidance, Managing medicines in care homes. Some medicines have specific instructions how they should be stored, such as in a locked cabinet secured to a wall, this was not in place.
● Where people were prescribed patches to place on their skin, for example, to control pain, the site where these were placed was not recorded on a body map. Pain patches can cause irritation to the skin if they are placed in the same position after removal. One person was prescribed a pain patch. The pharmaceutical guidance available with the medicine advised the patch must not be placed in the same position twice within a 14 day period. Staff were unaware of this. There was a risk people, who may already have frail skin, could experience a reaction and discomfort.
● Some people were prescribed as and when necessary (PRN) medicines, such as Paracetamol. PRN protocols were not in place to provide guidance to staff in how to administer the medicines safely. For example, the reasons the person is prescribed PRN medicine, how much medicine the person can safely take within a 24-hour period, the minimum time between doses and side effects to be aware of.
● Regular checks were not made of how many medicines were left in stock, to confirm the numbers tallied with the amount of medicine people had already taken. A record was not made of the numbers of medicines delivered at the beginning of the medicine cycle. We could not check that people had received their medicines safely, or if they had received too many or too few medicines, as there were no records to check against.
● The provider and registered manager had no process in place to audit medicines to make sure people were receiving their medicines safely.

The failure to ensure people received safe care and treatment and had their medicines administered safely was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There were insufficient numbers of staff to meet people's needs and keep them safe. The provider did not have a way of calculating the numbers of staff needed at different times of the day based on people's needs. The same numbers of staff were always on duty, irrespective of how many people were living in the service or their changing needs. The registered manager and staff told us they had more people than usual living in the service at the time of inspection. However, the numbers of staff had not changed.
● Only one member of staff was on duty overnight. The registered manager and staff told us this had never changed. Two members of staff told us when they worked a night shift, they always worked together, unofficially as they were not rostered to work together, as they did not think one member of staff was sufficient to keep people safe.
● The fire and rescue service visited Orchard Cottage before the inspection and told the registered manager the numbers at staff were not sufficient to keep people safe in the event of a fire. They told the provider they must increase the staffing levels immediately during their visit. The provider did this with the support of the local authority.
● The two senior care staff always worked together on shift and not with other staff. This meant care staff did not receive any supervision or observations of practice when on duty. The senior care staff said they were responsible for updating care plans but did not have the time to do so as they were always on shift providing care.

The failure to deploy sufficient numbers of staff was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had not recruited any new staff for over 12 months. A safe and suitable recruitment process was followed with checks in place such as application to the DBS. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Care staff on duty were responsible for cleaning the service as well as providing people's care and cooking their meals. This meant they did not have the time to do anything more than the basic cleaning. The service was not clean in parts.
● We were somewhat assured that the provider's infection prevention and control policy was up to date.
● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed as the service was not clean in parts.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.

Visiting in care homes
● People were able to have visits from family and friends when they wished.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People's needs were not assessed and regularly reviewed to ensure they received care that met their needs. When people moved into the service, a full assessment was not completed to identify their care needs and how they wanted to be supported.
- People's care plans were basic and did not provide the level of detail needed about people's individual needs. Some people's care records were dated 2019 with very few updates recorded, even though their needs had changed. One person's record stated they had a peanut allergy and had medicine to administer immediately if they had an allergic reaction. A member of local authority staff noticed this during a recent review and asked for further information. Staff told them the person did not actually have an allergy. A healthcare professional had not verified this. Staff told us the GP had confirmed the person no longer had a peanut allergy, however this had not been received in writing and not recorded in the person's care records. Although staff knew people well, their skills and knowledge were not up to date. There was a risk people may not receive appropriate and consistent care.
- A consistent approach was not taken to regularly review care plans and risk assessments. Some updates were written on the care plan document with the year the update was made recorded, but not the month so it was not clear if the information was up to date and relevant.

The failure to ensure people's care records were accurate and contemporaneous was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal

authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Staff did not have a good understanding of the MCA. People were not asked to give consent to their care, such as to live at Orchard Cottage and to receive care from staff. No mental capacity assessments had been completed. Staff confirmed they did not complete assessments, saying they relied on health care professionals to do this. Staff were not aware they must complete a mental capacity assessment if a person's capacity to make a specific decision was in doubt.
● One person's care record documented an incident where they had wished to leave the service and were intent on going through the main door despite staff advising them not to. The record stated staff restrained the person to prevent them from leaving. The person's care record gave no indication if the person lacked capacity to make this decision and no guidance was in place for staff to restrict their movements. A Deprivation of Liberty Safeguards (DoLS) authorisation was not in place to make sure their rights were maintained if they did need to have restrictions in place. No action was taken to seek appropriate advice or to update the person's care records following the incident to make sure sufficient safeguards were in place.
● Staff did not have an understanding of when an application should be made for a DoLS authorisation and none had been applied for.

The failure to ensure care and treatment was provided with the consent of the relevant person was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff did not have the skills and experience necessary to provide a safe service for people living at Orchard Cottage. Although staff had received mandatory training, all their training was by e-learning or workbooks. Staff told us they did not think this met their needs and they needed more training and supervision than they received. Staff said their skills in moving and handling were not sufficient as their training was not practical and competency based.
● Staff did not have the skills or experience to develop and review care plans and risk assessments to meet people's needs. Staff did not have a good knowledge of safeguarding vulnerable adults and the MCA even though they had received training.
● There was no observation of staff practice or checking their competency to carry out tasks and provide people's personal care. The registered manager did not have the training and skills to do this.
● Staff did not receive supervision or have an appraisal to provide professional support and identify areas for improvement and support their learning and development. Staff spoke highly of the registered manager and said they received practical support such as carrying out maintenance tasks and buying food and items they required such as equipment. However, staff needed ongoing guidance to keep up to date with best practice to provide a safe and good quality service and this was not available.

The failure to ensure there were sufficient numbers of suitably competent, skilled and experienced staff deployed was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were not always referred to the appropriate healthcare professionals to meet their health needs in a timely manner.
● Some people had not had the opportunity to see a dentist to assist with their oral care. One person had

pain with their teeth. Staff said they were unable to find a community dentist. However, once the person's issue was raised by the local authority following a visit, a community dentist was arranged who visited on the day of our inspection.

● One person had a letter in their care records reminding them of a diabetic eye screening appointment in March 2022. A record had not been made to confirm if the person had attended. We asked staff about this who said the person had not attended as there were no staff available to escort them. The person had still not attended their appointment at the time of the inspection. Staff said if people's family or friends were unable to take them to health appointments, they were unable to go as there was never enough staff to support this.

The failure to ensure people received care and treatment that met their needs was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The premises did not provide suitable accommodation for people living at Orchard Cottage. There was no signage to support people living with dementia to find their way around more easily. Rooms and corridors were small and not suitable for people with mobility needs.

● Decoration was dated and did not provide pleasant surroundings for people to live in. Communal areas were small with furniture that looked dated and unwelcoming.

● There was a pleasant garden area that some people used to go out for a walk around.

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

● People had a choice of meals and said they were happy with the food provided. People were supported to eat and drink enough to maintain their health and well-being. Snacks were provided whenever people wished.

● Mealtimes were a sociable time. People were encouraged to use the dining room, where they were able to sit together and chat. People were also given the choice to eat alone if they preferred.

● Staff said they did not run short of food supplies. The registered manager provided the food people and staff asked for.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

- The provider and registered manager did not have a system in place to assess and monitor the quality and safety of the service they provided. No audits were carried out to regularly check people were receiving safe care that met their needs.
- The registered manager was in attendance in the service most days, but also worked from home. They knew people well but had very little involvement with their care. The provider did not visit the service. The registered manager saw their role as providing practical support such as shopping for food, maintenance jobs and carrying out business tasks such as the finances and servicing contracts. They saw the staff role as providing and managing care and support.
- We found many concerns during the inspection. None of these were picked up by the provider or registered manager. They were not aware of the regulatory requirements or their responsibilities for example, when to report safeguarding concerns to the local authority.
- Notifications were not submitted to CQC when required. One person had sustained injuries following a fall and these had not been reported to CQC.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider and registered manager did not connect with other agencies and did not fully engage with people and staff to listen and make improvements to the service.
- Staff did not have the opportunity to engage in staff meetings. Staff told us they had the opportunity to speak with the registered manager regularly and they were always available on the phone to offer support. Staff said they had raised ideas for improvement, such as better training for staff and more staff on night shifts but told us the registered manager thought the service was running well as it was.
- Residents meetings were not held, and people were not given the opportunity to give their views in a questionnaire. The service was small, and staff said they spoke with people regularly and checked they were happy. However, there was no evidence kept of the outcome of these discussions to inform improvements.
- Staff knew people well and knew the things they liked and didn't like. However, people did not always receive the care they needed. They were not able to attend hospital appointments if relatives could not take them as there were not enough staff available, appointments had not been made with health care

professionals, such as the dentist, in a timely way.
● Staff did not have access to a computer which meant they were not able to access online resources or send and receive emails, for example to the GP or other healthcare professionals. They had to rely on asking the registered manager to do this from home. All care records were handwritten. These were not kept up to date. Staff told us they did not have the time to do this, and when they did, only had time to write a note on the document which meant records were not easy to understand. The lack of access to resources meant staff were not always able to access online healthcare referral systems for people in a timely way. This placed people at risk of receiving less than adequate care.

The failure to ensure assurance and auditing systems were in place to improve the service and provide effective governance was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
● The provider and registered manager did not have contact with other providers, registered managers or local authorities and agencies in order to keep in touch and up to date with local and national changes and initiatives.
● Staff worked well with some visiting professionals, however, were not always aware of what agencies were available to advise and support people and how to access them.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people received care that met their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure care and treatment was provided with the consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure people received safe care and treatment and had their medicines administered safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure people were safeguarded from the risk of abuse.

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

The provider failed to ensure people's care records were accurate and contemporaneous and to ensure assurance and auditing systems were in place to provide effective governance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient numbers of suitably competent, skilled and experienced staff were deployed.