

Orsett House Retirement Home Limited

Orsett House Retirement Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This inspection took place on 6 September 2017 and was unannounced. Orsett House Retirement Home provides personal care and accommodation for up to 49 older people who may have a dementia diagnosis. At the time of the inspection there were 48 people using the service.

There was a registered manager in post at the time of our inspection. 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.

People were not always supported to manage risks to their safety, as staff did not always follow the risk assessments. Accidents and incidents were not always investigated. Medicines were stored safely; however people did not always receive their medicine safely. People sometimes could not alert staff if they needed something as they were left in communal areas without staff support. People told us they felt safe living at the service.

People did not always have their rights protected as the principles of the Mental Capacity Act were not always followed. People did not always receive support from staff in an appropriate way to meet their needs. People were not always supported to monitor their health and seek support from health professionals. People had a choice of meals and drinks and were supported by staff that understood their preferences.

People did not always receive support in a way that maintained their privacy and dignity. People felt the staff were caring. Staff sometimes missed opportunities for interactions with people. People were able to make choices and were supported by staff to maintain their independence.

People's preferences were understood by staff however staff did not always follow people's care plans. People had limited opportunities to be engaged in meaningful activities. People understood how to make a complaint and the registered manager had a system in place to investigate and respond to concerns.

There were systems in place to monitor the quality of the service; however these were not always effective in identifying areas which required improvement. People and staff could approach the management team. The registered manager and staff understood their roles and responsibilities.

There was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regarding need for consent, good governance and safe care and treatment. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe.

People did not always have their medicines safely.

People sometimes had to wait for their care and support.

People were not always supported to manage risks to their safety.

People were not always safeguarded when incidents and accidents happened.

Is the service effective?

Requires Improvement ●

The service was not always effective.

People's rights were not always protected.

People were not always supported by staff with the knowledge and skills to meet their needs.

People were able to choose their food and drinks.

People were not always supported to monitor their health.

Is the service caring?

Requires Improvement ●

The service was not always caring.

People's privacy and dignity was not always maintained.

People were supported by caring staff however staff did not always have time to provide support in a caring way.

People were involved in choices and their independence was promoted.

Is the service responsive?

Requires Improvement ●

The service was always responsive.

People's needs were not always assessed and staff did not always follow peoples care plans.

People were able to enjoy meaningful activities but this was limited.

People understood how to make a complaint.

Is the service well-led?

The service was not consistently well led.

The systems in place to monitor the quality of the service were not always effective.

The registered manager and staff understood their roles and responsibilities.

People, relatives and staff found the registered manager was approachable.

Requires Improvement 

Orsett House Retirement 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.

This unannounced inspection took place on 6 September 2017. The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. When planning the inspection we reviewed the information we held about the service, including notifications. A notification is information about events that by law the registered persons should tell us about. We asked for feedback from the commissioners of people's care to find out their views on the quality of the service. We also contacted the Local Authority Safeguarding Team for information they held about the service.

During the inspection, we spoke with seven people who used the service, three visitors and three visiting health professionals. We also spoke with the registered manager, the provider, one assistant manager, two senior care assistants and two care staff.

We observed the delivery of care and support provided to people living at the service and their interactions with staff. We reviewed the care records of six people and three staff files, which included pre-employment checks and training records. We also looked at other records relating to the management of the service including audits and medicine administration records.

Is the service safe?

Our findings

We looked at the systems in place for managing medicines. This included the storage, handling and stock of medicines and Medication Administration Records (MARs) for people who used the service. We found where people required their medicines to be given without their knowledge this had been discussed with the doctor and pharmacist and advice was available to guide staff to do this safely. Medicines which required additional signatures and special storage were stored and recorded correctly. However our observations showed staff giving medicines to people and we found that not all staff were explaining to people what their medicine was for or confirming that the person had taken their medicine.

We found medicines were stored safely and staff were aware of the procedures to follow to ensure people received medicine as prescribed. However, we found staff were not always following these procedures which meant we could not be assured people were receiving their medicines safely. For example, we found staff were administering medicine for one person that was out of date, staff were unaware the medicine was out of date. This medicine should have been replaced after 28 days however it was still in use 5 days after the discard date, we made the staff aware of this and they confirmed new medicine would be ordered that day. This meant the person was at risk of receiving medicine which would not be effective in treating them.

Some people received medicine on an as required basis. We found there was no guidance in place for staff to show when the medicine should be given. Staff were able to tell us when people received their medicine. Records were completed to show the medicine had been administered; however the impact this had on the person was not recorded. We found one person had been receiving as required medicine daily, staff told us the person needed this on a regular basis, so we advised the provider to speak with the person's doctor to see if this should be given regularly. This meant people may be over medicated or not receive sufficient medicine at the intended time. We looked at medicine stocks and found the medicine administration record totals did not match the stock of medicines in some cases. There were minor differences in totals and staff were confident that this was a counting error. The registered manager had undertaken audits of medicines, however this had not identified the issues we found. This meant the provider could not be assured peoples medicines were being managed safely.

People were not always supported to manage risks to their safety. Staff could describe where people were at risk and could tell us about how people were supported to minimise these. However, staff were not always following peoples risk assessments. For example one person was assessed as requiring a specific diet by the Speech and Language therapy Team (SALT) as they were at risk of choking. Staff understood the requirements but told us they did not always provide the drinks for this person as instructed by the SALT assessment as the person did not like the drinks given in this way and would refuse to drink. We spoke to the registered manger about this and they said they would seek advice about this person from the SALT team regarding their refusal to drink. This meant the person was left at risk of choking due to an inappropriate diet.

We found peoples risks were assessed however where things changed these were not always reviewed. For example, one person had been seen by a health practitioner and found to have a sore area which required

treatment to prevent a pressure sore. We found there was no risk assessment in place and no plan to describe what actions to take to prevent this from developing into a pressure sore and there was no monitoring in place to check if the treatment was working. This meant the person could develop a pressure sore. This showed people were not supported to manage risks to their safety.

We found where accidents and incidents had taken place these were not investigated and action was not always taken to minimise the risk of this happening again. For example, one person had recently fallen, there was no documented time of the fall and no details of the circumstances of the fall or any action taken. This meant the person may be at risk of further falls and information was not available to update the risk assessment. In another example one person had three falls and these were not investigated and no review of the person's risk assessment and care plan was completed. This meant people remained at risk of future falls. We spoke to the registered manager about this and they told us they would make improvements to how this was managed going forward.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment.

People had mixed views about whether there was sufficient staff. Some people told us they felt there was always staff around to support them, whilst others told us they did not feel there were always enough staff. One person said, "At bedtime they're pushed. When you want to go to bed you have to wait because they're busy with other people". Another person said, "I don't think there is enough staff. There are a lot of people to care for and it is hard work". Staff had mixed views about the staffing levels, with staff commenting it can be busy during the mornings and those responsible for medicines administration can get called away from their medicines rounds. Other staff told us evenings could be busy as there were a number of people that required two staff to support them with repositioning. We saw there were times during the day where staff were not present in communal areas for short periods of time which left people without the ability to call for assistance. This meant people sometimes had to wait for their care and support.

People were provided with care and support by safely recruited staff. We found checks had been carried out before new staff started work. This included checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable staff from working in a care setting. Records showed the provider checked proof of identity, employment history, and obtained information about conduct in previous employment.

People and their relatives told us they felt safe using the service. One person said, "I have a sensor mat in place it sounds a buzzer if I was to have a fall". A relative told us, "My relative is safe, we can go away without worrying". Staff could describe different types of abuse and understood how to report any concerns. However, we found staff had not always escalated incidents of potential abuse to the registered manager. We saw there had been an incident between two service users which had not been escalated to the registered manager. We spoke to the registered manager about this and they confirmed they would investigate and make the required referrals. We could see other referrals had been made and investigations carried out with reports made to the appropriate body. This meant people were not always safeguarded from potential abuse.

Is the service effective?

Our findings

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

We checked to see if the provider was working within the principles of the MCA. Staff told us they always sought consent from people before offering care and support and could describe how consent was sought. Staff told us where people lacked capacity to consent; a decision would be taken in their best interests. However during the inspection we observed staff did not always seek consent. For example, one person had some of their possessions locked away and their relatives had consented to this. However there was no evidence to suggest the person had consented and there was no evidence that they lacked capacity to make this decision. The registered manager confirmed this was discussed with relatives but they were unable to provide any evidence of the person having consented despite them having capacity to understand this decision. This showed that whilst consent was understood by staff this was not always sought.

Where people lacked capacity to make decisions staff could describe how they made decisions in the person's best interests. However we found this was not documented in the care plan and capacity to make individual decisions had not been assessed. The registered manager told us they would review people's care records and complete best interests meetings where required. This showed that whilst staff understood how to make decisions in people's best interests, the records of decision making were not always in line with the principles of the MCA.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We observed people were being supported that had their liberty restricted and applications to the authorising body had been made. However, we found people had not had their capacity assessed prior to an application for a DoLS, there was no evidence of assessments to determine if people had capacity. This meant the principles of the MCA had not been followed. We saw DoLS applications did not cover all the restrictions in place. For example one person had a DoLS application to cover them living at the home but this had not covered other restrictions. The person had bed rails in use to restrict their movement at night but this was not referenced in their DoLS application. The registered manager told us they would review DoLS applications to ensure they contained all restrictions. This meant the principles of the MCA had not been followed and people's liberty was being restricted without the correct safeguards in place.

This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

People and relatives told us they felt staff understood their role and how to support people effectively. One

relative told us the staff had received specific training to enable them to meet their relative's needs, they added, " Before my relative came here, they had a medical problem, with the support from staff this has now gone". Staff told us they received training using booklets and some face to face sessions. Staff confirmed the training helped them to understand their role. The registered manager confirmed staff received training in all aspects of their role. However we observed staff were not always demonstrating their knowledge of how to support people safely. For example, we observed staff supporting someone to transfer by using an under arm lifting technique. This is not good practice and can result in people sustaining injuries. In another example we saw staff moving people in wheelchairs without their foot rests in place. This practice places people at risk of injury as their feet may become trapped. Staff were not always seeking consent when administering medicines and medicine procedures were not always followed. We spoke to the registered manger about this and they said staff should be aware of how to provide this care safely. The registered manager confirmed they checked staff competency through observations and within supervision sessions, however there was no documented evidence of the competency checks shared with inspectors. This showed that whilst staff had received training in aspects of their role they were not always using the skills to support people effectively.

People were not always supported to maintain their health and wellbeing. Relatives told us they were informed if their relative was unwell and had seen a medical professional. Staff told us they monitored people's health and referrals would be made to appropriate bodies. One staff member gave the example, "We monitor people's weight once a month, if there are any concerns we use special monitoring charts for food and fluid. If we're still concerned, we get the SALT team involved". We spoke with visiting health professionals and they told us they found the staff were supportive in managing peoples conditions and followed the advice they were given, reporting any changes to people needs. However, we found some people had not been referred to health practitioners to seek advice about their care. For example, one person had not been sleeping well and had disturbed nights on a number of occasions. We found there was no plan in place to manage this and no discussions had taken place with any health professionals. In another example one person had lost weight and whilst this had been recorded there was no action taken to seek advice about this person's weight loss. This showed whilst the service monitors people's health and care needs, they do not consistently act on issues identified, this means people may not have the best possible outcomes and their health could deteriorate.

People and their relatives told us the food was good and they could choose what they wanted to eat. One person said, "We have a choice of main meal. If there's something you can't eat, they'll give you something else". Another person added, "The food's very good. I like my food, especially a roast dinner. I'm a good eater. I eat most things. We normally have a sandwich or a salad for tea. For breakfast, we get a choice of cereal or porridge". We observed the cook speaking with people about their preferred choice of meals. We also saw a picture menu was available to assist people with making choices. However, we observed staff did not always use this when people may have benefited from seeing their choices to make a decision about their meal. This showed people could choose their meals and drinks.

Is the service caring?

Our findings

People and their relatives told us staff were respectful. One person said, "The staff are respectful. They let me do what I can for myself". Another person said, "I found the personal side of it quite difficult at first but they're very good. They do knock and say, we're just coming in to check that you're ok". Staff told us they understood the importance of maintaining people's privacy and dignity. However we saw staff were not always considerate of people's dignity, we observed staff using terms to speak with people that were not dignified and found staff were not considering how they supported people to maintain their dignity. For example, we observed staff providing care in a way which was not considerate of people's feelings. For example, one person was crawling around on the floor and staff walked past this person several times they did not attempt to engage the person on meaningful activity. We asked staff about this and they said the person often did this, we saw this was identified in his assessment but there was no care plan in place to guide staff to try and engage this person in meaningful activity. We checked if there was some way the person may be encouraged to participate in an activity to distract them. Staff then told us there was some equipment which may encourage the person to engage in activity. Staff fetched this item and we found the person became engaged in using this whilst sitting in a lounge area. This showed that whilst people had some positive experiences staff were not always ensuring people's needs were considered. This showed people's dignity was not always promoted.

People told us staff were caring and kind. One person said, "They are good workers; very helpful". Another person said, "The staff have been kind. They do knock and they do respect me". Relatives told us they felt staff were caring. One relative gave the example, "My relative can get upset when I leave, the staff are always kind and offer comfort when this happens". Visiting health professionals also told us people were supported by caring staff. One commented, "The staff here are lovely, they are very caring and they act on any concerns straight away". Staff told us, they loved their job role and felt they were able to treat people like a family member. One staff member said, "We have developed good relationships with people and their families". We saw some positive interactions between people and staff however there were times when interactions could have been improved. For example when staff were supporting people with their meals there was little interaction between people and staff. This meant there were some missed opportunities for staff to interact with people.

People were supported to make choices about their care and support and retain their independence. One person said, "We have a choice of main meal. If there's something you can't eat, they'll give you something else". People described that they were able to choose what they did during the day, where they spent their time and how much support they received. One person told us about how staff allowed them to be independent with their personal care as they realised how important this was to them. Staff told us this was important to maintain people's independence and allow people to make choices. We observed people making choices throughout the day for example, people were asked to choose what they would like to drink and eat and where to sit. Records showed people were able to make choices about their care and care plans were written to encourage independence. For example, plans detailed which aspects of care people were able to complete without assistance from staff. We saw staff following these plans during the day. This showed people were encouraged to maintain their independence and make choices about their lives.

Is the service responsive?

Our findings

People and their relatives told us staff had a good understanding of their needs and preferences. One person told us, "I prefer a bath and always have one once a week, the staff help me with drying my hair". The person added, they prefer to get up early which is what they have always done and staff support them with this. One relative said, "The staff know my relative well, they know all their likes and dislikes". The relative was able to share examples with us. Staff could describe people's needs and preferences to us and how people's needs should be met. However we observed staff were not always following people's care plans. For example, staff were not following risk assessments for people with regards to their dietary needs or safe moving and handling. We found some people had needs that staff were aware of but these were not always documented in people's care records. For example, one person was living with diabetes, whilst staff could describe how to support this person this was not documented in the care plan. This meant that whilst staff understood people's needs they were not always meeting them as set out in their care plan.

People did not always have their needs assessed and plans put in place. For example, we found one person was living with diabetes which needed to be controlled by following a special diet. Whilst staff understood how to meet this person's needs and they were receiving a special diet there was no documented risk assessment of care plan guidance for staff on how to meet this person's needs. This meant the person was at risk of not receiving support to manage their diabetes.

People and their relatives were involved in their assessment, care plans and reviews. One relative told us, "The staff involved us in the care plan when my relative first came in. They like to sleep in the afternoon; having done so all their life". They adapted my relatives' room and moved the call bell so they can ring from the chair or bed". We saw reviews were taking place of people's care plans. However these reviews did not always take account of significant events which had taken place. For example one person had experienced a number of falls and although the care plan had been reviewed there was no reassessment of the risks associated with falling and no action had been taken to try to prevent the falls. This meant whilst reviews were taking place they were not always effective in identifying changes to people's needs which in some cases left the person at risk.

People told us they were supported to follow their interests and take part in social activity. One person said, "Sometimes we have singers. I do like that. We usually go across to the other side and we also have an exercise lady that comes in". Another person said, "If it's a nice day, we go into the garden to sit". People told us they were supported to meet their spiritual needs. One person said, "The priest will come and give me Holy Communion every month". Another person said, "I was active in the Church. The Minister comes to see me about once a month. It's very important to me". Staff told us there was a staff member employed to provide activities for people. Staff could describe the type of interests people had and the things they enjoyed. They told us the time spent with people depended on how many tasks they had to complete. However, on the day of the inspection we observed people were sat in the lounge with little interaction from staff unless they were supporting people with a care task. We saw one person was left wandering from lounge to lounge without any interactions. This showed people sometimes had limited opportunities for engaging in meaningful activity.

People and their relatives understood how to make a complaint. One relative told us, "There is a booklet which you can write in or you can go straight to the manager and say if there is a problem". We saw there was a complaints policy in place and the registered manager could explain how complaints would be investigated and a response given. There had not been any complaints since our last inspection. This showed the registered manager had a system in place to receive and respond to complaints.

Is the service well-led?

Our findings

The registered manager did not have effective systems in place to identify concerns and make improvements to the quality of the service people received. For example, we found there was a medicines audit in place which looked at the administration of medicines, the audit had not however identified the concerns we found with medicines such as out of date medicine being in use, stock counts not being correct and poor recording of as required medicines. We spoke to the registered manager about this and they confirmed the record of the audits could not demonstrate any changes made following these audits and they would not have identified the areas of concern we found with medicines. This meant people were at risk of receiving medicines which were ineffective and being over medicated.

The registered manager told us care plans were audited as part of the review, however we found these reviews had not been effective in identifying changes to people's needs and care plans and risk assessments had not been updated following incidents and accidents. This meant people's needs were not always met in the most appropriate way and care plans were not always fully reflective of people's needs.

Where people had accidents or incidents, these were documented by staff in people's care plans but there was no evidence of any investigation or actions taken to minimise the risks of further occurrences. Accidents and incidents were not triggering a review of people's care plans and risk assessments. We spoke to the registered manager about this and they confirmed there was no monitoring of accidents to look for patterns and enable action to be taken. This meant people remained at risk of reoccurring accidents and incidents.

The registered manager did not have systems in place to ensure people's rights were protected by following the principles of the MCA. For example, staff were making decisions in people's best interests, however there had been no documented discussions about this. In a further example, people with DoLS applications in place had not had their capacity assessed to determine if an application was required. Where people had a DoLS application this had not considered all the restrictions for people. This meant people were at risk of having their liberty restricted without the correct safeguards in place.

The registered manager had not identified where staff were not using appropriate methods of providing care and support. For example, we saw someone transferred using underarm lifting and staff walking with this person holding them under their arms. We spoke to the registered manager about this and they confirmed there was no system in place to check the competency of staff with manual handling. There were times when people had to wait for their care and support. We were told the staffing levels were decided by the provider. There was no system in place to determine how many staff needed to be on duty or how they should be deployed. This meant the issues we found with people waiting for their care and support had not been identified by the registered manager.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance.

People, relatives and staff told us they knew the registered manager and the providers and were able to

approach them with any concerns they had. One person said, "I can talk to the manager". Relatives told us they could approach the manager about things and they had been very accommodating. Staff told us the registered manager was approachable and they felt able to raise matters with them. One staff member said, "I have support from the registered manager and the deputies and seniors as well". Staff told us the registered manager offered them support in their role. They told us they had access to them continually and could seek support through their team meetings and supervisions. The records we saw supported this. We saw the registered manager was available to staff throughout the day. This showed the registered manager was approachable and people and staff were comfortable in seeking support.

The registered manager was notifying us of significant incidents for example DoLS approvals and allegations of abuse. The rating from the last inspection was on display in the home. This showed the registered manager understood their role and responsibilities.

People and their relatives had been asked for their feedback. The registered manager told us they had not carried out any resident meetings but they conducted a survey annually to find out what people thought about the service. They also said that people and relatives raised matters with them informally. We saw evidence of the survey that had been completed however the results had not been analysed so we could not identify if there had been any improvements following the feedback. This showed people and relatives had their views sought but it was not clear how this was used to drive improvements.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not working within the principles of the MCA.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not assessing peoples risks and taking action to mitigate them.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place were not effective at identifying concerns.