ONH (Herts) Limited

The Orchard Nursing 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?	Good
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 was carried out on 5 July 2016 and was unannounced. At their last inspection on 29 March 2016, The Orchard Nursing Home was found to not be meeting all the standards we inspected. The issues related to the safety and welfare of people, staffing and the management of the service. The provider sent us an action plan stating how they would make the necessary improvements. At this inspection we found that they had made some of the improvements set out in their action plan but in some areas the service required further improvement to meet the regulations. This was in relation to management of medicines and the management of the service. We also found that people were not always protected from the risk of abuse.

The Orchard Nursing Home provides accommodation, care, nursing and support for up to 63 older people, some of whom are living with dementia. At this inspection 41 people were living at the service.

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

People's medicines were not always recorded accurately and staff knowledge in regards to safeguarding needed to be improved and unexplained injuries needed to be reported. People's individual risks were assessed and mitigated where possible.

People's dignity was not always respected and attention to the smaller details was not always considered. The activity programme in the home had reduced and consideration had not been made on how care staff could supplement activities for people.

The systems and leadership put into place needed more time to allow them to embed and develop further. People, relatives and staff were positive about the changes to the management and leadership in the home.

People were supported by sufficient numbers of staff who were recruited through a robust process. Staff had received training and supervision and told us they felt supported.

People had their consent sought and the service worked in accordance with the Mental Capacity Act. We found that people and their relatives were involved in planning their care but work was needed on how to ensure this was consistent and documented.

People enjoyed their food and had their nutritional needs assessed. People had access to health and social care professionals as needed.

People told us their care needs were met and their plans gave guidance to staff to meet their needs. We also

found that confidentiality was promoted and that people knew how to make a complaint and were confident that manager would respond appropriately.

In relation to the areas they were not meeting the standards, 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 consistently safe.

People's medicines were not always recorded accurately.

Staff knowledge in regards to safeguarding needed to be improved and unexplained injuries needed to be reported.

People's individual risks were assessed and mitigated where possible.

People were supported by sufficient numbers of staff.

Staff were recruited through a robust process.

Is the service effective?

Good

The service was effective.

People were supported by staff who received training and supervision.

People had their consent sought and the service worked in accordance with the Mental Capacity Act.

People enjoyed their food and had their nutritional needs assessed.

People had access to health and social care professionals as needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity was not always respected and attention to the smaller details was not always considered.

People and their relatives were involved in planning their care but work was needed on how to ensure this was consistent and documented.

Confidentiality was promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The activity programme in the home had reduced and consideration had not been made on how care staff could supplement activities for people.

People told us their care needs were met and their plans gave guidance to staff to meet their needs.

People knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The systems and leadership put into place needed more time to allow them to embed and develop further.

People, relatives and staff were positive about the changes to the management and leadership in the home.

The Orchard Nursing 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Before the inspection reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We also reviewed information the provider had been sending us since the last inspection, this included the action plan.

During the inspection we spoke with 10 people who used the service, 12 staff members, six relatives, the regional manager and peripatetic manager. A peripatetic manager is a manager employed by a provider to manage services while there is not a permanent manager in post.
We also received feedback from professionals involved in supporting people who used the service and reviewed the recent reports from service commissioners. We viewed information relating to five people's care and support. We also reviewed records relating to the management of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 29 March 2016 we found that the service did not ensure people were protected from risk or harm. At this inspection, although we found there had been some improvements made in relation to how risks were mitigated, their remained continued concerns in relation to medicines management, and staff knowledge in regards to ensuring people were protected from the risk of abuse required further development.

The provider had whistle blowing and safeguarding policies and procedures in place. The management demonstrated a clear knowledge of what actions to take in the event of any safeguarding concerns. Staff members confirmed to us that they had received training to give them the necessary skills and knowledge to recognise abusive practice and were clear that any suspicions of abuse should be reported immediately. There was information available throughout the home to guide staff to report any safeguarding matters however, not all staff members we spoke with were clear about how to report any concerns to outside agencies, even when posters providing this information was pointed out. We identified issues that should have been considered or reported under safeguarding procedures to ensure that people were not at risk of abuse had not occurred as required and staff had not ensured the proper process was followed. For example, we identified issues regarding unexplained bruising or skin tears that had not been sufficiently reviewed.

Therefore this was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The arrangements for the management of people's medicines needed further improvement to ensure they were consistently safe. We observed a staff member encouraging people with their medicines, going at their pace and without rushing them. Staff were appropriately trained and confirmed to us that they understood the importance of the safe administration and management of medicines. However, records relating to the stocks of medicines held at the home were not always accurately completed which meant that it was not always clear if people had received their medicines as prescribed. We also found that similar issues and an issue where two people may not have had their medicines as prescribed was identified during an audit which indicated that issues with medicines had been ongoing since our last inspection. We discussed this with the management team and they acted immediately to investigate the discrepancies with records and resolve any issues which demonstrated that they responded promptly to ensure people received their medicines safely.

However, due to the issues identified this was a continued breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff supported people to move safely using appropriate moving and handling techniques and equipment. For example, we saw two staff members using a mechanical hoist to assist a person to transfer from a wheelchair to an armchair. The staff reassured and talked with the person all the way through the procedure and we observed them check that the sling was appropriately fitted before they lifted the person.

Risks to people`s health and well-being were identified and risk assessments had been developed detailing the measures to be employed to mitigate these risks. For example we saw that a person had been assessed as being at a high risk of falls when mobilising independently. Staff carried out preventative measures to manage the risks to the person including checking that the person had their walking aid at hand and also wore appropriate footwear. People who had been assessed as requiring bedrails on their bed to prevent them falling had protective covers over the rails to reduce the risk of entrapment unless they had specifically requested otherwise.

We checked pressure mattresses for people who had been assessed as being at risk of developing pressure ulcers and we found that they were at the appropriate setting for their weight. Records were available to confirm that regular bedrail and mattress checks were undertaken to help ensure people's safety and wellbeing. Staff told us that people were assisted to reposition at appropriate intervals to help maintain their skin integrity and records were maintained to confirm when people had been assisted to reposition.

People and their relatives told us that they felt there had been significant improvements made in regard to staffing levels at the home. They recognised that a successful recruitment campaign had been undertaken which meant that the use of temporary staff had reduced. People told us that they got their needs met promptly. One person said, "Staff are always around, they are helpful." One relative told us, "It is nice to see consistent staff because they get to know my [Relative] and their needs."

Staff members told us that although they had previously been concerned about staffing levels in the home they felt that there were now enough staff available to meet people's needs. Staff told us that many new staff had been recruited since the previous inspection and that this was an ongoing programme. They told us that the recruitment of a permanent staff team had made a significant difference to the standard of care provided for people.

Newly recruited staff confirmed that a robust recruitment process had been followed prior to commencing their employment with the service. For example, disclosure and barring service checks [DBS] had been made and references obtained to help ensure staff were safe to work with vulnerable adults.

Good

Is the service effective?

Our findings

People told us that they felt staff were appropriately skilled for their role. One person said, "The staff are all very good. That makes a big difference."

Staff received training to support them to be able to care for people safely. Staff members told us of various training elements that they had been provided with and we saw reference to training courses planned. This included basic core training such as moving and handling, safeguarding vulnerable adults and dementia awareness. However, we found that some staff had inconsistent knowledge in regards to safeguarding people.

Staff told us that the management team was supportive. Staff confirmed that they received regular supervision from a line manager. All staff we spoke with said they received support as and when needed and were fully confident to approach senior staff and management for additional support at any time.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met that service was working in accordance with the MCA and DoLS guidance. We found that the service was working in accordance with MCA and DoLS.
People were encouraged to make their own decisions their consent was sought before care was provided. Where people were unable to make their own decisions, a capacity assessment was completed and where needed, best interest meetings were held to ensure people received the right support. DoLS applications were applied for appropriately and these were pending an outcome, and whilst a decision was pending staff ensured the least restrictive option was used to promote safety was practised.

People told us that they enjoyed the food provided for them. One person told us, "The food is much better lately." We noted there was a new chef and people and their relatives were aware of them. They told us selections of fruit and cakes were offered through the day. Assessments had been undertaken to identify where people may be at risk from poor nutrition or hydration. Where concerns had been identified we noted that specialist advice had been accessed and their advice had been incorporated into care plans and actioned.

During the lunch service we noted one person who did not eat their soup and when the main course was placed in front of them they pushed it away. Staff told us that this was perfectly normal and that the person usually started to eat their meal once the other diners had left the dining room. Consideration had not been given to finding alternative ways of encouraging the person to eat their meal whilst it was fresh and warm.

Such as offering them an alternative and quiet location to eat or serving the person's meal at a separate time. We discussed this with the management team who told they would immediately address this to help ensure a suitable dining environment for this person.

People's health needs were met. We saw records of health appointments attended including physiotherapist, speech and language therapist, chiropodist and dentists. A social care professional told us that they had found the service to be proactive in identifying concerns in relation to a person' s health and welfare needs and in accessing the appropriate support for them.

Requires Improvement

Is the service caring?

Our findings

People told us that the staff were kind and caring. One person said, "I like it here, the staff are all friendly." Another person said, "Staff are very kind." Relatives told us they thought the staff team were kind and caring. One relative told us that one of the nurses had, "The best bedside manner, if everyone learns from them they will do a good job." However, one relative told us that the staff were kind but sometimes the smaller things, such as delivering a newspaper on time or changing a person's top if they had dripped food onto it did not always happen.

We saw that although the staff were kind, the smaller more attentive tasks were not always recognised. For example, when a person said they were cold, staff had to be prompted by a senior member of the management team to close the window and when a person wanted a mug for their tea, they were given a cup, despite being asked repeatedly by the person's relative. Eventually the staff member retrieved a mug from another floor but it was a long process for this to be carried out. On a second occasion a person had been asking for a cup of tea and was repeatedly told by staff that they were busy and they would make their tea soon. The person had a bowl of porridge placed in front of them but pushed it away. After a period of 15 minutes a staff member gave the person a cup of tea which they immediately started to drink and the relief and delight on their face was evident. The person was then happy to eat their porridge even though it was cold by this time.

One person was sat at the breakfast table and was fast asleep with their porridge in front of them. It was only when prompted by a member of the senior management team that staff helped the person to go back to bed.

Practice varied amongst care staff in how they supported choice. For example, some care staff asked people if they would like to use a clothing protector at mealtimes whereas other staff just put them on for people with no interaction at all. We heard a staff member ask, "Would you like me to put this on for you or just on your lap?" Whereas another staff member approached a person saying, "Here you are [Person's name]" as they put the clothing protector around the person's neck.
Another example was that some staff showed people the meal choices so that they could make their decisions based on the look and smell of the meals whereas other staff just showed people the menu despite the fact that it was too small for them to see or that they did not have the capacity to understand.

Staff did not always use appropriate language when referring to people or tasks around the home. For example, when we asked where the nurse was the response we received was, "They are feeding." This terminology does not promote people's dignity.

This was an area that requires improvement. We discussed this with the management team and they acknowledged that there was still work to do in this area and had a plan in place to embed this knowledge into staff and to encourage them to use their initiative.

Some people told us that they were more involved in the planning of their care and some relatives also told

us they had been involved in reviewing people's care needs. One relative said, "We work together now and I really think it has made things better for [person]." They gave us examples of how this had improved and what changes had been made to their relatives care. Another relative told us, "I have a really good relationship with all the carers and nurses." However, one relative did tell us that they felt that communication still needed improvement. We found that involvement in planning and reviewing of people's care was not consistent and this needed further development to ensure that this was clearly documented.

The environment throughout the home was warm and welcoming. People's individual bedrooms were personalised with many items that had been brought in from their home such as cushions pictures and lamps. We saw that people were relaxed and comfortable to approach and talk with care staff, domestic staff and management alike. We observed all staff interacting with people in a warm and caring manner.

People`s right to privacy was promoted. We saw that staff knocked on people's doors before entering their rooms. Staff acted on people`s preferences to have their bedroom doors open or closed and we saw staff closing bedroom doors when personal care was delivered.

Relatives and friends of people who used the service were encouraged to visit at any time and we noted from the visitor's books that there was a regular flow of visitors into the home. Some people who used the service did not have the capacity to make decisions about their care and support or to communicate clearly and we noted that an external advocacy service was available to provide people with support in this instance.

People's care records were stored in a lockable office on each floor in order to maintain the dignity and confidentiality of people who used the service.

Requires Improvement

Is the service responsive?

Our findings

The activity programme for people had reduced over recent weeks. The management team, staff and people told us that this was due to a member of the activities team recently leaving and the post was filled but the new staff member was pending recruitment checks before they could start work. One person said, "There used to be activities but they have tailed off recently. I don't do anything. I watch TV." People told us that they had external entertainers such as singers come into the home to provide entertainment for them from time to time and that they enjoyed this. One person said, "We get asked if we want to go anywhere of interest." We were told that there was an upcoming trip to some gardens.

However, during the course of the inspection we saw that people did not have any stimulation and engagement. One staff member located a ball and started to try to engage with one person after we had asked them what they did to involve people. Relatives told us that there was a distinct lack of opportunities to involve people. One relative said, "There is no fun, no entertainment."

We saw staff were sat in communal areas but they did not engage with people or involve them with daily tasks around the home. The culture was such that activity was the specific role of the activities co-ordinator and there was no understanding amongst the care staff team that providing stimulation and engagement was part of providing care for people. This was an area that required improvement.

People who used the service and their relatives told us that they would be confident to raise any concerns with the management team. A relative told us they would be confident to raise issues with the manager because they were, "Approachable and personable." We saw that information was displayed on how to make a complaint and the management team visited people daily to check if things were ok. Any concerns were investigated and shared with the provider. However, we did note that one complaint that was yet to be signed as completed had not been reported to the provider on their internal system.

People told us that they had their needs met. One person said, "I'm happy here. I've got everything I want. Staff give me everything I need. I need help with things, like getting dressed." Relatives also told us that they felt that people's needs met. One relative told us that they needed to prompt or check with staff to ensure that everything was carried out in a way that met their relative's needs. However they said, "[Relatives] care never suffers though, they are very kind." We noted that people received care that met their needs and at a time that suited them. We observed staff supporting people in accordance with their care plans.

People had individual plans in place with gave staff clear guidance on how to meet people's needs. We also saw that key information was displayed in the nurse's station to ensure staff did not forget certain support tasks or information in the event of a medical emergency. This information including how needed to be repositioned regularly, who required support to eat and drink and choices in relation to gender of the staff who supported people. This helped to ensure that people's needs were met safely and in accordance with their preferences.

Requires Improvement

Is the service well-led?

Our findings

When we inspected the service on 29 March 2016 we found that the systems in place to monitor the quality of the service and leadership was not effective. At this inspection, although we found that there had been improvements, there remained some areas that needed further development.

People, relatives and staff told us that the instability of management had been a significant factor in the concerns that had occurred at the service. We were told by those we spoke with that a permanent manager was needed to sustain improvements. We noted that during a period of change the service had been heavily supported by a senior management team and that when things start to improve, these resources are be reduced. This is an area that required consideration to ensure that the necessary improvements are made and also sustainable prior to support measures being removed.
We found that permanent nursing staff had been appointed and this had provided stability to the floors and ensured a consistent oversight of staff practice and people's welfare. However, we noted that when the nursing staff were busy with clinical task or medicines, staff still needed direction. For example, to identify and meet people's needs. On the day of the inspection a senior member of the management team carried out this role but we discussed with them how this would be addressed in the long term or on a typical day when they are not in the building. The regional manager told us that they would review the timings of the medicines round to enable the nurses to provide supervision at key times. The nurse told us they would work more closely with the senior care staff to ensure they provided more structured supervision.

There were systems in place to monitor the service and address any issues found. These were working in accordance with the action plan that the provider had sent us. However, we noted that these were still not as effective as they should be. For example, we noted that a medicines audit had addressed shortfalls but there was no action recorded of what was done to address these shortfalls. The regional manager told us that a daily record had been implemented to ensure stocks were tallied at the time of administration. However, we noted that this was not in place on one of the units and there were discrepancies in records on two of the three units indicating that this system was ineffective. We also found that a complaint hadn't been logged onto an internal monitoring system and the staff rota did not accurately reflect the staff who worked on shifts. These issues had not been identified by internal quality systems.

Additionally we found that unexplained bruising and skin tears were not reviewed appropriately at management level and therefore were not investigated or reported under the safeguarding process. Staff knowledge in relation to safeguarding was inconsistent.
There issues had not been identified by the management team, despite it being an issue in the service previously.

Although we found that in a short time frame there had been improvements made to the service, which ensured the safety and welfare of people, the need for further development and embedding of good practice and systems meant that this was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People and their relatives told us that they felt the management and the leadership of the service had improved. One person said, "[Manager] is nice, see them around, they had a lot to do, it's better now." A relative said, "It's so different, so much better now." Another relative told us, "[Manager] is very approachable and nice." People knew who the peripatetic manager was and also were aware of a new manager who was on holiday. We saw that the peripatetic manager knew everyone well and walked around the home regularly.

Staff were positive about the management of the home. One staff member said, "[New manager] is amazing, I wish [they] were permanent." Another staff member said, "There have been so many positive changes, I feel good coming to work now." We noted that the new manager was in post to support the home until such time as a permanent manager was recruited.

During the course of the inspection we noted that the management team were open and approachable. We noted that they had a regular presence around the home and addressed the people who used the service by name.

Staff told us that management assisted with mealtimes, this showed that the management familiarised themselves with all aspects of the home's performance and by working alongside the staff team they were able to drive forward improvement.

Relatives of people who used the service told us that the manager had made a positive difference to the way the home operated which reflected on the general feeling when they entered the home. One relative said, "There has been a significant improvement across all areas, [Manager] is really good and staff seem to be much happier and settled now."

Staff told us that the manager had brought about many improvements since they had been in post. One staff member said, "[Manager] is a breath of fresh air, they demonstrate character and interaction." Another staff member said, "It is so much better now, I am really happy now, it is less stressful." Staff told us that the improvements included stability, support, staffing numbers, reduced agency staff usage and generally creating a calm and inclusive ethos.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines records were not always accurate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from the risk of abuse as staff knowledge was inconsistent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place did not always identify and address shortfalls in the service.