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 caring?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was carried out on 25 October 2016 and was unannounced. At their last inspection on 5 July 2016, they were found to not be meeting all the standards we inspected. This was in relation to safety of people, safeguarding and management systems. They sent us an action plan setting out how they would make the necessary improvements. At this inspection we found that they had not made the required improvements.

The Orchard Nursing Home is registered to provide accommodation for up to 63 people. The home provides support with personal care and nursing care for older people, some of whom live with dementia. At the time of the inspection there were 51 people living there.

The service had a manager who was not yet registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the 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. The manager had started their application by applying for checks with the Disclosure and Barring service (DBS).

We found that unexplained bruises and injuries were not always investigated or reported appropriately, and that staff did not always practise safe moving and handling techniques. We also saw that records relating to pressure care management were inconsistent and not always completed. Staffing deployment and organisation needed to be reviewed. However, people were supported by staff who were recruited safely and medicines were managed safely.

Although we observed some positive interactions with people and staff, people were not always treated with dignity and respect. We also found that privacy was not always promoted.

Management systems were not used consistently or fully embedded throughout the service. While there had been some improvements in regards to the management of the service, there still remained areas that needed to be addressed.

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.

Unexplained bruises and injuries were not always investigated or reported appropriately.

Staff did not always practise safe moving and handling techniques.

Staffing deployment and organisation needed to be reviewed.

People were supported by staff who were recruited safely.

Medicines were managed safely.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect.

Privacy was not always promoted.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Management systems and expectations were not consistent or fully embedded throughout the service.

There was a new manager in post.

There had been some improvements in regards to the management of the service.

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 reviewed a copy of the action plan the provider sent us following the previous inspection.

The inspection was unannounced and carried out by two inspectors.

During the inspection we spoke with five people who used the services, two relatives on the day of inspection and two others who we spoke with before the inspection, five staff members, the newly appointed manager and the operations director. We received information 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

When we last inspected the service on 5 July 2016 we found that medicines were not always managed safely, unexplained bruises and skin tears were not reported or investigated and people did not always receive safe care. At this inspection we found that although the management of medicines had improved, they had not made all of the necessary improvements in the other areas.

Staff members were receiving training to help ensure they had the knowledge to recognise abuse. One staff member told us that they would report any concerns to the nurse or higher up in the management team if needed. There was information available throughout the home to guide staff to report any safeguarding matters however, staff were not clear about how to report any concerns to outside agencies, even when posters providing this information were displayed. We found that some injuries, such as bruises to shins were not recorded on people's body maps indicating that they had not been identified as an injury. Where body maps were completed and an accident and incident form was completed, where these were unexplained injuries, they had not been referred to local authority safeguarding or received an investigation to try and ascertain their cause. This was also an issue at the previous inspection.

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

Staff did not always use safe moving and handling techniques. We observed staff holding people's wrists or hands when helping them stand or when walking with them. Another person was supported to walk with no aids which resulted in the person leaning backwards whilst walking placing them at risk of falling. This put them at risk of injury due to how staff were holding them and placed staff at risk of injury. This person's moving and handling plan, which had been completed in January 2016, stated that they walked independently and had not been reviewed or updated to reflect their current level of mobility and therefore they had not been assessed for mobility aids that may have been required. We also saw a staff member physically sit a person up from a lying position on their bed by briskly pulling them into a sitting position manually, even though the person stated they wanted to stay on their bed. We noted that the person put themselves back to laying down and the staff member said they would come back later.

We saw from care records that people who were assessed as needing two, three or four hourly repositioning did not always receive this. Staff told us that as people were moved from chair to wheelchair they did not need any additional repositioning. Repositioning charts were not completed in accordance with people's assessed needs, and where there were some entries, these had gaps of several hours more than what was documented as needed. We noted that most people had automated pressure relieving air mattresses. However, one person who had a mattress that was manually set had been set to the wrong weight. The person weighed 39kg and the mattress was set between 51 and 75kg.

Due to the ongoing issues with moving and handling and inconsistent pressure care management, this was a continued breach of Regulation 12 of the Health and Social Care act (Regulated Activities) Regulations 2014.

People told us that mostly they felt safe but that staffing was an issue. One person said, "I do feel safe." Another person told us, "If you want a bedpan they vanish and come back in 20 minutes and they say what do you want." One relative told us, "Overall, I do think [Relative] is safe." However, they went on to say, "[Person] feels they don't come quick enough when they are called." They also said, "Staffing numbers seem to have improved recently." We noted that there appeared to be plenty of staff around on the ground and middle floor. However, on the top floor, people were left sitting and waiting at the table for breakfast for up to an hour before they were served.

Generally throughout the day, call bells were answered promptly and people were supported in a timely way. However, we noted that after lunch when everyone needed to use the toilet, this resulted in people waiting for long periods of time. We heard one person say, "Sorry I've done it now and I'm in a mess." The person was taken to their room, where they were left to wait again for another 10 minutes as staff were too busy to assist them. We spoke with a staff member about this who told us, "There are five of us, 19 people, lots of people need feeding and most need two staff to help them, we can't get to them all at once, there's not enough staff." We discussed deployment and organising of staff with the management team to avoid people experiencing these long delays to access the toilet.
People's medicines were managed safely. We saw that medicine records were completed consistently, handwritten entries were countersigned, there were appropriate storage facilities and the system was audited regularly. We observed staff administer medicines and noted that they worked in a safe way.

Safe and effective recruitment practices were followed to help ensure that staff were of good character, physically and mentally fit for the role and sufficiently experienced, skilled and qualified to meet the needs of people who used the service. We saw evidence that identification checks and permanent address checks of applicants had been undertaken.

Requires Improvement

Is the service caring?

Our findings

People's dignity was not always respected and staff did not always display a caring approach. One person told us, "Most of the staff are caring, some of the [other] staff are not as caring, they don't seem to have the right attitude." Another person said, "99% are kind, some a bit rushed and brisk." A relative told us of their experience when a person moved into the home. They said, "We didn't get much of an introduction. We felt lost, no one explained to us how everything happens, this is an alien environment to us. It felt chaotic so we couldn't ask people." They went on to say that now, "Care wise they are good and patient with [Relative.]" and, "Nurses are very helpful."

We found that on the second floor which mainly supported people living with dementia was an area where staff appeared less attentive. We noted that people had their position changed without staff asking them or informing them, one of which was made jump by staff suddenly moving them, and had food put in front of them without conversation or explanation. People were then seen to have aprons put on them before eating without being asked. One person was seen to be trying to ask for attention when staff wheeled them into the dining room, 'parked' the wheelchair at the table and walked away. They were tearful and held on to our hand when we approached them. We also noted that one person sat with their trousers undone and staffed walked with this person to the dining room and did not acknowledge that their trousers were undone or help them to do them up.
We saw that one person, who was displaying behaviour that challenged others, was extremely anxious and when asked, staff showed us the scratches they had received and were unable to describe any techniques they could use to relieve the person's anxiety. We saw that when staff went in their room, their manner, tone and positioning was loud and did not demonstrate kindness. The person's care plan was very basic in relation to their needs and did not give staff a sense of how they could support them well. Staff appeared to lack understanding regarding supporting people who lived with dementia. For example, asking questions such as, "Where do you want to sit here or there?" This was said in a strong accent and the person was clearly confused, so the staff member just shouted the questions at them much louder. We discussed with the management team as there was a need for staff to have better understanding and communication in this area to help alleviate the anxiety levels.

We also found that people's privacy was not always promoted. People who were cared for in bed had their doors open. As we walked around the home we saw people in a state of undress during the day. This was recorded in plans as a way for staff to observe people as they walked around the home rather than as the person's preference.

Due to people not being consistently treated with dignity and respect, this was a breach of Regulation 10 of the Health and Social Care act (Regulated Activities) Regulations 2014.

We did note some attentive interactions. We saw when someone was struggling to drink with their cup, a straw was brought to them to help promote their independence and when someone was feeling unwell, two care staff went to them and also got the nurse to come and check on them. We noted that the nurse on the top floor took time explaining things to people and checking on them. The most positive experience was on

the middle floor where we heard staff speaking with people and asking how they were and again on the ground floor where staff engaged well with people. One person told us about a staff member that they felt they could depend on. They said, "[Staff member] is very kind, she even gets me shopping if I need it."

Requires Improvement

Is the service well-led?

Our findings

When we last inspected the service on 5 July 2016 we found that the management systems in place were not effective in identifying, addressing and resolving issues in the home. At this inspection we found that they had made some improvements, however this had not been consistent.

There was a new manager in post who had been at the home six weeks. They were being supported by the operations director, who was supporting the home in the regional manager's absence. The regional manager, who had been in regular contact with the service, was on annual leave at the time of the inspection. As a result the systems put into place following previous inspections to monitor and address issues in the home, were not being consistently used and the team responsible for managing the service were unable to locate these or ascertain if they had been completed. For example, a care plan audit which was particularly important due to ongoing concerns from the local authority about the content of these. We also found that information relating to people's care needs was not up to date. For example, in relation to moving and handling.

Records indicated that there had been no supervisions undertaken at the home since August 2016. We asked the manager if they had undertaken any supervision since coming into post and they told us that they had not. They did however say that the regional manager had carried out, "… loads of supervisions.", but the management team struggled to find the records to evidence this.

A catering manager in the provider's organisation had undertaken an audit of catering arrangements in the home on 30 September 2016. The audit identified areas for action with dates for some tasks to be completed. The catering manager had undertaken a subsequent visit to check on the progress of the identified actions. However, there was no evidence to show what actions had been completed and which were still outstanding.

The manager reported that the regional manager had undertaken two monitoring visits and provided us with a copy of the most recent visit undertaken in September 2016 and they did not identify issues with records not being completed. We also reviewed the regional managers monitoring visit report for August 2016 and noted that they had found that pressure relieving mattresses and cushions were in use, were appropriate for people's level of risk and were set to the correct weight for people. The regional managers monitoring visit for August 2016 also identified that all accidents and incidents had been triangulated, documented and actioned as appropriate. However, we found this not to be the case for September and October. Some of which had also been identified by the regional manager's audit.However, even with these checks in place, all of the charts we reviewed during the inspection, which were dated October 2016, had not been completed.

The operations director advised us that the provider had a suite of audits, including infection control, care plans, environment and medicines. They undertook to try and find the recent audits and action plans for us, but were unable to during the course of the inspection. The infection control audit was sent to us after our visit. However, these audits had not identified that staffing, at peak times of the day, was not meeting

people's needs and therefore there was no plan in place to address the issues or manage the situation.

The manager told us that the issues they had addressed and their action plan was, "In my head." When we raised the concerns found during our inspection, in particular in relation to the top floor of the service, the manager said, "I am not shocked about what you found on the top floor but I am disappointed." This meant that they were aware of the issues but were unable to show us what they were doing to address the issues.

We reviewed accident and incident forms from 21 September 2016 until the date of this inspection, which had not been entered onto the providers monitoring system. We noted that there had been no record of incidents or accidents recorded between the 10th and 21 October 2016. We asked the management team to check the separate units of the home to make sure that we had all of the records. They confirmed that there were no further incident or accident forms available and suggested that maybe there had been no incidents during this period. We find this unlikely when looking at the trends and patterns across the home. The manager was not aware of any unexplained bruises or injuries and had not identified bruises that had not been entered onto the body maps.

We asked the manager what they did with the providers falls analysis. They told us that they looked at the analysis in order to identify trends but that no trends had been identified in the past five weeks. We found that there had been unexplained bruises or skin tears that had not been identified as part of the monitoring systems, and therefore not reported appropriately. These continued to not be reviewed appropriately at management level and therefore were not investigated or reported under the safeguarding process. These issues had not been identified by the management team, despite it being an issue in the service at the previous inspections.

We noted that there were two agency staff in building at the time of the inspection, both were working on same floor. We discussed with this with the management team as the deployment of agency staff was an issue previously. The manager and operations director agreed that this should have been managed better and the agency staff split across the floors of the home.

Due to the ongoing issues and inconsistency with the management systems, this was a continued breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The manager had held meetings with staff sharing what they wanted to achieve and any areas that needed improvement. For example, it was acknowledged that e-learning had been an issue because people had difficulty with their logins etc. The manager advised that there would be support for them every week Thursdays and Fridays for the foreseeable future to support them with e-learning.

People, their relatives and staff were optimistic that the manager would make and sustain the necessary improvements. One staff member said of the new manager, "I like her, she's about more, I feel more supported than I have been before." Another staff member told us, "If anything goes wrong, [the manager] is here straight away."

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 10 HSCA RA Regulations 2014 Dignity and respect People were not consistently treated with dignity and respect.

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 did not receive consistently safe care and support that met their needs.

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 Where people had unexplained injuries, these were not routinely investigated and reported as needed. Some injuries had not been documented.

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 Governance systems were not being used consistently or effectively in all aspects of the service.