Angel Care (Orchid Care Homes) Ltd

Orchid Care 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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 17 and 18 August 2017 and was unannounced on the first day. Orchid Care Home provides care for people who may require nursing care and for people who are living with dementia. Orchid Care provides care and accommodation for up to 83 people. On the day of the inspection 83 people lived in the home. The home is owned by Angel Care (Orchid Care Homes) Ltd. This was the first rated inspection of this service since a change in legal entity.

A registered manager was employed 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.

Medicines were not always managed safely. We inspected medicines at a time when the provider was switching to a new medicine provider. We found some people had not received their medicines as prescribed. We also found some medicine administration sheets were unclear which could lead to error. There were discrepancies in topical medicine administration (skin creams) and a lack of protocols in place to guide staff in administering medicine which people might need occasionally, known as PRN (Medicines that are taken "as needed" are known as "PRN" medicines.)

The registered manager and staff had attended training on the Mental Capacity Act 2005 (MCA). Staff were aware of when people who lacked capacity could be supported to make everyday decisions and staff understood how to gain consent to care and treatment. A staff member told us they gave people time and encouraged people to make simple day to day decisions. Where people lacked the capacity to make decisions for themselves, there were some processes in place to ensure that their rights were protected. Where people's liberty was restricted in their best interests, the correct legal procedures had been followed. However, documentation in people's care records did not support the Mental Capacity Act Code of Practice being followed. We found people did not have individual capacity assessments in place to guide staff about what decisions people were able to make for themselves when there was concern over their decision making ability. There was little written evidence that any effort had been made to enable people to understand the decisions being asked of them. Advance care plans were in place but undated and signed by people's relatives who did not have the legal authority to sign these. These had also been written by staff when care records indicated people no longer had capacity. Capacity assessments in place were generic and not decision specific.

People's care records required improvement. We found there was not enough detail in care plans to guide staff. For example, if people had mental health needs, skin care needs or particular health needs such as diabetes.

People told us meals were of sufficient quality and quantity and there were always alternatives on offer for them to choose from. People were involved in planning the menus and their feedback on the food was sought. Allergies and preferences were known. We observed people's meal time experience on one of the

units. The way lunch was served was not always tailored to meeting individual preferences and needs. People at risk of poor hydration or nutrition we monitored closely and cared for well. However, people's care records lacked sufficient detail on how to manage their dietary needs or requirements. These issues were fedback to the registered manager who took prompt action to address concerns.

People told us they felt safe using the service. There were risk assessments in place to help reduce any risks related to people's care and support needs. Staff had received training in how to recognise and report abuse and were confident any allegations would be taken seriously and investigated to help ensure people were protected.

People were kept safe by suitable staffing levels. Relatives told us there were enough staff on duty and we observed unhurried interactions between people and staff. This meant that people's needs were met in a timely manner. Recruitment practices were safe. Checks were carried out prior to staff commencing their employment to ensure they had the correct characteristics to work with vulnerable people.

Staff received a thorough induction and essential training to ensure they were skilled in their roles. Competency was monitored and staff were supported through a regular system if informal and formal supervision. Additionally health and social care qualifications and enhanced clinical skills training was offered to staff to meet people's needs.

People had their healthcare needs met. Robust handover processes ensured important information was shared quickly with staff. Prompt referrals were made to external professionals when required. People were supported to see a range of health and social care professionals including social workers, chiropodists, physiotherapists and doctors.
Staff were thoughtful and kind. Their care and love for people at Orchid Care made people feel they mattered. Staff and relatives gave many examples of staff making people someone feel special. Feedback we received about staff was good.
End of life care was good. People's last days were dignified; pain free and relatives were fully involved and supported at all stages. However, end of life care plans were minimal.
There was a positive culture within the service. The registered manager had clear values about how they wished the service to be provided and these values were shared by the whole staff team. Staff talked about 'personalised care' and 'respecting people's choices' and had a clear aim about improving people's lives and enabling opportunities where possible.

There was a management structure in the service which provided clear lines of responsibility and accountability. A registered manager was valued and well respected. They were supported by a caring team of nurses and support staff who had designated management responsibilities. People told us they knew who to speak to in the office and any changes or concerns were dealt with swiftly and efficiently.

Feedback received by people, relatives and professionals about the service and staff was positive. The registered manager and staff monitored the quality of the service by regularly speaking with people to ensure they were happy with the service they received. People, relatives and professionals told us the management team were excellent, visible and included them in discussions about their care and the running of the service. However, systems and processes required improvement to ensure audits were identifying potential problems within the service related to mental capacity, medicine management, care planning and records keeping.
We found three breaches of regulations, namely Regulations 11, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have advised the provider to take at the end of this 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's medicines were not always managed well.

There were sufficient staff on duty to meet people's needs safely. Staff were recruited safely.

People were protected by staff who could identify abuse and who would act to protect people.

People had risk assessments in place to mitigate risks associated with living at the service.

Staff followed safe infection control procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always assessed in line with the Mental Capacity Act 2005 as required. Staff however always asked for people's consent and respected their response.

People received support from staff who knew them well and had the knowledge and skills to meet their needs.

People were cared for by competent staff. Staff were well supported through training and supervision systems. People received a healthy, balanced diet and had their dietary needs met.

Is the service caring?

Good

The service was caring.

People and relatives were looked after by staff who treated them with kindness and respect. People and visitors spoke highly of staff. Staff spoke about the people they were looking after with fondness.

People felt in control of their care. People were listened to and

there was a strong emphasis on the person's personal identity. Staff helped people find different ways to be involved and express their views on their care.

People received compassionate, dignified end of life care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records lacked detail to guide and direct staff on how to care for people. Care records did not always reflect the care people were receiving.

People received personalised care and support, which was responsive to their changing needs.

People were involved in the planning of their care and their views and wishes were listened to and acted on.

People knew how to make a complaint and raise any concerns. The service took these issues seriously and acted on them in a timely and appropriate manner.

Is the service well-led?

Requires Improvement

The service was not always well led.

The internal monitoring systems within the service did not identify the issues we found during this inspection.

There was a positive culture in the service. The management team provided strong leadership and led by example. There was a strong commitment to providing high quality care.

The provider and registered manager had clear visions and values about how they wished the service to be provided and these values were understood and embedded within the staff team.

People's feedback about the service was sought and their views were valued and acted upon.

Staff were motivated and inspired to develop and provide quality care.

Orchid Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 17 and 18 August 2017. The first day of the inspection was unannounced.

The first day of the inspection was carried out by two inspectors, a specialist nurse advisor and two experts by experiences. An expert by experience is a person who has personal experience of using or caring for someone who lives with dementia. The second day of the inspection was carried out by two inspectors.

Prior to the inspection we reviewed the records held on the service. This included the Provider Information Return (PIR) which 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. We also reviewed previous inspection reports and notifications. Notifications are specific events registered people have to tell us about by law.

During the inspection we spoke with 29 people, 10 relatives and 14 staff, this included the registered manager, deputy manager, nurses, care staff and the chef.

To help us assess how people's needs were met, we reviewed ten care records in detail. This included medicine charts and information, assessments, risk assessments and essential care information such as skin charts kept in people's rooms. We attended morning handover one unit on the second day and talked to staff about people's needs.

We reviewed 15 medicine administration records, training records and other records held within the service to show how the registered manager reviewed the quality of the service. This included a range of audits and questionnaires to people, family and professionals. We read minutes of meetings and policies and procedures. We discussed staff recruitment with the registered manager.

Prior to the inspection we received feedback from the local authority quality team. Following the inspection we contacted four healthcare professionals, we spoke with two mental health nurses and health care professional from the hospice.

Requires Improvement

Is the service safe?

Our findings

Medicine management was not always safe.

The registered manager informed us that the service had recently changed medicine suppliers and that a national pharmacy now provided the medicines to the home. The new supplier had provided training sessions regarding their systems.

MARs (Medication Administration Records) had been signed following administration however we found two instances where signatures were missing. One person had started recently on a medicine twice a day to help behaviour they were exhibiting, but over a two week period there were 13 gaps on their MAR which indicated it had not been given. However, when the stock of medicine was counted this demonstrated they had received their medicine as prescribed. Another person was prescribed a laxative twice a day and we found four days where they appeared not to have had this. This could have impacted on their bowel health.

Appropriate codes had been entered onto MAR sheets when medicines had not been administered. We saw a MAR sheet on which staff had entered the code recording that two of the person's eye medications had been unavailable. Records indicated that one had been unavailable for seven days and the other over four days. The Clinical Lead nurse said that this was due to the change to a new pharmacy provider. Failure to administer prescribed medicines may increase the risk to people's health and welfare.

The majority of MAR sheets had been pre-printed by the pharmacy. However there were some that were still in use from the previous pharmacy provider that had been hand written. This was when staff had transcribed details of a prescription or alteration onto the MAR. We found incidences, both on the new and old MAR sheets, where handwritten amendments had not been signed by the person who did the transcribing, or that a witness signature had not been obtained. Signing hand written amendments and getting them witnessed is seen as good practice as it reduces the risk of transcription errors.

We found one MAR sheet in use that had been photocopied. However the photocopy was of poor quality and the full details of the prescribed medicines were not fully visible on two sheets as the left hand side of the pages had been cut off. A note had been attached to the chart stating 'Charts not clear, need reprinting'; however the chart had been used for over two weeks. This could increases the likelihood of a medicine error.

We found that there were two systems in place relating to the recording of prescribed topical medicines, such as creams and lotions. On Bluebell Unit records were seen in separate files that were kept in people's rooms. Care staff signed these charts following application of the topical medicine. Body maps, to specifically indicate which area of the body the topical medicine should be applied to were in use. On Rose Unit, the nurse informed us that, although the care staff applied the topical medicine, they then informed the nurse, who signed the person's MAR sheet.

In two cases we found discrepancies on topical medicine recording charts. One chart stated that the person

required a prescribed cream to be applied daily. However, records indicated that staff applied it either two or three times a day. Another chart stated a cream should be applied twice a day, but records indicated that it was only being applied once a day.

Individual care plans relating to medicine management were in place although in one case a person's plan had not been updated and was not a true reflection of their current medicines. Incorrect medicine care plans could cause staff confusion and error. Plans we reviewed indicated that people were assessed regarding their ability to manage their own medicines and to self-medicate, although the Clinical Lead nurse informed us that there were no people currently doing so.

Not all people had protocols in place with regard to the use of 'when required' (PRN) medicines. This is seen as good practice as it directs staff as to when, how often and for how long the medicine can be used and improves monitoring of effects and reduces the risk of misuse. The registered provider's policy regarding PRN protocols stated 'Individual protocols must be completed for each service user's prescribed PRN medicines'. The manager was aware of this issue and was currently working to provide these.

People's needs with regards to administration of medicines had not always been met in line with the MCA. The MCA states that if a person lacks the capacity to make a particular decision, then whoever is making that decision must do so in their best interests. For example, some people were unable to consent to having their medicine. People's doctors had been involved in these decisions but there were no individual assessments completed to assess people's capacity before the best interest decisions had been taken. This showed the correct legal process had not always been followed. We spoke to the registered manager about one incident in March 2017 where one person who had been particularly distressed, had been given a medicine in their tea, without their knowledge. The correct procedures for administering medicines in this way had not been followed. The provider's policy for the use of covert medicine administration had not been followed in this instance.

Medicines were not always managed safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Registered nurses were responsible for the administration of medicines and the home's Clinical Lead nurse had been nominated to have overall responsibility for medicines management. The Clinical Lead informed us that nurses had received medicine management training; and that competency checks were undertaken twice a year.

We observed part of a medication administration round and that medicine was administered to people in a safe and organised way. Staff wore a tabard with 'Do Not Disturb' written on in order to ensure minimum distraction during the medicine round. Staff demonstrated awareness of the needs and preferences of the people they administered the medicines to. They confirmed that they had received training with regard to the new provider's systems and that they had undergone competency checks.

Peoples medicines were provided in individually labelled boxes or bottles, which were stored in separate containers for each person within the medicine trolleys.

Any medicine allergies were recorded on MARs and a photo of the person was attached. Other details recorded included the person's preferred method of taking their medicine and a list of any medical conditions.

The quantity of medicines received was recorded on MAR sheets and witnessed by two people and

thereafter, the total remaining was checked each week. A current list of staff signatures was available.

Where people had been prescribed trans dermal patches a record sheet, including a body map, was kept in order to record where on the person's body the patch had been applied.

Controlled Drugs (CD's) were stored securely and stock levels checked daily by two staff members. An appropriate fridge for storing medicine was available and the temperature recorded daily. The temperature of the medicine storage area was also recorded daily. Temperature records seen indicated that medicines were stored appropriately. Records of medicines returned to the pharmacy were kept and two witness signatures obtained.

People told us they felt safe and relatives confirmed their loved ones were protected from harm. Our observations of people showed they were calm and relaxed at Orchid Care Home.

People were protected by staff who knew how to recognise signs of possible abuse. Staff felt reported signs of suspected abuse would be taken seriously and investigated thoroughly. Training records showed that staff completed safeguarding training regularly and staff accurately talked us through the action they would take if they identified potential abuse had taken place. Staff knew who to contact externally should they feel their concerns had not been dealt with appropriately by the service. Staff told us safeguarding issues and possible signs of abuse were discussed regularly within team to ensure everyone understood the different forms of harm and abuse. Staff explained what they might look out for including changes in people's mood such as anxiety and bruises. Policies and notices related to safeguarding and the local contact telephone numbers were visible within the service. We reviewed the safeguarding alerts which had been made within the service, the registered manager kept a safeguarding audit tool and any learning was embedded promptly to avoid a reoccurrence. For example, if there were steps staff could take to minimise altercations between residents.

People's needs were considered met in the event of an emergency situation such as a fire. People had personal evacuation plans in place. These plans helped to ensure people's individual needs were known to staff and to emergency services, so they could be supported and evacuated from the building in the correct way. Staff at the home had participated in the fire training and there were weekly fire drills.

Regular health and safety checks had been undertaken within the home including the servicing of equipment such as the hoists and lifts. Most routine maintenance was carried out by the maintenance man, staff recorded broken items / faults promptly and these were quickly repaired. Regular checks were undertaken on the environment and staff were alert as they walked around the home and in people's rooms; this helped to ensure the environment safe.

People were supported to take everyday risks to enhance their independence and enable them to feel in control where possible. For example, those people who liked to wash independently but needed some staff support to reach areas such as their backs and feet were supported. Staff were thoughtful regarding people who liked to be mobile but were at risk of falling.

Falls and other incidents were analysed for trends and themes. A falls audit had led to additional staff on one unit at the service. Staff told us they made sure people had the equipment they needed around them such as their call bells and mobility aids to encourage their use. Staff knew people well and those who might try to walk unaided. Pressure mats and mattresses were in place for these people so staff could respond promptly to support these people. Staff told us they checked rooms to ensure they were uncluttered and made sure people had footwear to reduce the likelihood of falls. Staff were aware of those people whose

mobility had changed over time and had updated people's risk assessments and care plans accordingly.

Risk assessments highlighted individual risks related to people's diet, skin care and mobility. Those who were at risk of developing sore skin had special equipment in place to reduce the likelihood of their skin breaking down, for example cushions to sit on and special mattresses. Personal care plans highlighted checking people's skin vigilantly; using prescribed skin creams when needed and helping people maintain their mobility. Repositioning checks were in place and carried out frequently.

People were kept safe by a clean environment. All areas we visited were clean and hygienic. Protective clothing such as gloves and aprons were readily available throughout the home to reduce the risk of cross infection and hand gel was visible in the communal areas for people and staff to use. Staff were able to explain the action they would take to protect people in the event of an infection control outbreak such as a sickness bug. One relative told us, "They take a lot of care to make sure everything is clean and tidy and that means a lot to [X] as she was always so fussy about things like that."

Safe recruitment practices were in place and records showed appropriate checks had been undertaken before staff began work. Staff confirmed these checks had been applied for and obtained prior to commencing their employment with the service. A probation period was in place for new staff to help ensure the service recruited staff with the values and competence they wanted. The registered manager took action promptly to address any shortfalls with new staff. This helped ensure people were kept safe.

Staff, people and relatives told us there were sufficient numbers of staff on duty to keep people safe. A dependency tool was used to ensure staffing levels met people's needs. Staff were visible throughout our inspection and conducted their work in a calm, unhurried manner. People told us staff were there when they needed them and they responded to their call bells usually within five minutes. The registered manager checked call bell response time regularly. In the event of sickness staff worked flexible to provide continuity of care for people. The service did use agency staff as a last resort but the registered manager advised this had reduced significantly over the past 12 months. Staff we spoke with confirmed that these were the staffing levels they normally worked with and they generally felt that there were enough staff on duty day and night to meet people's needs. One said "Staffing is normally ok. We don't use a lot of agency here." Another said "We sometimes drop to four but they try to get someone in. It's busy but okay."

Requires Improvement

Is the service effective?

Our findings

The service was not always effective.

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 whether the service was working within the principles of the MCA.

Staff spoken with confirmed that they had received training with regard to the MCA however, we found decision specific mental capacity assessments were not in place for the 10 people's care plans we reviewed. For example, one person's care plan file contained a document regarding permission to take photographs, use of bedrails, support with medicines, treatment and care, and sharing of information. This document had been signed by the person's relative and was dated 20th April 2017. The person had a 'mental capacity assessment for less complex decisions' on file dated 24th August 2015. This stated that the person was 'unable to understand information as not responsive, unable to show response or verbalise.' There was no evidence available to show that specific capacity assessments had been undertaken with regard to the issues recorded on the permissions form, in order to make an informed decision in the person's best interests. It was also unclear if the person's relative had power of attorney for health and welfare to give them the legal authority to act on their relatives behalf.

Some people had advance care plans in place (Advance care planning (ACP) is a voluntary process, in which patients can set on record choices about their care and treatment and, in particular, any advance decision to refuse a treatment in specific circumstances, including those where they may have lost capacity in future). However, these had been completed after an assessment had been made that they did not have capacity. Another person had a diagnosis of dementia but no mental capacity assessments had been completed although their relative did have legal authority to manage their finances. A further person had a pressure mat in place to alert staff if they moved as they were a risk of falling. There was no mental capacity assessment in place regarding this decision although staff were providing care in the person's best interests. We were unable to find written evidence that staff had tried to help people understand the decisions they were being asked to consent to and how they arrived at conclusions people did not have capacity.

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). DoLS applications had been appropriately made. The registered manager was aware of the legal process they were required to follow and sought advice appropriately from the local supervisory body. However, the mental capacity assessment which leads the registered manager to complete a DoLS application was very generic. We showed one example to the registered manager to explain our findings.

People who used the service were not protected against the risks associated with inadequate mental

capacity assessments. The registered person had not acted in accordance with the Mental Capacity Act 2005 when assessing people's capacity to consent to care and treatment. This was a breach of Regulation 11 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware of when people who lacked capacity could be supported to make everyday decisions and staff understood how to gain consent to care and treatment. A staff member told us they gave people time and encouraged people to make simple day to day decisions. For example, what a person liked to drink or wear and what they wanted for lunch. However, when it came to more complex decisions the relevant professionals were involved. This process helped to ensure actions were carried out in line with legislation and in the person's best interests.

When asked what they would do if a person who lacked capacity refused their support with personal care, one member of staff said "You can try and persuade them, but you can always come back later, or try another carer. You can't force them." Another said "We respect their wishes, you can't force anybody." When asked how the gained peoples consent to support a senior carer replied "You ask permission and ask what they want to do; give them a choice."

Following the inspection, the registered manager sought advice on the MCA from the local authority who visited to give advice on MCA assessments. The registered manager advised us they also intended to attend further training on the MCA.

Ensuring good nutritional intake was important to the home. The Head Chef visited people on their admission to discuss any particular dietary requirements and attended meetings with the residents to discuss food preferences to aid meal planning. People received healthy, nutritious home cooked meals to help maintain their appetite and keep their weight stable. People were involved in decisions about what they would like to eat and drink. For example we observed people enjoying faggots during the inspection which they had requested. Care records identified what food people disliked or enjoyed and listed what the staff could do to help each person maintain a healthy, balanced diet.

People's care records highlighted where risks with eating and drinking had been identified. Staff were able to tell us how they would respond to any nutritional concerns they had. Care records noted health conditions such as diabetes, if the person was of a low weight and choking risk assessments were evident. Staff were mindful of those at risk of weight loss and monitored their food and fluid intake closely. Staff confirmed if they were concerned about weight loss / gain they would discuss people care with their GP. However, although staff knew people's needs we found greater clarity was required in people's documentation. For example, people who required their food to be thickened did not always have clear directions for staff in their care records. Various terms were found in care plans such as 'stage two thickened fluids' or 'custard consistency' but there was a lack of consistency in describing exact requirements throughout. Likewise people who required their fluid monitored did not have specific details to guide staff to the amount of fluid they should be encouraging people to have.

We observed people's meal time experience on one of the units. The way lunch was served was not always tailored to meeting individual preferences and needs. The plate of food served was of standard size and included all the items on offer – meat/vegetarian alternative, potato, carrots, and beans. There was no opportunity for residents to help themselves to vegetables from a dish on the table. One resident who has a health condition which meant they could only manage small portions. They told us they were served the same size portion as everyone else and this put them off her dinner. Another resident told us the home 'didn't do Cheerios' which was her cereal of choice. All the residents were provided with disposable bibs at lunchtime without being asked if they wanted one to protect their clothing. We also observed one person

having their blood sugar checked whilst sitting at the dining table waiting for lunch to be served. We fed these issues back to the registered manager who agreed to discuss these issues with the staff and people involved and review parts of the dining experience where required.

We observed residents who required assistance from staff receiving this in a quiet, unobtrusive manner. The staff and kitchen were aware of those who needed their food cut up and those on special diets. The registered manager and the deputy manager observed mealtime experiences each week on a different unit. Their observations included the layout of the table, meal presentations, and the quality of the food, communication between people and staff and choices offered.

People felt supported by skilled staff who effectively met their needs. They told us "Yes, staff are well-trained." Staff we spoke with all confirmed that they received regular training and updates. We spoke with a care assistant who said that they had "Lots of training" and told us they had obtained an NVQ level 2 in health and social care. A second staff member said that they had a level 3 diploma in health and social care. Staff had undertaken the appropriate training for their roles and had the right skills and knowledge to effectively meet people's needs before they were permitted to support people. Training was ongoing in areas such as first aid, dementia care, moving and handling, skin care, diet and nutrition and food hygiene. All staff were encouraged to develop themselves and undertake additional health and social care qualifications to support their work. The service linked with organisations that provided sector specific training and link groups where best practice was discussed for example the local hospice for end of life care. Some staff had undertaken additional training to be trainers in certain areas such as manual handling and funding was being sought to provide staff with a "dementia experience". Staff told us "We're always doing training." Staff felt encouraged to improve their knowledge and skills by the registered manager and appreciated this.

Staff undertook an induction programme at the start of their employment at the home. The registered manager made sure staff had completed an introduction to the home and had time to shadow more experienced staff and get to know people. The Care Certificate induction was in place and used for new staff. This is an identified set of standards that health and social care workers adhere to in their daily working life to promote consistency amongst staff and high quality care. A care assistant who was new to the home confirmed this saying "It was a good experience and I was able to ask the seniors any questions and the nurses were brilliant."

Staff felt supported by a regular system of supervision and appraisal which considered their role, training and future development. Comments included "Yes, we have regular one to ones." In addition to formal one to one meetings staff also felt they could approach the registered manager, qualified nurses and senior care staff informally to discuss any issues at any time. Staff found the management team supportive "Doors always open, the registered manager and deputy are approachable and helpful."

Staff communicated effectively within the team and shared information through regular verbal and written handovers. This supported staff to have the relevant information they required to support people's needs on a day to day basis. One staff member commented that they felt the best thing about the home was "How everybody works together and communicates."

A regular, weekly doctor's visit supported care for people at the service. Staff told us the local doctors valued their judgement and opinion and relationships were good. Staff were mindful of each individual's behaviours and mannerisms which might indicate they were not well or in pain. Staff were alert to signs of urine infections which may cause confusion. Prompt referrals to external healthcare professionals such as doctor's, physiotherapists, and occupational therapists enabled people to maintain good healthcare and

receive the appropriate treatment they needed quickly. In addition, chiropodists, dieticians, tissue viability nurses (skin care nurses) and opticians visited people to ensure they had access to healthcare services and ongoing support to maintain their health. People, where they were able, understood their own health issues. For example one told me that she was avoiding dairy products as the doctor had suggested this to improve stomach issues. Another person told us they had broken a tooth and the deputy manager had arranged for her to be seen by a dentist and organised transport there. One person was expecting a visit from a physiotherapist that afternoon and was clear about this and the exercises they needed to do to support her health needs. A relative shared that her grandmother's weight had dropped significantly when she was unwell and that it had been monitored and was now approaching what would be expected. The grandmother joined in this conversation and was aware of this care plan.

Good

Is the service caring?

Our findings

Throughout the inspection, we observed that respect was a mutually shared value between people, relatives, professionals and staff. People and relatives all praised the staff and were consistently positive about the care they and their family members received. People told us and we observed they very well cared for, they spoke highly and fondly of the staff and the quality of the care they received, "'They do everything in their power to make you happy"; "They look after you very well"; "Everyone here is amazing". A common feeling among residents and their relatives was that they felt 'so lucky to be here'. Other people shared, "If I've got to be anywhere [rather than at her own home] I'd choose to be here"; "I desperately didn't want to come into a care home, but it's actually a relief. I still feel I can be myself and I'm not relying on my family". A relative told us, "Dad came in here on a stretcher. We weren't expecting him to live more than a few weeks. They have literally nursed him back to a point where he is enjoying life". People repeatedly told us, "They are all my favourite. They are all so kind and caring"; "I'm always teasing them and they tease me back! We have a good laugh together".

We observed staff were calm, cheerful, positive and caring. They seemed to know the residents well and want the best for them. Staff very effectively encouraged participation in activities in a non-patronising way. They built effectively on what people could do. For example, when giving the quiz answers they expanded on the answers and cues given by residents eg the answer to one question was Shirley Temple and they then talked about her films and tried to sing 'The Good Ship Lollipop'. Staff knelt down and ensured they were at an appropriate height to communicate with residents. They used touch carefully and in a reassuring way to convey their attention and concern eg a gentle hand on the shoulder or arm. Staff were patient with people, we observed one staff member showing a resident various different areas they could have breakfast. The person led staff by the hand to different areas until the person decided where they would be most comfortable. All interactions we observed between staff and residents were warm, polite and courteous.

When asked how staff developed caring relationships with people living in the home, they said, "I make sure they are comfortable, develop trust, and try hard to be kind to them, respect them, and find out about them by talking to them or to their families." Another staff member replied "We all enjoy our jobs; it's a nice place to work. The ladies (living here) are all so lovely, like our own family. You get to know them well and build up a relationship with them and their families." When asked if they would move their parents into the home if needed, staff replied, "Yes, I am content with care and the staff here."

People told us their independence was encouraged. One person told us, "They know I want to get back to how I was so they let me do things for myself - even though it takes longer".

Relative feedback about staff and the care of their loved one's was positive. Comments included, "Mum's care is the most important thing, she is very well cared for"; "Care staff work very hard, they are pleasant and knowledgeable."

We reviewed comments people and relatives had left on the internet review sites and thank you cards, "Staff are always cheerful, nothing is too much for them. Rooms and facilities are always clean. A great friendly

caring atmosphere"; "Our first visit, it seems a really nice place, unfortunately our relative was not too good but appears to be getting well looked after"; "They look after their residents well, also a great place to work."

People were respected by all staff within the service. Staff honoured how people wanted to be addressed and adjusted their manner to suit people's preferences. For example, some people liked to be called by their first names; others preferred a more formal address. People told us their privacy and dignity was respected. One person told us, "I asked one of the nurses to have a look at my pad because I was worried about an infection. She came to my room and closed the door so we could talk in private". Staff told us, "We always make sure that doors are shut and curtains are drawn when we are doing personal care and I always knock their doors before going in." They added "We don't discuss things (with other residents) it's their own business." This helped ensure people's privacy and confidentiality was respected.

People told us, staff listened to them and took appropriate action to respect their wishes. Staff knew people well so observed facial expressions and bodily movements if they were unable to communicate verbally. We observed staff always talked to people regardless of their cognitive state.

People told us the things which mattered to them, for example their laundry and receiving care as they liked were respected. Staff knew, understand and respond to each person's diverse cultural, gender and spiritual needs in a caring and compassionate way. Information was available about different faiths and staff acted on this if required.

People were given information and explanations about their treatment and support when they needed them so they could be involved in making decisions about their care. To ensure people were listened to and their wishes respected, information about advocacy services was available to people and advocates used to support people's decision making when required. Staff understood the processes involved when relatives / others had lasting power of attorney. This enabled staff to protect people's rights around decision making and to also support families.

Those people who had relatives and significant others involved in their care were always kept up to date in a timely way. Relatives told us how they valued this, "I trust them 100% to look after mum. They always ring me to keep me informed".

Friends and relatives were able to visit without unnecessary restriction. Visitors told us they were always made to feel welcome and could visit at any time. We observed many relatives and people enjoying afternoon cake and tea in the ground floor café. Messaging application was used to maintain contact with family unable to visit, for example those who lived abroad or far away. Relatives all confirmed they visited at all times of day, could stay as long as they wished and participate in their loved ones care as much as they wanted. Relatives were also invited to the residents' meeting and activities such as the recent fete held at the service.

Birthdays and special occasions were celebrated. One couple had a romantic, private meal cooked for them to celebrate their 41st wedding anniversary. The table had been laid with rose petals and candles to mark the occasion.

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by palliative care specialists. End of life care was compassionate, dignified and pain free. Services, equipment and medicines were provided promptly when needed. Nursing staff were well trained in the use of syringe drivers, verification of death and end of life care. Relatives received an information pack following a person's death to help them with the making

arrangements required. Professionals we spoke with regarding end of life care told us the team was good and their experience of supporting the staff care for people at the end of their life was positive. The local hospice staff visited the service to support staff to debrief if required and held teaching sessions.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive.

People's care records lacked detail, did not always record interventions taken in response to care needs and in some cases were not an accurate reflection of people's current care needs. For example, we looked at the records of a person who was diabetic and received insulin injections. They had a care plan in place with regard to the management of their diabetes. The plan had been reviewed by staff monthly, including the month of our visit. The care plan stated that the person required their blood glucose monitored four times a day. We looked at the blood glucose monitoring record, which showed this was happening only twice a day. The nurse on duty confirmed that this was the case. This could cause error for staff guided by people's care plans.

We saw that one day the person's blood glucose had been recorded as particularly low as to cause concern at 0700hrs. No further blood glucose levels were recorded until 0700hrs the following day. There were no entries in the person's care plan or daily notes recording any interventions taken in respect of this incident and the clinical lead nurse and nurse on duty were unaware of it. Although there was a care plan in place relating to diabetes, this did not contain specific instructions detailing actions to be taken should the person have low blood glucose readings. The plan stated staff should 'observe for signs' of hypo and hyperglycaemia (high and low blood glucose levels) but did not specify what these might be for this person, or any other with diabetes.

Another person had been assessed as being at very high risk of developing pressure sores. Their care plan for skin care indicated that they needed specific pressure relief air mattress. Details of the type of mattress and the required inflation pressure were recorded. Also written was 'While I am in bed my position needs to be changed regularly' although the frequency was not stated. At the front of the care plan file was a document entitled 'My preferences' on which was recorded 'reposition 3-4 hourly.' This was also recorded in the person's care plan for mobility. The care plans had been last reviewed on 6th July 2017. The person did not have any pressure sores. When we visited the person, we found that they were not lying on an air mattress (although an appropriate alternative had been supplied). We looked at records of positional changes for the last 3 days. We found that on each night during this period, the person's position had not been recorded as being changed for a period of approximately five to six hours. We brought this to the attention of the nurse in charge. They stated that the person was now receiving end of life care and that their care plan had yet to be updated to reflect current practice. This could mean not all staff are consistent in their care for this person.

We found end of life care plans were not personalised, there were instructions in the event of death but these were not individualised to people's needs. We spoke with the registered manager regarding developing these care plans to provide greater detail. They agreed to action this.

One person we reviewed had been living at Orchid Care since mid-July 2017, on the day of the inspection we found they had no care plans in place. This person had been identified as high risk in a skin assessment tool

but there was no care plan to guide staff how to minimise the risk to their skin. Staff told us they went into their room in pairs due to the person displaying behaviour that may challenge. There was no written guidance in place for staff to direct them how to manage their behaviour in these instances. This might mean staff use different approaches and are not consistent in how they care for the person. We fed this back to the management team who addressed this immediately who wrote a care plan during the inspection.

We found where people had mental health needs, their care plans lacked detail. For example, one person we met displayed behaviour which at times impacted on others. Although professionals were involved in supporting their needs, there was no information for staff in their care plan to describe the action being taken by the service. This could lead to an inconsistent approach by the staff team.

Many people had specific assessments undertaken for example to assess levels of agitation or depression. We found the results of these did not always contribute to people's care plan and it was not clear whether reviews of these assessments had occurred to monitor whether treatment had an effect.

Records were not always accurate or complete. They did not always include a record of the care and treatment provided to people or decisions related to people's care and treatment. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had their needs assessed before they moved to the home. Information had been sought from the person, their relatives and other professionals involved in their care. Information from the assessment had informed the plan of care. Staff told us they felt a good assessment was fundamental to ensuring people's care needs could be met.

People had care plans that reflected their likes and dislikes and people's particular routines. Staff knew people's likes and dislikes. The residents and relatives we spoke with felt that the staff knew them well and treated them as individuals. One person told us, they felt that one of the carers would be able to choose a library book which she would enjoy 'because she knows the kind of thing I like.'

People who were able, and where appropriate, those who mattered to them, were actively involved in all aspects of their care to help ensure their views and preferences were recorded, known and respected by all staff. Relatives told us they were invited to discuss people's care at all times. Developing care was a partnership between those involved, this meant people and relatives felt listened too and valued.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. People's needs were reviewed regularly and as required. Where necessary the health and social care professionals were involved for example regular multi-disciplinary meetings discussed people's care and recovery in depth.

Everyone at the home was recognised as an individual and empowered and supported to make choices regarding their care. People were encouraged to have as much control and independence as possible. Staff gave us examples of how they used different forms of communication to encourage people to make decisions and for those unable to verbally communicate staff were familiar with their non-verbal communication methods. For example, staff told us knowing people well meant they were familiar with their facial expressions, gestures and sounds.

People had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest other activities they would like to complete. People told us, "There's something to do every day of the week, but I'm not much of a joiner in!" Three activity co coordinators were available six

days a week and passionate about their roles. In addition to group activities people were able to maintain hobbies and interests, staff provided support as required. The activity timetable was clearly displayed and given to people so they knew what was on throughout the week. Activities included a walking club, dancing, armchair keep fit, a barge trip, visits from a donkey and fundraising events. During the inspection people enjoyed tap dancing and the Orchid Care choir sang. A variety of pets were available for people including rabbits, guinea pigs, fish and a lizard. Fundraising and donations received throughout the year was used for residents to have a special December. This year the service had reindeers booked for people to enjoy following a very successful visit from donkeys which people had enjoyed.

Community links and relationships were facilitated and encouraged to ensure that people did not become socially isolated. Local schools visited on special occasions, for example remembrance day. The registered manager was discussing the possibility of preschool age children visiting the home after recent research has highlighted the beneficial effects of this on older people.

Staff had a good understanding of people's social and cultural diversity, values and beliefs and these were acknowledged and met. People and their relatives told us how they were supported to meet their faith needs and how that had helped them at difficult times for example illness. A regular Baptist service was held at Orchid Care.

People's needs were met as they moved between services, for example if people needed to attend for appointments or go to hospital, external services were given detailed information about people. Staff attended appointments if required to ensure good communication and handover. The service worked closely with external agencies for example social workers, occupational therapists and advocates to support if they wished to return home or their needs changed and they required a different care setting.

There was a positive, open and transparent culture when dealing with concerns or complaints. The policy was clearly displayed in areas of the home. People and those who mattered to them knew who to contact if they needed to raise a concern or make a complaint. People's concerns and complaints were encouraged, investigated and responded to in good time. Reflection and any areas of improvement were considered following any complaint to the service. Relatives told us they never felt discriminated against for raising any issue and any concern, however minor was listened to and taken seriously.

Requires Improvement

Is the service well-led?

Our findings

The service was not always well-led.

Prior to the inspection we had received the local authority's report from a visit they had undertaken in January 2017. This visit identified the same issues we did during this inspection related to care planning, medicine, end of life care planning, and capacity assessments. The registered manager and provider had various quality assurance systems in place to drive continuous improvement. However, neither the provider's checks or the registered managers checks had been fully effective. This meant issues identified during the inspection had not been picked up through their internal systems.

The registered manager was receptive to inspection feedback and acted promptly following the inspection to address issues identified, for example contact was made with the MCA / DoLS lead for advice.

Systems and processes in place were not established and operated effectively to ensure good governance. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Audits were carried out in line with policies and procedures. Audits included staff recruitment audits, a monthly home manager audit incorporating weights, dependency scores, falls and any safeguarding within the service; call bell audits and observational care audits. Areas of concern identified through these audits then formed part of the registered manager's rolling action plan. These were reviewed frequently by the operations manager. Staff were informed of improvements required at regular meetings which were held.

All people, relatives and staff were complimentary about the registered manager and deputy manager. They told us the registered manager was visible and approachable, "[X] and [X] are very approachable". Professionals told us, "The manager is an exceptional lady, I feel staff have a lot of respect for her, she values their input and opinions." The atmosphere within the service was warm, friendly and calm. Staff communicated well with each other and everyone was clear about their role and supported one another.

There was a management structure in the service which provided clear lines of responsibility and accountability. A registered manager was in post that had overall responsibility for the service and knew people and staff well. They were supported by a deputy manager, other nursing and care staff who had designated management responsibilities for example medicine audits and staff supervision. Staff, people, relatives and external health and social care professionals all told us they knew who to speak to in the office and had confidence in the management and staff team. The registered manager informed us they were supported by a regional manager and the provider, both whom visited frequently undertaking their own quality assurance audits of the service. The registered manager commented in the Provider Information Return (PIR), "I feel very lucky that I am working for a proprietor that offers me full support; he is happy to listen to new ideas and is very quick to provide anything that the residents may need."

During our conversations with the registered manager they displayed integrity and kindness. They led by

example, were proud of the work they did, cared about the people and staff at the home and would not ask any staff member to do anything they would not. The PIR told us, "I have great passion for what I do and I am a firm believer that improvements can always be made, we are always looking at ways we may be able to do things better. During our relatives and residents meeting it is also a question that I will always ask. I operate an open door policy for everyone so that I am quite accessible to anyone that may wish to talk to me".

People and staff had confidence the registered manager would listen to their concerns and would be received openly and dealt with appropriately. Relatives told us, "We can pop in to the office at any time". Staff were positive about how the service was run.

Staff told us they felt empowered to have a voice and share their opinions and ideas they had.
Staff meetings were regularly held to provide a forum for open communication. The registered manager told us and staff confirmed they were encouraged and challenged to find creative ways to enhance the service they provided. Staff told us they felt empowered to have a voice and share their opinions on the projects being developed at the service. For example, the new lounge on the dementia unit and the memory boxes which had recently been introduced.

The service worked in partnership with key organisations to support care provision, this supported people's health and social care needs. Healthcare professionals who had involvement with the home confirmed to us, communication was good. They told us the service worked in partnership with them, followed advice and provided good support.

Staff had clearly adopted the same ethos and enthusiasm and this showed in the way they cared for people. Staff talked about personalised care and promoting independence and had a clear aim about improving people's lives and opportunities. Staff were kind and valued their individual responsibility towards people's care, valuing each team member.

People benefited from staff that understood and were confident about using the whistleblowing procedure. The service had an up to date whistle-blowers policy which supported staff to question practice. It clearly defined how staff that raised concerns would be protected. Staff confirmed they felt protected, would not hesitate to raise concerns to the registered manager, and were confident they would act on them appropriately.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. Questionnaire feedback about the quality of care took place and other themed questionnaires on activities, food and the environment. These were available in the café at the entrance. Feedback was positive and listened to.

The registered manager was always looking to improve and plans for the future included the new lounge. The registered manager was also keen to improve the care planning process and embrace technology and look at how IT advances could improve people's care and outcomes.

The registered manager promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations. We used this information to monitor the service and ensure they responded

appropriately to keep people safe.

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Need for Consent Regulation 11 (1) (2) (3) The legislative framework of the Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards (DoLS) were not always being followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe Care and Treatment Regulation12 (1) (2) (g) Care and treatment was not always provided in a safe way. Medicines were not always managed in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Good Governance Regulation 17 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 People's care records were not always complete, contemporaneous, or an accurate reflection of decision made regarding their

care.

Systems and processes were not sufficiently robust to assess, monitor and improve the quality and safety of the service.

There were not adequate systems in place to assess, monitor and mitigate risks relating to the health and welfare of service users.