Angel Care (Orchid Care Homes) Ltd

Orchid Care Home

Inspection report

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Tel: 01793753336

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09 May 2019

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Orchid Care Home provides care to people who may require nursing care and for people living with dementia. Orchid Care Home accommodates up to 83 people in three separate units, each of which has separate purpose-adapted facilities. There were 76 people using the service at the time of the inspection. One of the units specialises in providing care to people living with dementia.

People's experience of using this service:
People told us they felt safe living at the service. However, we found people were not protected from all risks because assessments regarding the risks of mobility and falls were not always reviewed and updated following an incident. Accidents and incidents were not always analysed for trends and patterns which resulted in some people not being referred to health care professionals. People told us there were not enough staff to keep them safe.

There was no registered manager in post. The management and governance arrangements of the service were not adequate and therefore staff felt unsupported by the management team. Medicine audits were effective, however, care plan audits failed to identify shortfalls revealed during our inspection. We were not always notified about accidents/incidents taking place in the service.
Staff were recruited safely and they knew how to protect people from abuse.

Rating at last inspection: At the last inspection the service was rated requires improvement (published 11 November 2018) and there were multiple breaches of regulation. Following the last inspection we asked the provider to complete an action plan to show what they would do and by when to improve. At this inspection we found improvements had not been made and the provider continued to be in breach of the regulations.

Why we inspected: We undertook this focused responsive inspection on 9 May 2019. This inspection was carried out following concerns reported by health professionals about staffing levels not being appropriate to meet people's needs. At the previous inspection in October 2018 we had rated the service 'require improvement' with breaches of regulations in the 'safe' and 'well-led' domains. At the latest inspection we looked to see if improvements in these areas had been made since the last inspection.

Enforcement: We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of Regulation 18 CQC (Registration) Regulations 2009. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up: We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

Details are in our Safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Orchid Care Home

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. The inspection was prompted in part by notification of an incident reported to us by an ambulance crew.

Inspection team:
This inspection was conducted by three inspectors and two Experts by Experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this
type of care service.

Service and service type: Orchid Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The home had a newly appointed interim manager in place. Until the recent appointment the home had been run by a manager who had stepped down just before the inspection to become the deputy manager.

Notice of inspection:
This inspection took place on 9 May 2019, and was unannounced.

What we did:
Before the inspection we reviewed the information we held about the service and the service provider. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law.

Due to concerns regarding night shift staffing levels we started our inspection early in the morning in order to check care provision provided by night staff. During the inspection we spoke with seven people and five relatives . We spoke with four staff members and the regional director who was available throughout the inspection.

We observed care interactions and reviewed care records for seven people who used the service. We looked at six staff recruitment and training records. We looked at records regarding medicines administration and other records relating to the running of the service. These included incident and accident monitoring and auditing systems.

After the inspection we were contacted by one healthcare professional and we received requested evidence from the management of the service.

Requires Improvement

Is the service safe?

Our findings

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

RI: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk of people being prone to harm. Regulations may or may not have been met.

At our previous comprehensive inspection in October 2018 we had identified a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Documentation relating to the fire evacuation and the fire risk assessment had been incomplete and out-of-date. The pressure relief equipment had not always been used correctly. There had been no protocols for staff to follow regarding the oxygen therapy provided to a person using the service. At this inspection we found that the service had taken appropriate action to address these issues. However, we found that more improvements in other areas were needed in order to keep people safe.

Staffing and recruitment

● People, their relatives and staff told us there were not enough staff to keep people safe. One person's relative told us, "I think they do have a problem with not enough staff". Staff told us they were unable to provide safe and effective care with the current staffing levels. One of the registered nurses told us, "We have two healthcare assistants and one nurse at night. At the moment we have 29 people in this unit. As one person is allocated one-to-one hours, one of the healthcare assistants goes to that person which leaves only one healthcare assistant and one nurse for the whole unit. Two staff members cannot manage at night. All the people have dementia but some of them also have challenging behaviour. We need to increase staffing levels at night. It is very hard to manage at night. [Person] had two falls this shift already".

● We looked at the staffing levels in the unit supporting people living with dementia at night. We found the numbers of deployed staff were inadequate. For example, one person was known to have had frequent falls. Staff were supposed to monitor this person's whereabouts to ensure they were safe. However, low staffing levels at night did not allow staff to keep the person safe. This person had a pattern of regular falls early in the morning, however, this had not been analysed by the service and remained unaddressed at the time of our inspection. During the early morning of the inspection this person fell twice. We saw that staff at night were extremely busy and there were not enough of them to assist all people in the dementia unit. Some people were already up looking for support but staff were too busy at that moment to provide them with immediate assistance. As a result, one person walking around the communal areas wearing only their socks and their incontinence pad as there were no staff available to help them get dressed.

● Staff from other units told us the staffing levels were too low and this resulted in a high number of unwitnessed falls. A member of staff told us, "I think staffing is the problem. This is the hardest floor because of the high number of people requiring double handed care. On top of that, one carer is always delegated to the kitchen, to help with breakfast, dining, tea round and so on". Another member of staff told us, "When people have falls, we feel it is our fault as we are not there. If we had more staff, the number of falls would reduce". We saw there was no thorough analysis of falls to identify patterns and the level of support people needed.

Assessing risk, safety monitoring and management

● The information included in people's care plans contradicted information used in dependency tools. Therefore the planned number of staff were not based on people's actual needs. For example, one person's care plan stated that the person needed assistance with meals as they were unable to hold and use cutlery and were unable to chew their food. However, the dependency tool stated the person fed themselves with moderate assistance. Another person was allocated one-to-one assistance due to frequent falls, however, their dependency tool stated that the person was able to mobilise independently. Staff told us that people's care plans were reviewed by staff who did not know people's needs well and therefore were not accurate. For example, one member of staff said, "Peoples dependency needs proper reassessing. [The deputy manager] has done that not knowing person's needs".

This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Health and safety checks were carried out in areas such as fire alarm, emergency lighting and water checks.

●Risk assessments were in place to ensure people were supported in a safe way. However, risk assessments were not always updated with information on how to keep people safe following accidents/incidents. For example, one person's accidents/incidents records showed that they had frequently slipped off their chair which had resulted in falls. These incidents had not been analysed or action taken to mitigate the risk. The person subsequently suffered a serious spinal injury as a result of falling off their chair.

Learning lessons when things go wrong

● Records of accidents and incidents lacked detail and did not evidence that any monitoring took place of people after they had been involved in a safety incident. For example, one person was known to have frequently experienced falls and were unable to use the call bell. Safety measures introduced for this person such as bed rails proved to be ineffective. However, there was no reflection on why they were ineffective or how to introduce alternative safety measures. There were no reviews to show the service had reviewed and considered action they could take to minimise the risk of falls. The service had not taken any action to re-assess the person and their ability to sit on a chair, neither had they sought any support from external health professionals who might be able to help with reducing the risk. We discussed our concerns with a nurse who told us they would arrange for a referral to an occupational therapist so that the person could be re-assessed for other safety measures allowing them to use their chair safely.

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

Systems and processes to safeguard people from the risk of abuse

● The provider had systems and processes in place to ensure people were protected from the risk of abuse.

● Staff remained well-trained with regard to safeguarding and knew how to deal with any issues relating to people's safety.

● People told us they felt safe living in the home and their relatives confirmed that. One person's relative told us, "She is safe here but some of the residents can be quite difficult at night". One person told us, "They manage my medicines perfectly and on time".

Using medicines safely

● Staff knew people well and also knew how they wished to have their medicines administered. Staff were knowledgeable of the purpose of medicines they were administering.

● Medicines were administered in line with people's prescriptions and staff followed good practice. There were no gaps or omissions in Medication Administration Records (MAR). All medicines were stored in line with current legislation.

● Where people were prescribed 'as required' (PRN) medicines there were not always protocols in place to guide staff in when the medicines were required. Stocks for boxed PRN medicines were not maintained. We checked stocks for three people and they were incorrect. However, these shortfalls had been identified by the provider's audits and they were taking action to address them.

Preventing and controlling infection

● We saw that the home was clean and free of malodour throughout the duration of our inspection.

●Personal protective equipment (PPE) was available for staff, such as disposable gloves to use to help the spread of infection.

Inadequate

Is the service well-led?

Our findings

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

Inadequate: There were widespread and significant shortfalls in the service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

At our previous inspection in October 2018 we had identified a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's care records had not always been complete, contemporaneous, or accurate. Systems and processes had not been sufficiently robust to assess, monitor and improve the quality and safety of the service.

At this inspection we found there was no evidence of the service's improvement, which was insufficient for the service to maintain the rating of Requires Improvement.

Following the inspection in October 2018 the service sent us an action plan outlining how it would make sure that all issues identified in the report would be addressed.

On the day of the inspection we found some aspects of the action plan had not yet been met. A key point on the action plan was that the service would be routinely audited and areas identified for improvement or concern would be acted upon. We found that risks and issues had not always been identified. The insufficient staffing levels, lack of accidents and incidents analysis, risk assessment and review continued to leave some people at risk.

Continuous learning and improving care

● Accidents and incidents were recorded on an individual case-by-case basis. However, there was no system that would enable the service to have oversight of all the accidents and incidents within the service. As a result, identifying trends and patterns of incidents was hindered. The management had completed and signed a monthly review of incident and accident records without identifying the concerns we found.

● The service conducted a series of audits to ensure the service was operating effectively. Where concerns were identified, action plans were devised to ensure issues were addressed promptly. For example, where medicines errors had occurred, these were investigated and shared as lessons learnt. Where required, staff competences were re-checked before they could administer medicines again. However, we found that quality assurance systems were not effective in identifying the issues we found at the inspection. These included insufficient staffing levels and the lack of systems to monitor accidents and incidents.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People who used the service, their relatives and staff had opportunity to express their opinion. However, there was not always evidence that the service had taken action to address the opinion's expressed by them. People had founded a 'Friends of Orchid Care Home' group which aimed to discuss issues important for the

service and to be a link between the service and people. We could see from minutes of the meeting between 'Friends of Orchid Care Home' and the management team people had raised the issue of inadequate staffing levels. However, the management team had not effectively investigated staffing levels or reviewed people's dependency assessments and the tool used to calculate staffing levels. Staff told us they had asked the deputy manager to increase the staffing levels, however, nothing had been done to address this issue. A member of staff told us, "We've been going on about having more staff but nothing has been done".

● A recent audit carried out within the service revealed that more people expressed their opinion that the service was getting worse rather than improving. The responses had not been explored to find out why people thought the service was not improving.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

● The service did not always maintain links with professionals involved in people's care. The day after our inspection we were contacted by a healthcare professional who expressed their opinion about the service. The healthcare professional told us, "We had a good working relationship with the service when they opened. However, this relationship has declined with the time and with changes in the management team". They told us that the service did not liaise with them as often as before to assess people's needs, regardless the fact the number of people using the service remained this same. This meant staff were not always helped to ensure they were providing care in line with professional guidance. We looked at people's records which confirmed that people were not always referred to healthcare professionals following accidents or incidents which had taken place within the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● There was no registered manager in post. The home had a newly appointed interim manager in post. Until the recent appointment the home had been run by a manager who had stepped down just before the inspection to become the deputy manager.

● Staff knew their roles and responsibilities. They told us that the recent changes within the management were positive and they felt more involved with the new interim manager. A member of staff told us, "I didn't feel [deputy manager] involved with us well. It's better with [interim manager] now".

● The service had previously been inspected in October 2018 and September 2017 and repeated breaches of our regulations had been found at both inspections.

● Services are required to notify CQC about important events by law. We were not always notified about some accidents and incidents and one allegation of neglect within the service. For example, one person receiving one-to-one support suffered a fall because a member of staff left them unsupervised. We were not notified about this incident.

This was a breach of Regulation 18 CQC (Registration) Regulations 2009.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● There were low levels of staff satisfaction, and high levels of stress and work overload. Reporting of incidents, risks, issues and concerns was unreliable and inconsistent.

● Most relatives we spoke with thought the management and all the staff were approachable. However, one person's relative told us they felt the management team had not been open and transparent.

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 18 Registration Regulations 2009 Notifications of other incidents The registered provider failed to notify the Care Quality Commission (CQC) about notifiable incidents that occurred in the service.

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 The provider failed to assess the risks to the health and safety of service users receiving the care or treatment. Care and treatment was not provided to people 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 Records relating to the care and treatment for each person were not always accurate. The registered provider had failed to assess, monitor and improve the quality and safety of the services provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People's needs were not met by sufficient numbers of staff and suitably deployed at all times to meet their personalised needs.