Orchard Care Homes.com (3) Limited

Laureate Court

Inspection report

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Date of inspection visit: 18, 19 and 25 November 2014
Date of publication: 04/03/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This unannounced inspection took place on 18, 19 and 25 November 2014. Laureate Court provides accommodation and nursing care for up to 82 people who have nursing needs and people living with dementia. There were 78 people living at the home when we visited. Laureate Court is divided into three units. Keats unit provides accommodation for up to 32 people who require residential care. Byron and Shelly units provide accommodation and nursing care for up to 25 people each.

There should be a registered manager for the service. 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. There was a manager on site who was not registered with the Care Quality Commission. The manager had been employed at the home since 23 September 2014.

After our last inspection in September 2013 we asked the provider to take action to make improvements to cleanliness and infection control, and how the quality of the service was monitored. The provider sent us an action plan to tell us the improvements they were going to make. We inspected the home on 7 February 2014 and

Summary of findings

saw the provider had achieved their action plan and the service was compliant. Since the last inspection there had been a change in management and a number of staff had left the service and new staff had been employed.

At our inspection of 18, 19 and 25 November 2014 we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

We received some conflicting views from people who use the service and their relatives about the care provided. While some people were very happy, most people we spoke with were not. In addition, the observations of the inspection team and the records we looked at showed breaches across a number of regulations.

People's safety was being compromised in a number of areas. This included how clean the home was, how well medicines were administered, the support for people who could become agitated or distressed and the lack of staff understanding of the people who lived there. During our inspection very little social activity took place for a large proportion of people. We were concerned that people living on Byron unit were not provided with any social interaction during the three days of our inspection, although activities were advertised.

Staff were not always following the Mental Capacity Act 2005 for people who lacked capacity to make particular decisions. For example, the provider had not always completed mental capacity assessments and held best interest meeting where required.

We found that people's health care needs were assessed. However, people's care was not planned or delivered consistently. In some cases, this either put people at risk or meant they were not having their individual care needs met. People were not always supported to eat and drink enough to meet their nutrition and hydration needs.

Although relatives told us that staff were kind and caring, we saw that care was mainly focused on completing tasks and did not take into account people's preferences. Relatives told us that staff were rushed and sometimes not around to support people. Relatives we spoke with gave examples of where their relatives' dignity had been compromised.

We were informed that recently, the nurses who had been employed at the home had left the company, along with a number of the care staff. We asked the project manager why this was, and was told the manager had left and the project manager had taken over in the interim, prior to the existing manager commencing employment. The nurses were not happy with some changes that were being made. This had left the home in the position where they relied on agency nurses and some agency carers. However, the manager told us that three new nurses would be starting work at the service within the next few weeks. We also met some care staff who had just commenced working at the service.

We saw the care plans for six people who used the service. These were not always reflective of the person's current needs. There was a lack of social stimulation on the Byron and Shelly units.

We saw the manager was dealing with two concerns and had met with one person's family to discuss the concerns they had raised. However, several relatives told us they didn't complain anymore, as nothing changed. Others felt unable to complain as the manager displayed a 'do not disturb sign' on the office door.

Audits were completed but not always effective as they did not always identify areas for improvement.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not enough staff with the right skills and knowledge to meet the needs of people who used the service.

People were not cared for in a clean and hygienic environment.

Risks associated with people's care were identified but care records did not always give clear direction on how to prevent the risks from occurring.

We found inconsistencies in the medication records. This included gaps where medicines had not been signed for and no explanation had been provided about why they had not been given. We found inconsistencies in the medication records.

Staff knew who to inform if they witnessed any abuse taking place.

Is the service effective?

Inadequate

The service was not effective.

Care staff had received training that allowed them to support people safely. For example, infection control, moving and handling and dementia care. However, we did not see staff putting their skills and competencies into practice.

People who used the service were not always supported to have sufficient to eat and drink and to maintain a balanced diet.

Is the service caring?

Requires Improvement

The service was not always caring.

We found a lack of consistency in staff approach and while some individual staff were kind and caring, others lacked compassion and an understanding of how to communicate with and support people who had complex needs. There were instances where people's dignity had not been promoted or maintained

Is the service responsive?

Inadequate

The service was not responsive.

We saw some care records had a generic best interest decision covering all aspects of care. This was not in line with the Mental Capacity Act 2005 which informs that best interest decisions should be time and decision specific.

Two relatives we spoke with felt they could not raise issues with the manager as there was always a 'do not disturb' sign on his office door. We raised this with the project manager and the sign was removed.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

All the relatives we spoke with knew there had been changes in management recently. Some relatives we spoke with did not know the name of the new manager and told us they had not seen him interacting with the people who lived at the service. Some relatives had met the manager at a recent relatives meeting and were pleased the meeting had taken place.

We spoke with the manager about how he ensured the service delivered a high quality of care. We were shown some audits which had been completed. Some of the areas of concern we found during the inspection had not been identified prior to our visit.

Laureate Court

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 checked 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 18, 19 and 25 November 2014 and was unannounced on the first day.

The inspection team consisted of a lead inspector, a second adult social care inspector, a specialist in dementia care and an expert by experience who had experience of older peoples care services. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the information in the PIR along with information we held about the home, which included incident notifications they had sent us. We contacted the commissioners of the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the visit we spoke with eleven relatives of people living at Laureate Court, two nurses, five care staff, one team leader, the manager, the project manager and operations manager. We observed care and support in communal areas and also looked at the environment. We reviewed a range of records about people's care and how the home was managed. These included the care plans for six people. 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. We also spoke with five visiting healthcare professionals.

Inadequate

Is the service safe?

Our findings

Through our observations and discussions with people we found there were not enough staff with the right skills, experience and knowledge to meet the needs of people particularly on Byron and Shelly units. We spoke with people's relatives and most of them told us there were frequently times when no care workers had been in the lounge areas and relatives had to summon help when people had been in need of assistance or needed protecting from harm. Two relatives told us they didn't feel their family members were safe. One visitor said, "I don't feel my relative is safe because there isn't enough staff to support people." People's relatives also told us that several staff had recently left the company, since then relatives had noticed staff shortages and an increase in agency staff, who did not know the needs of their family members.

One relative we spoke with on Byron unit expressed serious concerns about the number of staff. They told us that their family member often looked unkempt with several days' growth that indicated they had not been shaved; their clothing were dirty and they only wore socks, not slippers. The relative said, "I have brought in four pairs of slippers and they have all gone missing." The relative went on to say, "You can never find staff when you visit and it's even worse at weekends." They told us that they had made several complaints but nothing seemed to change.

During our observations we found there were insufficient staff on duty to provide care and support which met people's needs. The manager told us staffing levels were set by the provider, and were not based on the needs of people who used the service. We observed that people had to wait for periods of up to 20 minutes to receive assistance. For example we observed lunch on Byron unit and saw that people were left with their meal for 20 minutes before staff returned to offer assistance.

One member of staff we spoke with said, "The unit (Byron) is often understaffed or staffed with some agency workers. There was one day recently when we were able to provide adequate care in a timely manner. This was because there were four regular care staff and a nurse who was prepared to offer hands on care but this is a rare occurrence." Another member of staff said, "We have struggled to meet people's needs and there has been occasions when we have had three carers and one carer on induction, plus an agency nurse. This made it difficult to meet people's needs. Staff on induction should be extra to rota, but this does not always happen."

We looked at the staff duty rota and saw that planned staffing levels were maintained. However, we saw from the rota that staff sickness at weekends had historically been a regular occurrence. The manager told us they had taken action to address this and staff sickness had reduced. We noted from the rota that agency nurses were often used and on the day of this inspection both registered nurses on duty were agency nurses. Although they had both worked at the home previously they did not know the people who used the service. For example, we observed that they had to ask care staff to confirm they were administering medication to the correct person. The manager told us that several nurses had left and they were in the process of recruiting more permanent nurses but there had been very little response to recruitment adverts already placed.

This was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (Staffing).

We looked at care records and found they included assessments which had been completed to help staff identify risks associated with the person's care. Where risks were identified, the assessment indicated that a care plan should be devised detailing how care and support was to be provided to minimise the risk and protect the person from the risk of harm. We saw care plans which did not provide clear detail on how to prevent or minimise risks and did not specify how the person should be supported.

During our observations we saw that some staff were not familiar with the people they were caring for and did not know what care they required to meet their individual needs and keep them safe. For example, we saw in one care plan that a person should be offered a pureed and fortified diet, due to the risks of weight loss and choking. We saw that the person was offered a sandwich and we asked the staff if they were aware if the person had any dietary requirements. The member of staff told us they should be offered a soft diet but this was not recorded in the person's file. The staff member was not aware that the person was at risk of choking or weight loss or what care they required to ensure their safety.

Inadequate

Is the service safe?

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (care and welfare).

We checked to see if medicines were ordered, administered, stored and disposed of safely. We looked at the MAR's (Medicine Administration Records) for people and found gaps where medicines had not been signed to confirm they had been administered or a code entered to explain why they had not been given. We saw some codes entered on the MAR did not match the codes at the foot of the MAR sheet. Therefore the reason recorded for not giving medicines was not always correct. The manager told us that this was due a recent change in pharmacy and the new MAR sheets were slightly different. The new MAR sheets had been introduced that staff were not familiar with and had not received training which had resulted in inaccurate information being recorded. From these records the reason why a persons medicine had not been administered could not always be determined therefore could not be monitored.

We noted that some people were taking medication on an 'as required' basis (PRN). However the service was not operating within the provider's medication policy and procedure around PRN medication. The policy clearly stated that any medication given as required should have the reason why it had been given and the effect it had documented on the reverse of the MAR and an entry made in the person's daily notes. Although each person taking PRN medicines had a PRN guidelines form held with their MAR we saw this had not been recorded in line with the providers guidance.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (Management of medicines).

We saw medicines were stored correctly. The service had a controlled drug cabinet that complied with law. We saw that staff checked the balance of controlled drugs each time one was administered and this was recorded so that there was a clear audit trail. Medications requiring cool storage were kept in a fridge which was situated in the medication room, the room was kept locked. We saw that temperatures were taken of the fridge and the medical room.

We observed a team leader on Keats unit whilst they administered medication. The staff member was aware of people's needs and how they preferred to take their medication. The staff member explained what they were doing and signed the Medication Administration Record (MAR) following each administration. We saw that people were asked if they were ready for their medication and it was given at a time to suit the person. We also observed a nurse administering medication on Byron unit. We saw that the medication was taken to the person, and where needed the nurse sat with the person until they had taken their medicines.

During our inspection we found concerns about the cleanliness and hygiene of the home putting people at risk of acquiring an infection. We found the home and some equipment was not clean. For example we saw one person sitting in their bedroom in a chair, which was dirty. We saw areas around the home which were visibly dirty and poorly maintained which meant they could not be effectively cleaned. For example, on Byron unit the legs of a shower chair were rusty and the tiles were cracked, worn and uneven around the shower. We saw a laundry bag and two red plastic bags containing soiled laundry were left on a shower room floor and remained there for several hours. We raised this with the project manager who asked the ancillary staff to move them. One bathroom on Shelly unit was full of chairs, moving and handling equipment and the bath panel was missing. The project manager told us they had requested a full refurbishment for this bathroom, but there were no timescales for completion.

We saw chairs and tables in the lounge areas on Byron unit were not clean and showed signs of food staining. Crumbs had accumulated under seat cushion pads and some food was encrusted on tables. We did not observe staff washing their hands or offering people who used the service hand washing facilities prior to meals being served. We found unpleasant odours throughout the home. Relatives we spoke with said there was an odour in the home. One relative said, "There's a smell in the home all the time."

We asked the manager for the last infection control audit and saw this had been completed in February 2014. This had some action points which had clearly not been completed. For example, the audit identified unpleasant odours, food stains on some lounge chairs, and issues around hand hygiene.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (Infection control).

Inadequate

Is the service safe?

We spoke with five staff about their understanding of protecting vulnerable adults. We found they had a good knowledge of safeguarding adults and could identify types of abuse, signs of abuse and they knew what to do if they witnessed any incidents. Staff we spoke with told us that they had received training in safeguarding adults. We saw the manager had reported safeguarding alerts but there was no log to show any actions taken and or any lessons learned.

The service had information which contained contact numbers for the Local Authority, and managers within the company. Staff were aware of these contacts and would use them if they felt they were required to do so.

Inadequate

Is the service effective?

Our findings

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We used this tool to observe people who were residing on Byron unit, over lunch and Keats unit during breakfast. We saw meals were nutritious and looked appetising. Whilst observing lunch on Byron unit we saw there was very little interaction between staff and people who used the service. Staff verbally gave people two choices, but did not show people what was available. This would have been good practice and would have assisted people living with dementia in making a choice. We saw that food being taken to people in their bedrooms was taken on a trolley, which did not keep food hot. Food was covered, but by the time the people received their meals they had gone cold. There were no drinks taken to those people who ate their lunch in their bedrooms.

In contrast, we observed breakfast being served on the Keats unit and saw staff assisted people well. There was soft music playing and people were offered choices. People who were able to assist themselves to get their breakfast were given this opportunity. People told us the meals were nice and they enjoyed them.

We spoke with staff about what they would do if they identified any concerns associated with a person's diet. They told us they would raise issues with the team leader or nurse who would contact the GP or other professionals such as the dietician and the speech and language therapist.

We observed staff assisting people who used the service but some staff were not aware of the person's needs, preferences or choices. One person who had just woke up, indicated they were thirsty. We asked staff if they would get a drink for them and they asked the person if they would like tea, coffee or juice. The person, who was living with dementia said, "I don't know." The staff member repeated the question and the person started to become agitated. We asked the member of staff what they would usually prefer and they did not know. The staff member, who was an agency worker, did not do anything to find out what their preferences were, but brought them a drink of juice. The persons care plan clearly stated their beverage preference but the agency nurse had not referred to this.

People who used the service were not always supported to have sufficient to eat and drink and to maintain a balanced diet. We observed lunch on the Byron unit and saw that staff were only in the dining room intermittently when they had to fetch something or when serving meals. For the rest of the time people were left without support. During these times we saw some people who required assistance, but no staff were available to assist. For example, one person was left to eat their breakfast which had gone on the table and floor. The person had a plate guard which had become detached from the plate. We saw the person was struggling to eat their breakfast. We asked a member of staff if someone would support the person however it was fifteen minutes before a staff member was available to support this person.

We spoke with relatives who visited Byron and Shelly units at mealtimes to ensure their relatives had their meals and the assistance they required. One relative told us that their relative was unwell and required lots of fluids. We saw a handwritten note on the person's bedroom door asking staff to ensure the person took fluids regularly. The relative told us the fluid chart in the persons room indicated that no fluids were given on the evening and night of the 17 November 2014.

We saw that some people on Byron unit did not receive drinks regularly throughout the day because they were walking around the unit and were not prompted to drink. We saw some people received drinks they did not want or like because staff were not aware of their preferences.

This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (meeting nutritional needs).

Staff received an induction before starting work at the home. This included training in safeguarding vulnerable adults, fire safety, infection control, moving and handling, dementia care and the Mental Capacity Act 2005 (MCA). The induction programme was organised by the providers own trainers and we were informed that staff also shadowed more experienced staff until they were deemed competent. Further training was also available to care workers such as National Vocational Qualifications (NVQ) in care and Diploma in Health and Social Care.

However we spoke with staff who told us new staff did not always get the opportunity to shadow experienced staff.

Is the service effective?

This led to staff not being aware of people's needs. One staff member said, "New staff are often counted in with the numbers, and therefore not shadowing and not having a chance to get to know people."

We asked the manager if staff received training in supporting people that displayed behaviours that challenged the service. The manager told us that they had raised this with their manager who said they would arrange for the company trainer to visit the home to complete training in this area. We spoke with staff who said they felt unequipped to deal with these situations.

We looked at records and saw that care staff had received training in their role. For example, infection control, moving and handling and dementia care. However, we did not see staff putting their training into practice. We observed care staff working on Byron unit. Their interaction was task orientated and we saw care was not person centred. For example, staff moved people without speaking to them and passed by people without speaking to them. One person tried to get the attention of staff by calling to them but staff ignored their calls.

We looked at ten staff files and found supervision was not undertaken in line with the provider's policy which stated 'supervision of staff should take place bi-monthly,' (one to one meetings with their line managers). The manager showed us a schedule which showed when staff were to receive supervision. It showed all staff had received one formal supervision since he had become the manager. Supervision prior to this had not taken place for most staff. On the schedule only three staff out of 72 staff listed had received their yearly appraisal. This meant staff were not supported and the manager was not monitoring their practice and performance to ensure they had the skills and competencies to meet the needs of people who used the service.

This was a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at how people consented to and were involved in their care. We saw care plans included a consent form but we saw this was not completed for one person. The care plan indicated that the person communicated well, but the records failed to show they had been involved in any discussions about consent.

The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

We saw some care records had a generic best interest decision covering all aspects of care. This was not in line with the Mental Capacity Act 2005 which informs that best interest decisions should be time and decision specific.

During the tour of the building we asked the manager how many people were subject to a Deprivation of Liberty Safeguard (DoLS). We were told there were six people living at the service who were subject to a deprivation of liberty safeguard. We looked at files for two of these people, to check the provider was meeting the conditions of the DoLS. We saw files contained appropriate paperwork such as a standard authorisation. However, one standard authorisation had expired in July 2014. We spoke with the team leader who showed us notes referring to a social work visit which took place in June 2014. The social worker had taken copies of the DoLS but there was no evidence this had been followed up. We saw that care plan evaluations had not identified this and indicated the DoLS was still in place. The team manager told us they would follow this up.

We saw that one person was given medication covertly. We asked what process was in place to support this decision. The project manager told us that the company policy was that a mental capacity assessment and best interest decision should be completed. We looked at the person's care record and found the person had two care plans to address this. One stated the person should be offered the medication and the other said it should be administered covertly. We saw a letter from the person's GP which informed staff to give medication covertly. There was no mental capacity assessment of best interest decision to support this. These arrangements had not been made in accordance with the Mental Capacity Act 2005.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service caring?

Our findings

We spoke with relatives who were visiting and we received some positive feedback about all three units. People's relatives told us staff were kind, caring and patient, but very busy. We observed some positive interactions on the Keats unit where staff took time to sit with people and engage in meaningful conversations while people were enjoying their meals.

In contrast we saw staff on Byron and Shelly units often did not have time to engage with people. Most of the time staff were rushing from one task to the next and some people who required assistance were ignored or forgotten about. For example, one person sat in a lounge area and was called out continuously. The person became quite distressed but was not acknowledged by staff.

We saw that some staff did not know the names of people on Byron unit. On one occasion staff gave us the incorrect name of one person. It was evident by the responses from staff that they did not know people and their individual preferences well. Therefore, positive and caring relationships were not always developed. We observed one person sitting in a small lounge eating a bowl of cornflakes at 12 noon. A care worker told us this was not a result of the person's personal choice, but because the unit had been short staffed that morning so breakfasts were late. We noticed this person did not have a drink and the care worker was unable to explain why, but brought a drink for them. The care worker said, "We've got an agency carer on duty this morning who doesn't know the residents, so we are behind with everything."

People's dignity and respect was not always promoted. We spoke with a relative who was unhappy because their family member was wearing someone else's trousers, which were several sizes too big for them and would have fallen down if they stood up. The relative said, "This has never happened before, but it's happened today and it's a matter of dignity and safety."

We saw a number of people who did not have any footwear on. One person's care plan indicated that they liked to wear socks and slipper however, we saw this person had nothing on their feet. Later in the morning we saw the staff put this person a pair of socks on but they did so while the person was sitting in the chair sleeping. This meant the person was not involved in the interaction. On our visit the following day we saw this person was wearing socks but no slippers. We spoke with staff about this and they did not know why this was. The person remained without their slippers.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (respecting and involving people who use the service).

Inadequate

Is the service responsive?

Our findings

We asked people's relatives if they felt involved in the care of their family member. One relative had been involved in a recent decision to move their family member to a different unit within the service which would suit the person better. We spoke with relatives who were visiting their family members on the Keats unit and they felt staff kept them updated of their family member's condition. One person said, "The staff would ring me if they were concerned or needed to contact the GP." Another relative said, "The staff called the GP out recently who prescribed antibiotics which were swiftly administered."

By contrast, we spoke with relatives visiting their family members on the Byron unit who were concerned they had not been kept informed of changed to their relatives care or condition. One relative told us that they were not informed when their family member had been admitted to hospital. They told us they only found out when the hospital rang them in error believing the contact number was for Laureate Court.

We spoke with people visiting their relatives on Shelly unit. One family was not aware their relative had a care plan. They were concerned about many aspects of their relatives care but did not know who to speak to about these issues. They said their family member had been living on this unit for about a year, but they told us they had not been involved in any meeting around care planning or care reviews. Some relatives said they were frustrated because the staff did not seem to know their relative very well and could not answer their questions about their relative's care.

People did not receive personal care which was responsive to their needs. People's needs were assessed, but care plans did not always reflect their most current needs.

We saw two people living on Byron unit had fifteen minute observation charts in place due to displaying behaviours which may challenge others. We saw the charts were not an accurate reflection of what was taking place. The charts only recorded where the person was at that time, such as the bedroom or lounge, which we observed to be incorrect, and did not give any other information. There was no written evidence to show what may have triggered the behaviour or defused the situation. One person's care plan stated that there were no triggers to cause the behaviour. The care plan stated some things the person liked and disliked . Through our observation we saw some potential contributing factors. For example, it was recorded that the person did not like loud noise, responded better with one person and liked their socks and slippers on. Before one incident when the person became distressed they had not been given their socks or slippers, the TV was loud, the telephone was ringing and three staff were assisting the person. Following the incident the person was given a cup of tea, which they threw on the floor. It clearly stated in the person's care plan that the person disliked tea.

The service had an activity coordinator in place who was being shadowed by another activity coordinator, who had just started working at the service. On the first two days of our inspection there were no activities taking place for people living on Byron or Shelly units, although activities were advertised. For example, we saw a poster displayed on all three units advertising a concert due to take place on the afternoon of our first day of inspection on 18 November 2014. This activity took place on the Keats unit. No one from the other units were invited to take part. Relatives we spoke with felt there was little stimulation for people. One relative told us they had raised this with the manager at a recent relatives meeting.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (care and welfare).

We looked at the complaints file and saw one complaint which had been recorded in July 2014. The manager also showed us copies of two complaints he had received over the past two weeks. The complaints file did not show what action had been taken or that any lessons learned had been shared with the staff team to avoid repeated concerns.

Some relatives we spoke with said they had raised concerns with staff and managers. Some relatives felt their concerns had been listened to and addressed. Others felt they were not listened to. One relative said, "I've had to battle to get staff to listen to me." Another relative we spoke with said, "I have raised concerns about the laundry and items of clothing going missing or returning from the laundry in a poor condition. No one is able to sort this out for me."

Inadequate

Is the service responsive?

Two relatives we spoke with felt they could not raise issues with the manager as there was always a 'do not disturb' sign on his office door. We raised this with the project manager and the sign was removed.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (Complaints).

Inadequate

Is the service well-led?

Our findings

Orchard Care had employed a new manager who commenced in post at Laureate Court on 23 September 2014. There was also a deputy manager who had commenced in post around the same time. Both these positions were supernumerary to the care hours provided.

All the relatives we spoke with knew there had been changes in management recently. Some relatives we spoke with did not know the name of the new manager and told us they had not seen the manager interacting with the people who lived at the service. Some relatives had met the manager at a recent relatives meeting and were pleased the meeting had taken place. They were told that the manager was looking to recruit more staff and this included a second activity co-ordinator. Some relatives were aware that a further meeting for relatives was due to take place in December 2014.

Through observations we saw staff lacked leadership and direction. Staff struggled to deal with some situations and there was no one around to guide and direct them. Some staff were new to the service and some were agency staff which was a contributing factor. When we inspected on the third day, 25 November 2014, we were informed that a team leader from Shelly unit had been made supernumerary to the rota in order to manage the unit on a day to day basis. Some mentoring had been given to them by a visiting manager from Orchard Care. The deputy manager had been given responsibility for managing Byron unit and the house manager from Keats unit had been informed they could work two supernumerary shifts per week to help them fulfil their management role.

The provider had systems in place to assess and monitor the quality of service that people received. However, this was not always effective. The manager and others nominated by him had completed audits in areas such as care records, infection control, medication, and the environment. The company compliance manager had completed an audit on a monthly basis. This audit looked at areas such as the environment, infection control, care plans, medication, staffing and complaints. The last audit was completed on 28 October 2014. The audit indicated there were many actions the service needed to address and an action plan was put in place.

Some of the areas of concern we found during our inspection had not been identified prior to our visit. During our inspection we saw several areas of the home which required cleaning. We spoke with the project manager and operations manager and were told that Orchard Care has a housekeeping audit and have dedicated housekeeping hours to check domestic tasks were being monitored. The manager told us that the housekeeping monitoring system had not yet been implemented and he had been unaware there were any shortfalls in cleanliness.

We looked at the latest infection control audit which had been completed in February 2014. The audit had identified some issues we had noted. For example unpleasant odours, dirty and worn chairs in lounge areas and issues around hand hygiene. This showed the audit was ineffective as these issues had not been resolved.

We saw that care plan audits had taken place and were scheduled to be completed every month. However, the care plans we saw were out of date and did not reflect the person's current needs. We saw one care plan had been audited in August, September and October 2014 but the issues we raised had not been identified. This showed the audit was ineffective.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (Assessing and monitoring the quality of service provision).

The manager showed us an action plan on 19 November 2014, which had been updated from our visit of the 18 November 2014. The timescale for all actions was immediate. The manager told us action points had been added as a result of our feedback.

We spoke with staff and some told us they found the new manager to be friendly and supportive. One person said, "I feel I could raise issues with him."

One relative we spoke with told us they were unhappy because they had to 'argue' with staff about their family member's care. They felt that because of their physical difficulties, their family member was being isolated in an upstairs lounge. This had since been resolved.

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 did not take formal enforcement action at this stage. 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 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The provider did not have suitable systems in place to ensure there were sufficient numbers of qualified, skilled and experienced persons employed to meet people's 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 2008 (Regulated Activities) Regulations 2010 Management of medicines **People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe administration and recording of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The provider did not have suitable arrangements in place in order to ensure that persons employed for the purpose of the regulated activity were appropriately supported in relation to their responsibilities.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The provider did not have suitable arrangements in place for obtaining, and acting in accordance with the**

This section is primarily information for the provider

Action we have told the provider to take

consent of people who used the service in relation to the care and treatment provided to them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider did not take proper steps to ensure each person who used the service received care that was appropriate and safe.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

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 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The provider's systems were not effective in monitoring the quality of service provision.**

The enforcement action we took:
A warning notice was issued to the provider requiring that they take action to ensure that effective systems were developed to assess and monitor the quality of the service provided by 30 January 2015.

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 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The provider did not have effective systems in place to protect people from the risks of acquiring a health care associated infection. This was because appropriate standards of cleanliness and hygiene were not maintained.**

The enforcement action we took:
A warning notice was issued to the provider requiring that they take action to ensure that effective systems were in place to protect people from the risks of acquiring a health care associated infection by 21 January 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The provider did not ensure that people who used the service were protected from the risks of inadequate nutrition and dehydration.**

The enforcement action we took:
A warning notice was issued to the provider requiring that they take action to ensure that people were protected from the risks of inadequate nutrition and dehydration by 21 January 2015.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

The provider did not have suitable arrangements in place to ensure people's dignity and privacy were maintained.

The enforcement action we took:

A warning notice was issued to the provider requiring that they take action to ensure people's dignity and privacy were maintained by 21 January 2015.