Mr Mukesh Patel

# Orchard Lodge Care Home

## Inspection report

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Date of inspection visit:
14 February 2019

Date of publication:
10 April 2019

## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service:
Orchard Lodge provides nursing care and accommodation for older people many of whom are living with life limiting conditions and some who are living with various forms of dementia. The premises is an older style, purpose built building with two floors. The service is registered to provide care for up to 28 adults. At the time of the inspection 19 people were living there.

People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Rating at last inspection:
At our last inspection on 17 and 19 December 2018 the service was rated Inadequate and placed in 'Special Measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Why we inspected:
We carried out this focussed inspection in response to information of concern we received about the service following our inspection in December 2018. At the time of this inspection we were aware of incidents being investigated by the local authority safeguarding team. As a result, we carried out this focused inspection to look at those concerns and this report only covers our findings in relation to those. This inspection did not assess performance against all five key areas and focussed only on the areas 'Safe' and 'Well Led'. The ratings from the previous comprehensive inspection for the other three key questions were included in

calculating the overall rating in this inspection. We will be returning to the service to provide a comprehensive overview of each key question.

People's experience of using this service:
People were not protected from the risk of harm because risk assessments, care plans and monitoring processes were not detailed enough to support staff to provide safe care.

People were at risk of dehydration because the provider had not kept accurate records . Staff were unaware of the need for target amounts of fluid each person should receive to prevent dehydration.

People were not protected from experiencing unacceptable levels of pain. This was because the service did not have adequate assessment tools in place to monitor pain when people were unable to tell staff verbally.

People were not protected from the risk of neglect. This was because the manager did not always identify, take action to address or report this, particularly when this risk was as a result of the person refusing care.

Care records did not contain information to show how staff made decisions about the administration of medicines at the end of people's lives.

Care plans did not contain information about people's needs and preferences in relation to end of life care, including information about care, medicines, spiritual, cultural and emotional needs. The service supported many people who were diagnosed with life limiting conditions and people who had recently died in the service, did so without their end of life care being effectively planned.

Management oversight of the service was not effective. The provider had made little to no progress to improve the shortfalls we reviewed at this focussed inspection since the comprehensive inspection in December 2018.

Records continued to be poor in quality and were not completed accurately or in enough detail to ensure people received safe, person centred care.

The registered manager and the provider has engaged positively with the commission through this inspection process and we noted that plans were being put in place to make improvements to the service.

Follow up:
The service continues to be in special measures. Following the inspection in December 2018 we took urgent action to impose conditions on the provider's registration. These conditions stopped the provider accepting new admissions to the home and required the provider to tell us the actions they had taken to address our concerns. Following this focussed inspection, the conditions will remain in place. We have asked the provider to send us weekly updates on action they have taken to improve the service. We will continue to check this service and will be returning within the timescales set out in our programme of inspection when we will check each key question.

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?

**Inadequate**

The service was not 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.

# Orchard Lodge 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.

We carried out a comprehensive inspection of this service on 17 and 19 December 2018 and found multiple breaches of The Health and Social Care Act 2008 (Regulated activities) Regulation 2014. The service was rated inadequate and is in Special Measures. This focussed inspection was prompted by information of concern received by the Care Quality Commission following the inspection in December 2018. This included allegations of neglect of a person who used the service who had died. This incident is subject to a safeguarding investigation and as a result this inspection did not specifically examine the circumstances of the incident.

However, the information shared with CQC prompted us to review of the care records of other people who had died at the service in recent weeks. This review led us to have concerns about the management of end of life care, pain management, support eating and drinking, and support with personal care. This inspection examined those risks.

Inspection team:
The inspection team was made up of two inspectors and an assistant inspector.

Service and service type:
Orchard Lodge is a care home with nursing. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This was an unannounced inspection.

What we did:
Before the inspection we looked at the records of the last five people living at the service who had died. We spoke with commissioners of the service and the local authority safeguarding team to seek their views about the service. We looked at information we had received about the service, including notifications.

During the inspection we spoke with three people who use the service, two visitors, two visiting healthcare professionals, two care staff, the deputy manager, the registered manager, a company director and the provider. We looked at care records for seven people, including daily records, care plans and clinical monitoring charts. We also looked at staff training records in relation to end of life care training.

Inadequate

# Is the service safe?

## Our findings

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

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse
- The provider did not have systems to protect people from the risk of self - neglect.
- Staff had received training about safeguarding people from harm, but did not recognise self-neglect as a potential cause of harm.
- The manager had not recognised or reported incidents of harm to the local authority.

Assessing risk, safety monitoring and management
- We looked at how staff supported people with personal care, particularly those people who were fully dependent on staff support.
- Care plans to support people with personal care lacked detail to guide staff in providing personalised care. This may have contributed to some people being reluctant to accept assistance.
For example, a member of staff told us that one person regularly refused support. They said the person sometimes agreed to it if they could watch staff in a mirror to see what staff were doing. This information was not in the person's care plan, so not all staff knew to approach care in this way. As a consequence, the person was at risk of harm because they did not accept care that would protect them from the risk of infection.
- Risk assessments were not detailed or personalised enough to effectively minimise the risk of harm to people.
- Many people at the service were permanently cared for in bed, although in many instances, no clinical reason for this was documented. For some people, this appeared to have been a way of managing the risk of falls as no other explanation was recorded.. However, this increased other risks such as a risk of social isolation and of developing pressure ulcers.
- People who were cared for in bed told us this was not by choice. One person said, "I would like to get up but [staff] never ask me."
- The service did not have a system or recognised tool in place to effectively assess pain, particularly for people who were unable to communicate their pain using words.
- Care Plans in relation to pain management were generic and did not give enough guidance to staff about how to recognise and support people who were in pain.
- People were assessed to check whether they were at risk of malnutrition, and they were weighed regularly. Staff had put in place food and fluid charts for people who they had identified as being at risk of malnutrition and dehydration. However, food and fluid intake charts, had not always been completed properly.
- Many fluid intake charts we looked at before and during the inspection indicated people were supported to drink far less than the amount they needed. This put them at risk of dehydration.

●New food and fluid intake charts introduced by the provider the day before this inspection showed clearer information about people's intake. However, target amounts of fluid for each person were still not recorded, which meant that staff still did not know whether or not the person had enough to drink. One staff member told us, "I did not know there was a target."

Using medicines safely

●Where people had prescribed medicines to help relieve pain and to reduce any discomfort at the end of their life, these had not always been administered. The deputy manager told us this was because people did not need the medicines. However, there was no record of how they made this decision and no record to show staff had accurately assessed the person as being pain free at the end of their life.

All of the above issues were a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staff had not received up to date training in end of life care and their competency was not regularly assessed to ensure they had the skills to provide a good standard of care.

●Staff worked intuitively rather than in line with a clear set of standards based on current good practice. This resulted in a lack of understanding of what good end of life care looked like and left people at risk of inconsistent and potentially poor care.

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

● There were enough staff on duty on the day of the inspection

●We did not review staff records to checks recruitment practice at this inspection. At the previous inspection in December we found the provider's recruitment practice was safe.

Preventing and controlling infection

● The service was clean and free of any unpleasant odours.

●Staff had received training in infection control practices and personal protective equipment such as gloves and aprons was provided for them.

● This aspect of care was not reviewed in detail at this focussed inspection but was covered fully at our inspection in December 2018.

Learning lessons when things go wrong

● The registered manager had shared the findings of the last inspection with the staff team and they were working together to make improvements to the service.

●Progress was slow and, in relation to the areas of care provision looked at on this inspection, little had been achieved to improve outcomes for the people living at the service.

● The registered manager recognised they had failed to take action to protect one person from the risks of self-neglect, and told us that they had taken action to reduce similar risks for another person at the service.

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 service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

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

- The registered manager's understanding of person centred care was not strong, and this resulted in people not receiving a service based on their individual needs.
- Clinical records were incomplete and sometimes incorrectly completed which meant an accurate record of the care provided was not available.
- In the case of some people who had died recently, the lack of complete records meant we could not be sure they had received the right care at the end of their lives.
- Records such as care plans and risk assessments were of poor quality and in many cases illegible.
- Although the registered manager had reviewed some care plans following the last inspection, and typed them to make them easier to read, the documents required much more work to bring them up to the required standard.

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

- There was a registered manager in post who was a registered nurse. They were supported by a deputy manager who was also a nurse, and one of the provider's directors was based in the service for much of the time.
- Systems in place to monitor the quality of the service were not used effectively to ensure people received good care. Issues we identified had not been picked up through audits or through the registered manager's day to day oversight of the service.

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

Continuous learning and improving care

- The registered manager and provider had made little progress since the last inspection in the areas looked at during this focussed inspection.
- However, the provider shared their plans to make improvements. This included providing support to the registered manager to develop their knowledge of person centred care and to improve the systems in the service.
- The provider had arranged for a registered manager from one of their other services to spend time at Orchard Lodge as a mentor to the registered manager.

● The provider confirmed they would consider appointing a consultant to support the development of the service if they considered that sufficient progress had not been made within two weeks.

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

● Staff made positive comments about the support they received from the provider and the registered manager. They all felt the registered manager was approachable, and that they could share any concerns they had with them.

● Relatives and people also said the registered manager was approachable.

● The registered manager and the provider told us they had shared the findings from the last report with staff, people and their relatives and were keen to involve them in making the necessary improvements.

● The registered manager had not considered ways to improve communication between the service and people who were not able to talk to them.

Working in partnership with others

●The provider worked with other key agencies, such as the local authority and the clinical commissioning group to ensure they were working towards making improvements to the service provided. However, they had not always reported concerns to other agencies as required by law.

● Prompts to make improvements from these agencies have been responded to proactively by the provider, although progress has been slow.