C&V Orchard Manor Limited

# Orchard Manor Limited

## Inspection report

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## Ratings

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

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|---|---|
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Inadequate** |
| Is the service caring? | **Inadequate** |
| Is the service responsive? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

This unannounced inspection took place on the 10, 11 and 17 October 2017. The inspection was prompted in part by increased notifications from the provider advising us that some people who lived at the home had sustained a serious injury. The information shared with CQC about the incidents indicated potential concerns about the management of people's care needs. This visit was also brought forward following information of concern being shared with us by the local authority. This inspection examined those risks.

Orchard Manor provides accommodation for up to 34 people who require personal care. At the time of our inspection there were 32 people living at the home.

At our last comprehensive inspection visit in November 2016 we rated the service as 'requires improvement' in all the areas we inspected. We found the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's rights were not protected through the effective application of the Mental Capacity Act (2005). The provider was in breach of Regulation 12 regarding safe care and treatment because the management of medicines was not safe. In addition the provider was in breach of Regulation 17 relating to the governance of the service. The provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service and had not maintained accurate complete and contemporaneous records in respect of each service user. After our inspection in November 2016 the registered provider sent us an action plan to show how they would meet the legal requirements of the regulations.

We undertook this unannounced inspection on 10, 11 and 17 October 2017 to check the registered provider had followed their own action plan and to monitor their compliance with the legal requirements of the regulations. During this inspection we found widespread and significant shortfalls in the service; which meant people had experienced harm and or had been exposed to the risk of harm. The required improvements had not been made and the service had deteriorated significantly. We asked the registered provider to take immediate action to ensure the safety of people who had been identified as at high and extreme risk of harm. During day one of our inspection we alerted the Local Authority about the serious safeguarding concerns identified. The local authority attended the service following our escalation and a number of health and social care professionals visited the home to carry out reviews. The Local Authority shared our concerns and provided the home with a team of staff to increase their staffing levels to ensure people were kept safe whilst we considered what further action to take.

There was not a registered manager in place and the home was being managed by an acting manager. 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.

At this inspection in October 2017 we found serious concerns about the safety of the service. People were at

risk of and at times had been subjected to unsafe and inadequate care and support. Risks to people relating to the management of people's physical and mental healthcare needs were not always identified, recorded and known to staff. Staff lacked knowledge of those at risk of choking and measures were not in place to minimise this risk. Skin integrity was poorly managed placing people at risk of injures. Clinical observations which could indicate health concerns were not understood and acted upon. People were not protected from harm due to staff not recognising and reporting safeguarding incidents to the local authority. People were at risk of injury due to unsafe moving and handling practices, poor maintenance of equipment and a lack of suitable equipment.

The home was dirty and smelt offensive. The systems in place to ensure good infection control and prevention and the cleanliness of the environment were not adequate. Infection control practices were reviewed by an infection control nurse and found to be unacceptable. There were insufficient staff numbers available to meet people's needs safely and in a timely manner. We could not be confident people always received their medicines as prescribed.

People were not supported by sufficient number of care staff who had the training, skills and knowledge to support them effectively. People were not supported in a way that protected them from unlawful restrictions. People did not have their rights upheld and protected due to poor understanding and implementation of the Mental Capacity Act.

People did not have their food and fluids intake managed safely when it had been identified that they were of risk of malnutrition and dehydration. Some people did have contact with healthcare professionals to maintain their health, however, staff had not always identified when healthcare support was required and subsequently throughout our inspection we found people whose healthcare needs had not been met. Sometimes people did not receive the appropriate health interventions when needed.

People did not have their privacy and dignity respected and were not always treated compassionately. We found occasions where people were in a distressed, anxious or unkempt state and the inspection team had to intervene. People were not involved in making decisions and choices about their care and support. Staff did not have time to build meaningful
relationships with people. Some language and daily records used by staff to describe people and their care needs was not dignified. People's individual cultural and language needs were not met and valued.

People did not receive personalised care which met their needs. The majority of care plans did not reflect people's current needs, and they were not an accurate or helpful tool for staff providing care. Staff did not know what people's needs were and how support should be provided. People had not received the opportunity to undertake any range of interesting and stimulating activities that they enjoyed. People did not feel that their concerns and complaints were listened to.

Leadership within the home was woefully inadequate and had failed to ensure positive outcomes for people who lived there. People had been placed at risk of significant harm and many had experienced avoidable harm. The registered provider systems in place failed to ensure people received the care and support they needed and had failed to monitor the quality of the service and ensure people were protected from harm. In addition the registered provider had failed to notify us of events as required by law.

The overall rating for this service was 'Inadequate' and the service was therefore placed into 'Special measures'. Services in special measures are kept under review. Following the inspection we took urgent action to cancel the registration of the provider as people were exposed to ongoing risk of harm and the provider failed to make sufficient and timely improvements. At the time of the publication of this report, our

action had been completed and there were no longer any people living at the service.

We found that the provider was not meeting all of the requirements of the law. We found multiple breaches in regulations. You can see what action we told the provider to take at the back of the full version of the 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?

**Inadequate**

The service was not safe.

The registered provider had failed to ensure people were sufficiently protected from the risk of harm to both their physical, mental and emotional well-being. People had experienced harm and omissions in the care and support they received.

There were insufficient numbers of staff on duty to meet people's care and support needs.

Systems and practices in the home failed to ensure that people lived in a clean home and that they were fully protected from the risk of infection. Equipment had not been maintained.

The management of medicines was not safe and people had not always received their medicines as prescribed.

### Is the service effective?

**Inadequate**

The service was not effective.

People did not receive care and support from suitably skilled staff to meet their care and support needs. Staff did not have the skills and knowledge to meet people's needs safely.

People did not have their rights upheld and protected in line with the Mental Capacity Act (2005)

The risks associated with people's nutritional and hydration needs were not monitored and effectively managed and people were not supported to ensure their needs were met in relation to eating and drinking.

People did not always receive medical intervention or support from the necessary healthcare professionals when needed. Staff did not always escalate issues to relevant medical professionals.

### Is the service caring?

**Inadequate**

The service was not caring.

The registered provider had not ensured the home was being run in a manner that promoted a caring, dignified and respectful culture.

People did not always experience kind and compassionate care and did not have their physical, mental and emotional needs met.

People were not supported or involved in making decisions and choices around their care.

## Is the service responsive?

**Inadequate**

The service was not responsive.

People did not receive personalised care that reflected their needs and preferences. People did not have their needs met by staff who understood what support was required.

People were not supported to take part in activities relevant to their individual needs and interests.

People did not feel their complaints and concerns were heard and addressed appropriately.

## Is the service well-led?

**Inadequate**

The service was not well-led.

There were no effective systems or processes in place to ensure that the service was safe, effective, caring, responsive or well led. The registered provider failed to protect people from unsafe care and as a result people had experienced inadequate care and support.

Quality audits were inadequate. Oversight of the service was poor. The provider failed to make sufficient and timely improvements.

The registered provider failed to notify us of incidents as required by the law.

# Orchard Manor Limited

**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.

This unannounced inspection took place on the 10, 11 and 17 October 2017. The inspection was prompted in part by increased notifications from the provider advising us that some people who lived at the home had sustained a serious injury. The information shared with CQC about the incidents indicated potential concerns about the management of people's care needs. We also brought forward our planned inspection to respond to concerns shared with us by the local authority. This inspection examined those risks.

The inspection team consisted of two inspectors and an expert by experience on the first day, two inspectors on the second day and three inspectors and two specialist advisors on the third day. The specialist advisors were qualified nurses. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

As part of our visit we reviewed information the provider had sent us in response to our last inspection which outlined the action they planned to take to comply with regulations. We asked the provider to complete 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. This was returned as requested. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any safeguarding matters. We refer to these as notifications. We reviewed the notifications the provider had sent us and in addition considered feedback provided to us by 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. We used all this information to plan what areas we were going to focus on during our inspection visit.

During our inspection visit, we met and spoke with 16 of the people who lived at the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us

understand the experience of people who could not talk to us. We also spent time observing day to day life and the support people were offered. We spoke with two relatives of people and two visiting health care professional to get their views. In addition we spoke at length with the registered providers, a registered manager and deputy manager who were covering managers, the acting manager, the acting deputy, two senior care assistants, the cook, the acting cook, two care assistants and two care assistants who were working at the home but employed by the Local Authority.

We sampled some records including 11 people's care plans and 15 people's medication administration records to see if people were receiving their care as planned. We sampled three staff files and the way the provider had applied their recruitment process. We sampled records about training and quality assurance to see how the provider monitored the quality of the service.

Inadequate

# Is the service safe?

## Our findings

At our last inspection in November 2016 we rated the registered provider as 'Requires improvement' in this key question and we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that people were placed at risk by the lack of clear systems and records to ensure that people who needed support received their prescribed medication as directed. Risks to people were not always reflective of their needs. There was not always enough staff to meet people's needs in a timely manner.

At this inspection in October 2017 we found that the issues had not been addressed and the service had significantly deteriorated. The provider had failed to ensure people received consistently good, safe care that was compliant with the legal regulations. The registered provider remains in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living at Orchard Manor were not receiving safe care and support and were placed at risk of harm. We identified serious concerns around the registered provider's ability to effectively assess and manage the risks to people living at Orchard Manor. These included how staff supported people to manage risks associated with their behaviour; staffing levels in the service both during the day and overnight; the safety of the environment with regard to fire precautions and infection prevention and how medicines were being managed. We found examples of where the registered provider had failed to keep people safe.

People were not protected from the risk of harm and many had experienced avoidable harm. Risk management plans did not give staff sufficient information and guidance about how to support people who had severe anxiety and mental health needs. Three people who lived at the home had been assessed as at risk of self-harm, depression, suicidal thoughts and behaviour which placed themselves at risk. Assessments to identify these risks were either insufficiently
detailed to guide staff about how to support people to mitigate risks, or where information was provided, this was not being followed by staff. For example, one person's risk assessment identified that they were to be monitored in relation to having access to sharp instruments. We found the person unsupervised in their bedroom shaving independently. This was evidence that this risk was not being effectively managed. We found people's care plans and risk assessments in respect of people's mental health needs were poorly documented and the management of people's behaviours did not ensure that people were safe. The registered provider had failed to ensure staff had sufficient understanding of how to monitor and support people with these complex needs. Behaviour monitoring charts were not in place. These charts are used to identify specific triggers to people's behaviours and how staff should manage the behaviour presented and offer support. There was no monitoring of trends to establish if there were patterns for people. This meant the service did not adequately mitigate or reduce the potential risk to people and other resulting from these situations.

Moving and handling practices were unsafe and placed people at risk of injury. People were not protected from the risks of poor moving and handling practices. We observed multiple occasions when staff supported people to stand up or transfer by holding the person under their arms and lifting. This inappropriate and

banned technique of supporting people increases the risk of injuries such as skin tears, dislocation or fracture. A member of the inspection team found a person on the floor in the communal lounge. We immediately called for staff. We observed three staff lifting the person from the floor to their wheelchair using the underarm lift. This put the person at increased risk of further injury. Whilst the registered provider advised us that staff had received training they had not put their learning into practice. In response to our concerns raised the registered provider arranged for a moving and handling trainer to attend the service to provide moving and handling training to all staff.

Improvements were needed to ensure people's safety in the event of a fire. The registered provider had not acted in accordance with the associated guidance for fire safety risk assessments in residential care premises. We found staff's knowledge about what to do in such an emergency was variable and the actions they said they would take were inconsistent. Some people's care plans included personal emergency evacuation plans (PEEPS), which described the support they would need to evacuate the building in the event of an emergency. However, we found these were not reflective of people's current needs and the support they would require in the event of a fire. For example, one person's PEEP had not been reviewed since 2015 and was not reflective of their current needs. The PEEP identified that the person was able to transfer from their bed to a wheelchair independently and this was not the case. The person told us that they were unable to get out of bed due to the specialist equipment the person required not being available in the home and staff confirmed this. The registered provider had been made aware of the need to obtain the equipment, however they had failed to do so. This placed the person at risk of being unable to leave their bed in the event of an emergency.

The support people received did not protect them from the risk of harm. Some people had been assessed as requiring 15 minute observations throughout the day and night to keep them safe. One person who had been identified to need this level of support told us, "I've not seen any staff all morning." We were unable to ascertain from looking at this person's daily care notes, the duty rota and speaking with staff whether this person received this level of care and support. This meant people were not being checked as planned to reduce the risk of harm. The registered provider had failed to ensure there was an effective system in place to ensure risks were monitored and managed in order to protect people from avoidable harm.

There was inadequate support in place to ensure people's health was maintained. Risks of health complications had not been assessed and plans implemented to reduce the risks. Although we saw that people's care records contained details of people's specific health condition there was no detailed guidance about how the person would need to be supported to keep them safe or detail of what staff should do in the event of a medical emergency. For example, some people had been diagnosed with diabetes and we found that people's care records had not been completed with sufficient detail to guide staff in how to support them safely for any risks associated with this condition or in the event of a medical emergency.

People did not receive safe care. We reviewed the care of people with indwelling catheters to maintain their continence needs. Risk assessments had not been completed and there were no individual care plans to guide staff on the signs to be aware of that could determine a blockage or infection. Staff told us and we saw that urine output was not being monitored because staff were not reading the amount when catheter bags were emptied. On three occasions, the infection control nurse and two of the inspection team were required to alert staff members to empty one person's catheter bag as it was full of urine. Failure to adequately support a full catheter bag had put the person at risk of pressure damage to their urethra.

People told us they did not always feel safe in their environment. One person told us, "Someone came into my room and hit me with a stick on my legs." Another person said, "You have to watch out for one person [they] can be violent when [they] lash out, it can be dangerous." People told us they did not always feel they

were protected from the risk of harm due to the lack of availability of equipment such as their call bell. One person told us, "Staff have removed my call bell alarm." We explored this concern further and we found call bell cords were not only out of reach for people to access but some were also missing from people's rooms. This was also corroborated by other professionals who had raised this as a concern with the registered providers after finding the call bell cords all stored in the office. This meant people were at risk of harm and were reliant on attracting the attention of staff passing by.

There were unacceptable levels of cleanliness at the home which placed people at risk of cross infection. People did not enjoy a clean home and were not protected from the prevention and control of infection. We found numerous carpets, chairs and mattresses were soiled, stained and offensive smelling. We found that some practices in the home needed to be improved to protect against the spread of infection. The toilets within the home, which were frequently used, were not being cleansed to an acceptable standard; some did not have toilet paper or paper handtowels in situ and most had dirty bars of soap available for people to use. We noted a number of dirty commodes and commode seats in people's bedrooms and dirty toilet brushes in bathrooms. We found offensive odours throughout the home and this was corroborated by a number of visiting health professionals. We were concerned about the procedures in place to manage laundry. We noted on all days of our inspection that there was not a dedicated member of staff in the laundry and found dirty and soiled laundry backing up.

Although there had been no outbreaks of infection the standards in place would not safeguard people against the risk of infection. We notified the Local Authority of our concerns who immediately arranged for an infection control nurse to inspect the home. The infection control nurse advised that they had noted a number of mattresses were unfit to be used; a number of mattresses and carpets were soiled and needed immediate cleaning. A number of people's beds had been made that morning by staff working at the home using soiled and dirty bed linen. A pressure relief cushion had been found covered in black mould. In addition a number of dirty and full urine bottles had been found on people's dining tables in their rooms. The audits and checks conducted in the home had failed to identify the issues and concerns that we had identified during our inspection.

People did not have the equipment they needed to keep them safe. The registered provider had limited understanding of their responsibility in relation to checking equipment and identifying hazards that may pose a risk to people's safety. Hoists and wheelchairs had not all been assessed as suitable for the person using them and they may have been using equipment that was not suitable for their needs. For example, we observed staff supporting a person to transfer that did not minimise the risk of injury to them. Initially staff attempted to use a standing hoist to transfer the person, it was apparent that the person did not have the ability to weight bear in their legs. Staff then made the decision to use the hoist available at the home. Whilst this transfer was done safely we looked at the person's risk assessment. The risk assessment identified that the person only used a wheelchair. It did not specify that a hoist was to be used, or what type of hoist or the correct type and size of sling required to move the person safely. Selecting the wrong size sling can result in discomfort if the sling is too small, or the risk of the person slipping through the sling if it's too large. We met and identified people with a range of specific needs that required them to have specific equipment that was not available for them within the home. Good practice is that everyone should have their own sling. In addition we observed one person being supported in a wheelchair without footrests and their feet were dragging along the floor. We were required to alert the staff member to the risk of potential harm. The staff member told us, "The chair is broken, we should be getting some more." In addition there were no records confirming this equipment had been checked regularly to ensure that it was functioning properly.

During our inspection we found that medicines were not consistently administered safely. People were not protected by effective management of medicines in the service. For example, one person's care record

identified that they required a medicinal pain relief topical cream to be applied to their body. Records we viewed showed that the topical cream had been omitted for 15 days. This practice put the person at risk of experiencing unnecessary pain and discomfort.

We found significant gaps in the medicine administration records (MARs) for eight people. It was unclear if people had received their prescribed medicines and topical creams or if it had been omitted at those times. One person's MAR's identified that they had not received their prescribed dose of antibiotics due to the person being asleep. There had been no consideration by staff at the home to refer this to the doctor to see if the timing of the administration could be changed. Another person's MAR's identified that their prescribed topical cream was 'still not available'. We found prescribed topical creams identified and named for individual people in other people's bedrooms. This meant some people were not receiving the correct prescribed topical creams which meant people's symptoms may not have been effectively managed.

Some people that were prescribed medicine PRN [when required]" did not have protocols in place to provide staff with enough information to know when the medicine was to be given. Two people were prescribed antipsychotic medicines [these are medicines to help control symptoms related to unsettled mental health] to be taken 'PRN'. We saw that that both people had been administered the medicines every day and not as PRN as prescribed. This had not been reviewed by the doctor. This medication has unpleasant side effects and is only prescribed for older people with caution. The registered provider had not taken action to reduce the impact of these side effects on people.

We checked the stock levels for some medicines and found that some did not match the MAR's. We saw that medicines were not stored safely. The medicines trolley was locked but it was not secured safely to a wall when not in use. We found one MAR's chart had been handwritten and the record had not been checked for accuracy and signed by a second trained and skilled member of staff. People did not all have an information sheet alongside their MARs. This meant that there was a risk that staff could not easily identify each person; know what allergies they had or any other key information regarding the management of their medicines. We looked at the management of medicines and found they had not been audited effectively. The audits had failed to identify the shortfalls we had found. We were advised on the third day of our inspection that medicine competencies were undertaken; these observations check that staff administer medicines safely to people. We were unable to view these on the day of our inspection as the acting manager could not locate the forms.

The registered provider had failed to ensure people were safe. A failure to ensure that risks associated with people's needs had been assessed and plans developed and delivered to mitigate the risks placed people at risk of harm. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

We found that people were not always protected from abuse and systems had failed to ensure people's well-being. We identified that the registered provider and staff had failed to recognise the widespread neglect and omissions in care people had experienced at the service. During day one of the inspection we made immediate safeguarding referrals for eight people and subsequently health and social care professionals commenced urgent reviews of each person's care and support needs and whether these were being met at Orchard Manor. The registered provider had failed to ensure staff had the appropriate knowledge and understanding to protect people from abuse and recognise when safeguarding referrals needed to be made. Some staff we spoke with were unsure of who to report concerns to outside of their organisation.

We found widespread incidents of neglect throughout this inspection. We spoke with one person in their

bedroom after we found them in a distressing state. The person's bedding and room was found to be soiled and offensive smelling. The person was found in a distressed and unkempt state and the person informed us they were in need of a drink. We asked staff to respond immediately to ensure this person was supported to be washed, had their bedroom cleaned and offered a drink. We found one person had been having serious symptoms which suggested their mental health required assessment. Staff had not recognised this and had taken no action to seek support for this person, despite them being in a distressed and anxious state throughout our inspection. We identified people who had not received the correct level of care to prevent them from developing pressure sores. For example, some people's care plans identified that they needed to have their skin checked daily, there was no evidence this had been completed. Some people had not been repositioned in accordance with their care plan. One person told us that new chairs had been delivered and that their pressure relief cushions had not been repositioned and that they were experiencing pain and discomfort and said, "I'm sick of asking." In addition There were no effective systems to demonstrate that daily mattress checks had taken place and the care plans did not consistently identify what pressure the mattress should be set at. We found there was no checks in place to ensure this had been done by staff. We referred these people to the Local Safeguarding Authority and they are now undertaking an investigation. We brought our concerns to the attention of the registered provider who confirmed they were not aware of the incidents.

People had not been protected from the risk of abuse and improper treatment and systems had not been established to prevent the risk of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment

At our last inspection in November 2016 we found there was not always enough staff to meet people's needs in a timely manner. At this inspection in October 2017 we found that there were insufficient staff numbers available to meet people's needs in a timely manner. We had to immediately intervene and instruct the registered provider to increase their staffing levels to ensure people were safe.

Staffing levels were inadequate and unsafe. People were not supported in a safe way as there were insufficient numbers of staff employed at the service. One person we spoke with told us about the wait they had after calling staff and said, "You have to wait for up to an hour and I don't like saying anything as I get into trouble." Another person said, "I had to wait two hours for the toilet, I was in tears." During our inspection we saw that staffing levels were inadequate to support people who lived at Orchard Manor. We saw people shouting for drinks and asking for staff to help them with their personal care needs. People who had been assessed as being at high risk of falling were left unsupervised and unsupported in the dining room. We saw people experienced delays in receiving their meals. During day three of our inspection we were required to intervene and asked the acting manager to identify a staff member to prepare and serve people their evening meal. People's anxieties were heightened due to waiting for food for extended periods exceeding one hour. On day one of our inspection there was a period of time when there were very limited staff available to support 31 people with their individual and complex needs. On day one of our inspection there was no dedicated staff available to carry out domestic duties which contributed to the poor cleanliness of the environment. In addition there was no dedicated catering staff due to the absence of the permanent catering staff. This meant staff responsible for other duties had been taken of the staffing rota to undertake catering duties. No risk assessments or related actions had been taken into consider the impact of this on the staff team and their roles and responsibilities.

The registered provider advised that people's dependency levels had not been reviewed and confirmed that they did not have a system or a tool in place to determine the number of staff required to meet people's needs. We raised our concerns with the Local Authority who provided the home with additional staff to increase the staffing levels to ensure people were immediately safe. The registered provider had no

contingency plans in place for the event of staff shortages. For example, there were no bank staff recruited or no contract developed with agencies who provide staff for providers to use to enhance their staffing levels.

The registered provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet people's care and treatment needs. This was a breach of Regulation 18 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. Staffing.

Staff told us pre-employment checks were completed before they started to work at the home. A member of staff told us, "I had to provide references and have my DBS done before I started work." We looked at three staff recruitment records and appropriate checks, reference pre-employment checks and DBS checks had been completed. DBS checks help providers reduce the risk of employing unsuitable staff. We did note that references did not confirm the validity of the people providing the information.

Inadequate

# Is the service effective?

## Our findings

At our last inspection in November 2016 we rated the registered provider as 'Requires improvement' in this key question and we identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that people's rights and freedom were not protected through the effective use of the Mental Capacity Act (2005).

At this inspection in October 2017 we found that the issues had not been addressed by the planned date or to the required depth to ensure people received consistently good, safe care that was compliant with the legal regulations. The registered provider remains in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.
The provider failed to ensure principles of the MCA had been adhered to. We checked whether the service was working within the principles of the MCA. One person we spoke with told us, "I have no voice." Staff were not always able to describe the basic principles of the MCA. Staff we spoke with told us that people were asked for their consent before they provided any care or support. However, this was not always seen in practice and people were not given the opportunity or support to make choices and decisions throughout the day. For example, on day one of our inspection we arrived at 07.30 am. We saw 18 people were up and dressed and sitting and or sleeping in the lounge. We asked staff if people had consented to getting up early and if this had been their decision. A staff member told us, "We just get people up if they are incontinent." We saw people being taken from the dining area to the lounge without being asked where they would like to go. We sampled people's care plans and saw many consent to care and treatment forms were blank and unsigned. The registered provider had failed to ensure people were asked for their consent prior to care and treatment being provided.

We saw that some people had bed rails and sensor mats in place. There had been no consideration of whether the restrictions being placed on people were in their best interests. We found a lack of detailed capacity assessments or best interest decisions recorded in people's care plans. We saw a number of people had refused their medicines, nutritional supplements and personal care and were deemed to lack capacity to understand the risks to themselves. No action had been taken in line with MCA guidelines to ensure decisions around these issues were taken in their best interests. This showed the registered provider had failed to ensure that people had their rights upheld and protected in line with the Mental Capacity Act (2005).

Two people received their medicines covertly, when tablets had been crushed and disguised in their food. We did not find evidence that the person had consented to this or that there had been a multi-disciplinary involvement for the best interest decision to give covertly. One person had a directive from a doctor but

nothing else. One person had a solicitor's letter on behalf of their relative but no other documentation. There was no evidence that the relative had the appropriate legal powers to make this decision. There was no evidence of regular reviews for these decisions. It is good practice that there are regular reviews of this method of administration so it can cease if no longer necessary.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found DoLS authorisations had been applied and authorised for nine people. People subject to authorised DoLS were not protected by those conditions in place because staff were not aware of the people whose liberty were being restricted. The staff we spoke were inconsistent in relation to which people were subject to a DoLS and were unable to explain how they supported people in the least restrictive way. Some staff told us they did not know what DoLS were and advised that they had not received training in this area. One member of staff told us, "I never heard of it…there is no-one here on a DoLS." Care records we reviewed lacked detail about the person's authorisation and or if any conditions were attached to them and there was no guidance available for staff to follow to enable them to support the person in the least restrictive way. The registered provider had not worked with the staff team to make sure they understood who was legally authorised under DoLS and how best to support them with their restriction, ensuring least restrictive practices were followed.

We saw that people were restricted to accessing the garden as it was padlocked. We saw one person sitting in the smoking area of the home and looking through the wooden slats which divided the home from the garden; they were not able to access the garden. Another person's care plan identified that it was in their best interests in respect of their mental health needs that they had free access to the homes grounds and garden. This assessment had been identified as a way of supporting the person when they were experienced heightened anxiety. This was not observed in practice on the days of our inspection.

Nine people's end of life plans recorded that they did not want to be resuscitated if they were unresponsive to immediate lifesaving treatment. We noted that the appropriate form had not been completed as they were photocopies. Two of the nine, 'Do Not Attempt to Resuscitate' (DNAR) forms that we reviewed had the wrong address recorded on them. A number of the forms had recorded that that the reasons for the DNAR were not life threatening conditions., For example one said, 'old age and housebound' another said, 'confused state' We noted that some of the forms were over two years old and had not been reviewed. There was no advanced plan stating people's choices and preferences in how they would wish to be supported at their end of life and there was no evidence that the wider national and updated guidance had been adhered to. Although DNAR decisions are the responsibility of an appropriate clinician, the registered provider had not challenged, or brought this to the attention of responsible medical staff.

The registered provider was not ensuring that people's rights were protected and this was a continued breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 11. Consent.

Staff did not have the skills or knowledge required to support people safely and promote their wellbeing. The registered provider could not demonstrate people were receiving effective care and support from staff who had the knowledge, skills and competency to carry out their roles and responsibilities. Training for staff was inadequate in providing them with the necessary skills and training that had been offered was poorly implemented by the staff team... Whilst we were told staff had received moving and handling training we observed a number of examples where staff did not display an understanding of how to use safe manual

handling techniques and as a result placed people at risk of injury. The registered provider had failed to ensure staff had understanding and knowledge of how best to support people with behaviours that challenge and or had complex mental health needs. They had not researched current best practice, nor had they

consulted other agencies for advice and guidance for people's specific and complex needs. This meant people's mental health needs were not recognised or responded to by the staff team. We identified a number of concerns about the competency and skills of some staff when we observed them providing care and support to people. For example there were people living with specific health conditions such as diabetes and schizophrenia and staff had not received any specialist training despite people living at the service requiring support in these areas.

We found that staff did not always have the skills to work effectively with people living with dementia. People we met were at differing stages of their dementia and there was no plan about how the service kept up to date with developments in this area to ensure the care provided was appropriate and reflected best practice. Staff had limited knowledge and understanding of how dementia affected people in their day to day living. Appropriate strategies were not in place and staff did not know how to respond effectively to people's heightened anxiety and distress which resulted in behaviours that were challenging. The registered provider was not able to demonstrate that they checked the competency of care staff to ensure they were equipped with the skills needed and were applying these into practice.

We saw a one-day induction was completed with new staff members. The registered provider advised that staff did shadowing with more experienced staff but there was no evidence to demonstrate this. We found care planning information was not always accurate and staff were not being equipped with the knowledge they needed to provide effective care and support. In addition as the existing care staff team had not always been equipped with the knowledge and skills needed to support people we were not assured that shadowing would give the new staff the knowledge they required to support people effectively. The registered provider had not yet ensured their induction processes were in-line with the Care Certificate. The Care Certificate is a nationally agreed set of fifteen standards that health and social care workers follow in their daily working life. It was launched in April 2015 and providers regulated by the CQC are expected to ensure that the standards of the Care Certificate are covered in their induction of new staff.

The registered provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet people's care and treatment needs.
This was a breach of Regulation 18 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. Staffing.

We identified serious concerns around the registered provider's ability to effectively assess and manage the risks to people's nutritional and hydration needs. There was poor monitoring and management of people's eating and drinking which put people at risk of dehydration and malnutrition. Support provided to those people with complex and dementia related needs was not sufficient to ensure they ate and drank enough. There were a number of people who had been assessed as being high risk of malnutrition and dehydration. One person had been assessed as high risk of choking. We saw advice from the Speech and Language Therapist team identifying that the person required a soft diet and thickener in their fluids. There was further health professional advice that the person should receive a high calorie, high protein diet with food supplements. We observed the person eating foods that increased their risk of choking. We intervened and advised the staff that the person was on a soft diet. The care and catering staff we spoke with were not aware of this person's dietary needs. In addition we observed another person eating a meal that was a risk to their well-being. The staff acknowledged their mistake and removed the meal replacing it with the

appropriate food. We spoke with one member of the catering team who advised us that there was no-one living at Orchard Manor with a food allergy. We saw in one person's care plan that they had an allergy to two types of fruit. This poor management and monitoring of people's eating and drinking put people at risk of harm.

One person had been admitted to hospital for weight loss. On their return it was noted that the person should be weighed on a monthly basis and should have their food and fluid monitored to mitigate the risk. We noted that the person's last weight had been recorded in June 2017. Staff told us that they were not aware that the person's food and fluids should be monitored. We saw two other people's care plans which identified them at being at high risk of malnutrition and required monthly weighs to monitor. There was no food or fluid charts in place for them and they had not been weighed as required. On day three of our inspection we were unable to view other people's weight records as they could not be located. Where people were assessed as being at risk of dehydration their fluid intake was not monitored effectively. Where we did see some fluid charts being recorded by care staff there was no oversight to ensure people were having sufficient to drink to meet their needs or take necessary action when they were not. We received two concerns that people had been admitted into hospital with dehydration. These incidents are being investigated by other agencies who will share the outcome of their investigations with us. We will use this information to identify if we need to take any further action.

Some people told us they enjoyed the food offered. One person told us, "My dinner was lovely." However, we found mealtimes were not a positive and pleasant experience for people. Mealtimes were disorganised and not flexible which meant people continued to experience delays in receiving their meals. There was no system in place to ensure that staff knew the whereabouts of people during mealtimes or whether people had received sufficient to eat and drink. We saw that one person had not been offered any lunch. We heard one staff member ask another if the person had eaten their lunch. The staff member advised that they didn't know. We saw one person had their food pureed. However, there had been no consideration made to the presentation of the food. All food items were mixed together rather than food being blended separately to enhance the presentation and taste of the meal. We noted that there was no adapted cutlery or aids in use to support people to maintain their independence.

The registered provider did not have suitable arrangements in place to make sure people's nutritional needs were met. This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People did not have their health needs monitored. We looked at the support people were given to access healthcare professionals when required. We saw records which showed people had access to district nurses and doctors. We found that some people who were diabetic had not received the specialist care they needed including chiropody or optical services which were important to maintain their well-being. This meant people's health conditions were not monitored robustly to prevent further harm.

On the third day of our inspection a member of the inspection team saw a person sitting in the communal area of the home, demonstrating that they were experiencing pain. Whilst staff were aware of this they advised "It was normal behaviour." The member of the inspection team intervened. After which staff contacted the emergency services. The person was found to be seriously unwell and admitted into hospital. Staff had not recognised or considered this person was unwell and it was only after intervention from the inspection team that medical attention was sought.

Failing to ensure assessments of people's care and treatment of their needs, including health is a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 9 Person- centred

care.

Inadequate

# Is the service caring?

## Our findings

At our last inspection in November 2016 we rated the registered provider as 'Requires improvement' in this key question. We found that staff were busy with tasks and did not have time to interact with people nor did they always respect people's individual wishes.

At this inspection in October 2017 we found that the issues had not been addressed and the service had deteriorated. People were not treated with dignity and respect. This had resulted in a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regarding dignity and respect.

People did not experience kind and compassionate care and we found numerous examples where people had experienced harm and serious omissions in their care. We found people in distressing states where their physical, mental or emotional health needs had not been adequately addressed or recognised by the provider. Overall the service provided at Orchard Manor was not caring and this could be demonstrated by the concerns found in the other areas of this report. The registered provider had not ensured that staff had all the information and support they needed to care for people adequately and as a result people experienced poor outcomes. The provider had not ensured care and support was delivered safely and that people's needs were met. The provider had not ensured people were cared for in a clean and comfortable environment. People were not aware of their care plans and had not been involved in the development of these. There was a lack of stimulating activities provided for people and there was a lack of systems in place to ensure that people could provide valuable feedback about their care and the service. The environment was not well adapted for people living with dementia. Hand rails and room doors were all white and the carpet was a single colour with no pattern, there was little for people to find to enable them to engage in independent activity and a lack of signage to help people orient themselves. There were some pictorial signs on doors to denote bathrooms and toilets, for example, but no signage to help people locate these independently. People were not always treated with care, dignity and kindness. We were concerned about the culture at the service and examples of poor practice, understanding and oversight displayed by the managers and provider.

The registered provider had not ensured the service was being run in a manner that promoted a caring and respectful culture. One person who was clearly distressed told us, "I'm treated like a pig, there's no-one to help me." Staff did not maintain people's dignity and privacy. People told us and we saw they had to wait long periods of time for staff to meet their care needs which meant people were often left in an undignified and distressing state. We saw people whose attire was soiled and odorous due to their unmet continence needs. We saw people sitting with clothes on that were covered with spillage from food. We saw people's appearance was unkempt and their personal hygiene not maintained. Some people had long and dirty finger nails. One person's care plan identified they should have their nails kept short and clean due to their habit of picking an open wound on their head. We observed this was not the case. The person had long and dirty mails and was seen continually picking their wound and staff had failed to attend to this. Staff did not pay sufficient regard or priority to maintaining people's dignity and self-respect and did not recognise their responsibilities to maintain and promote people's dignity.

We saw another person's dignity was not maintained as they were being examined by a visiting doctor in the dining area. The person's top clothes had been opened which meant they were exposing the top half of their body. Other people were sitting and eating at the dining table. We saw occasions where people were not appropriately dressed or had equipment exposed such as catheter bags. On one occasion we saw a person's catheter bag being emptied in the communal lounge area into a commode pot. We spoke to staff about this but they did not recognise the need to maintain people's privacy or consider how this practice affected people's dignity.

Staff used inappropriate and unacceptable language to describe people's care that did not promote their dignity. For example, one member of staff referred to people who required support to walk into the dining area as 'walkers'. People's behaviour was often referred to as 'aggressive' in people's daily notes without any consideration of why people had presented with behaviours that challenged. There were numerous occasions witnessed when personal information about people was spoken about in front of others living in the home, visitors to the home, and other staff. The information shared compromised the dignity of people using the service and breached people's right to privacy. We saw in one person's daily notes a member of staff had recorded that the person had 'whinged and cried'. This person was later found to have significant mental health needs that required treatment at hospital which had not been recognised by the staff team or the provider. Confidential information about people's daily care was also displayed on a board in a communal area of the home and we observed that care notes were left unattended throughout the day in dining areas.

People had mixed views whether they thought staff were caring. One person told us, "They are wonderful." Another person told us, "Some staff are really nice and some staff are not so nice…they shout and I say …. who do you think you are speaking to….they soon back down." We observed poor interactions and attitudes towards people. On one occasion a member of staff placed a drink in front of someone and abruptly said, 'here' and on another occasion we observed a person who was extremely distressed being told by a member of staff, "You will have to wait." Whilst we saw serious shortfalls in the approach of some staff there were some who did clearly care about those in their care. We saw very few occasions where there were positive interactions between staff and the people they were supporting. However, this was not consistent, observations throughout the day showed that interaction between staff and people seemed mainly task orientated, and when people required direct support with personal care, to move or when eating and drinking. This meant they did not have enough time to engage with people and promote their social interaction. Staff we spoke with confirmed they were often rushed and did not always have the time to respond to people's needs in a timely manner.

The registered provider did not have a good enough oversight or systems in place to ensure that staff had a consistent approach, that poor practice was recognised and appropriate action was taken to eradicate it. The provider did not recognise what dignified care should look like and how to ensure staff treated people with care and compassion.

Failing to treat people with dignity and respect is a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 10.

Staff did not have the time to build relationships with people; opportunities for staff to spend time with people were limited. We saw numerous occasions where people were sat in the lounge areas of the home without any interaction from staff. One person said, "sometimes it's very rare they [staff] will listen to me." We saw there were missed opportunities for staff to interact with people because they were rushed and did not have the time to spend with people. Staff had not considered how people would like to or wished to spend their time. For example, one person's care plan identified a personal goal to spend time gardening.

Their care plan provided no information for staff about how this person wished to be supported with this goal and there was no reference in their daily care notes with regard to this.

People told us they did not have an opportunity to express their views or be involved in decisions about how their care needs were met. We saw staff did not ask people about how they preferred their care to be given. People were not supported to make day to day choices nor encouraged to maintain their independence. On the third day of inspection staff were observed handing sandwiches out to people whilst they were sitting in the communal lounge without asking what people's choices and preferences were in respect of the filling. People were not given the opportunity to sit at the table to eat their evening meal. We found the registered provider's systems did not ensure people were supported in a caring manner and staffing arrangements in place impacted on the quality of care people received.

The registered provider did not ensure that staff had the knowledge and understanding to support people with their social, religious and cultural needs. One person told us that they did not enjoy receiving personal care from male carers. The person's care plan contained a preference to gender care form, but this was blank and unsigned. The care plan of one person whose first language was not English had identified that the person was to be supported by a member of staff who reflected their diversity and culture and was able to communicate in the person's preferred language. On all the days of our inspection it was noted that the person was isolated and was not able to converse with staff or other people. We continually heard staff saying 'I don't understand you'. Throughout our inspection we observed the person walking around the home. We saw the person in a continual state of distress and no action was taken to try and address this through exploring different approaches and routines. Staff were unable to respond to the person's needs in a meaningful way and told us, "It's their normal behaviour." This meant the person's needs were not known to staff and the person was at risk of social isolation. On another occasion we observed a member of staff offered one person a choice of meat dishes for their meal. We noted the person was a vegetarian and being offered meat could cause offence to someone with religious beliefs. There were no strategies in place for staff to provide consistent, effective and individualised support including people's cultural needs.

Inadequate

# Is the service responsive?

## Our findings

At our last inspection in November 2016 we rated the registered provider as 'Requires improvement' in this key question. Further improvements were required to ensure people's care plans were reflective of people's needs and improvements were required in supporting people to follow their interests.

At this inspection in October 2017 we found that the issues had not been addressed and the service had deteriorated further. The registered provider had failed to ensure that the care and treatment of people was appropriate, met their needs and reflect their preferences and had failed to ensure people had access to activities which would support their wellbeing and meet their individual needs and preferences. This had resulted in a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regarding person-centred care.

People did not receive care and support which met their needs and preferences and the provider had no systems in place to ensure person centred care was delivered. Staff were focused on tasks and did not involve or engage people in how they would like their care to be delivered. People did not receive care which enhanced their well-being. People told us they did not always get their needs met in the way they preferred or in a way that was responsive to their needs. They told us that due to staff always appearing busy and task focused they were not always asked about their preferences or how they would like their care to be delivered. We observed people being supported with their personal care needs at set times during the day and we saw people being offered drinks at set times during the day. We looked at care records to see whether people's personal preferences in relation to getting up and going to bed had been recorded. Care records did not include information on people's preferred routines and preferences. People's needs in relation to their physical and mental health were not always being met.

Staff had inadequate knowledge and understanding of what people's support needs and preference were and care plans did not provide sufficient information to guide them. They did not provide staff with information about people's preferences, what was important to them and how staff could support these. People who had complex mental and physical health care needs did not have care plans that reflected their preferences, how these needs impacted on their daily life, what worked well for that person in meeting their needs, for example when experiencing heightened anxiety. There were no explorations with people and their loved ones about things that worked well. The registered provider had introduced a tool called a 'map of life'. These tools are an essential part of person-centred care and a way of learning who people are, their likes and dislikes, life events, life history and personal preferences and beliefs. We did not find one map of life which had been completed. This meant staff did not have information about people their preferences or the support they required to keep them safe. The provider had made no attempts to develop their knowledge of people's needs.

Staff did not engage people in meaningful activity. None of the care records we sampled contained a care plan that adequately demonstrated how staff should respond to individual differing needs in relation to their social activities, interests and meaningful interventions. For example, one person's care plan identified that the person liked to sit in the garden and smoke a pipe and have a shower every three days but we saw

no evidence the person had been supported to do this. Another person's care plan stated 'I enjoy staff showing me pictorial books' This was not evidenced during any days of our inspection.

Care plans did not provide staff with sufficient information to care for people's needs as identified in risk assessments. For example, care plans for people living with dementia or people with mental health needs did not contain information about how it affected their ability to carry out daily tasks. It did not inform staff how to promote people's independence, whether additional equipment could be considered and how people's symptoms might fluctuate day to day. Without this information staff would be unable to act responsively to people's individual needs and this could impact on people's quality of life. Our observations of the care and support provided demonstrated that staff did not understand what people's individual needs were.
People could not be confident that a change in their needs would be appropriately assessed and action taken to ensure their needs were met. The registered provider did not understand the processes for evaluating people's care. The current processes in place for evaluating people's care was limited and did not lead staff to consider if care plans were working, contributing to other issues or were creating more difficulties for the person. The majority of reviews read as 'remains the same'. One person's care review stated 'remains the same' but we found evidence that the person had experienced variable mental health needs and serious episodes of self-harm with no reference to this contained within their records.

No recreational activities had been arranged. We found that some people with assessed needs in relation to social isolation were not being supported to become involved in any meaningful engagement. One person told us, "I like music…I just sit here all day and night." Another person told us, "There's nothing to and nothing to spend my money on. It's my birthday tomorrow but I won't celebrate it here." We saw an activity timetable advertised but none of the activities on the schedule took place. Staff told us that they arranged activities when they had time to but we saw no activities provided on the three days of our inspection. People appeared disengaged, sleeping or observing their surroundings. We saw people attempting to mobilise on many occasions and saw staff telling them to 'sit down' constantly. One person said, "I hate being on my own…I'm quite often on my own. It's the worst thing." There were no plans in place to support people who lived in their rooms to pursue activities they enjoyed or help to prevent social isolation.

Our discussions with the registered provider indicated they were not up to date with best practice in regards to how to make environments more 'dementia friendly' and how to provide meaningful stimulation and occupation to people who live with dementia. There was no stimulation provided to people living with dementia or mental health needs. For example, we saw no reminiscence activities or visual stimulation or use of familiar daily tasks to encourage physical mental stimulation. We observed people left to their own devices on the days of our inspection which resulted in increased anxiety levels, distress and social isolation escalating. The provider had not recognised these issues or taken any steps to address.

The registered provider had failed to ensure that the care and treatment of people was appropriate, met their needs and reflect their preferences. The registered provider had failed to ensure people had access to meaningful occupation which would support their wellbeing and meet their individual needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

The provider had ineffective complaints systems in place. People and their relatives told us they did not feel complaints and concerns were responded to effectively. One person said, "They [the staff] don't listen to any of my concerns, they don't have time." A relative we spoke with told us that they did not feel that staff had made enough of their loved ones changes in their physical health. We saw that the complaints procedure was displayed at the home. However, there were no contact details for the Care Quality Commission. In

addition there was no reference to the Local Authority or the ombudsman so that people and their relatives had access to contact numbers should they wish to raise a concern or complaint. The complaints process was not available in different formats to meet some people's specific communication needs and was not on display in different formats for people to refer to. This may restrict people's right to access a formal complaints process. The manager explained to us that they only recorded formal written complaints and did not log any verbal or informal complaints that were made. This meant the registered provider did not always listen to people's feedback, concerns and complaints to make improvement to their care and experiences of living at Orchard Manor.

Failure to investigate and take appropriate action in response to complaints is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service well-led?

## Our findings

At our last inspection in November 2016 we rated the registered provider as 'Requires improvement' in this key question and we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that the quality audit systems in place were not effective at identifying concerns and the improvements needed.

At this inspection in October 2017 we found that the issues had not been addressed by the provider and the service had deteriorated significantly placing people at risk of harm and unsafe care and support. The registered provider remains in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were inadequate systems in place to monitor the quality and safety of service provided and the manager and provider had failed to ensure people received the care and support they needed. As a result people were placed at the risk of harm and many had experienced actual harm as a result. There were widespread and systematic failings in the service being delivered and we found numerous occasions where people were distressed, anxious in a poor state of health and placed at on-going risk. The provider had not recognised the seriousness of the issues identified and did not have the skills to be able to make immediate improvements.

Many of the people living at Orchard Manor were extremely vulnerable, and are highly dependent on staff to support them with their individual physical and mental health needs. Our observations of peoples' needs and presentation during our inspections showed that they were not always receiving the necessary support to ensure risks to their health, safety and wellbeing were being effectively managed. We observed that some people were experiencing and or had been exposed to risk of harm. We found widespread failings; a number of the failings identified created serious risks to people's life, health or wellbeing, in some instances immediately. We were so concerned about our findings that we made immediate contact with the local authority to discuss the shortfalls and the immediate action that needed to be taken in order to keep people safe. The local authority attended the home on the first day of our inspection due to the issues we were finding and had escalated.

Our findings from inspection demonstrated that the registered manager and provider had little oversight of the service and had not taken timely and robust action to ensure people received safe care and support. They were not aware of the level of concerns which we identified during this inspection, despite the concerns being clearly in place before our arrival. Although we raised concerns on both days of inspection, the registered provider did not respond to these concerns in a timely manner or with sufficient action to be able to make the immediate improvements required.

We wrote to the registered provider on two occasions following the second day of inspection to outline our continued concerns because the evidence suggested the risks to the service and people safety had increased. Responsive action had not been taken in all areas and we remained concerned about the capability of the registered provider to drive forward the improvements needed because they did not appear

to fully aware of the risks in place, the action needed to minimise these risks or of the robust leadership needed to make timely improvements, ensure people are safe and that staff were supported.

The registered provider was not assessing, monitoring and mitigating the health, safety and welfare of people who may be at risk. Staff had not reported potential safeguarding concerns or when incidents had occurred. They did not report when staffing levels were unsafe or when they lacked the competency to provide safe care to people. People were receiving care and support which was not in-line with their needs. People's health had not been monitored or maintained. At times this care and support was unsafe because it was carried out in a way that it increased the risk of harm to people. The providers systems and oversight had not recognised these serious and immediate concerns.

People told us that they were not happy with their experiences and quality of live whilst living at Orchard Manor. One person we spoke with told us how they felt powerless by their situation and said, "I just want to go out to the bank to get my money. I feel like I'm in prison." Another person said, "I don't like it here." People's experiences of day to day living were poor. The registered provider had accepted to accommodate and support people with a wide range of physical, emotional and mental health needs. However, they had failed to demonstrate they had the right number, mix of staff, the premises or resources to support these varied needs.

There were no effective systems in place to monitor the quality of the service, or to ensure the effective management of risk. Audits had not been effective in areas such as risk assessments, care records, management of medicines, staffing levels and the application of the Mental Capacity Act principles. In addition the environment was filthy and unhygienic and immediate improvements were needed throughout the environment to ensure it was clean and to minimise the risk of infection. This had not been addressed by the provider or manager. The lack of an effective process to audit the quality of the service provided meant concerns regarding risks to service user's health, safety and well-being had not been identified and prompt action had not been taken to address these.

People's health and well-being was not sufficiently protected as the registered provider had failed to implement systems that ensured people received the care and support they needed. We found people's food and fluid intake was not being recorded and monitored and steps were not being taken to protect people's health and ensure they had enough to eat and drink. We found numerous occasions where the provider had failed to monitor and manage people's needs in relation to eating and drinking. We found people were at risk of developing pressure sores and required regular repositioning and skin integrity checks to reduce the risks. The provider had not ensured this monitoring had taken place.

The registered provider's systems had failed to ensure information was accurate and up to date and reviewed by appropriate staff, which meant concerns about people had not been escalated appropriately and staff had a poor grasp of what people's needs were and what support was required to keep them safe. We also found people's preferences were not always known by staff and followed when care and support was given. As the registered provider was not able to provide assurances that some people's health needs had been met we reported our concerns to the local safeguarding authority for further investigation and requested the provider addressed specific concerns immediately.

Quality assurance systems did not consider the impact of inadequate resourcing and deployment of staff. Our inspection demonstrated a failure in the infrastructure of the service to ensure the registered provider had effective oversight over deployment, numbers and skill mix of staff along-side robust quality assurance systems that identify issues prior to them becoming a potential risk to those in their care.

The registered provider had failed to ensure people had access to activities which would support their wellbeing and meet their individual needs and preferences. The registered provider had not ensured the home was being run in a manner that promoted a caring, dignified and respectful culture.

Accident and incident audits were not effective. There was no evidence that care plans and risk assessments were updated in response to changes to health or following accidents and incidents. For example, one person had returned from hospital on the 4 October 2017 and their care records had not been updated or reviewed.

Staff lacked direction and leadership in their work and did not understand their roles and responsibilities. There was an atmosphere of chaos during the days of the inspection with little evidence of any organisation or structure. Staff were not adequately supervised and the registered provider did not have systems in place to ensure the staff team demonstrated the right values and behaviours towards people.

We found the registered provider had not used people's feedback to make improvements to the quality of the service people received. The registered provider had not developed effective systems to ensure people felt heard. They had not ensured people were involved in actively sharing their feedback about the service and contributing to the development of the service. People told us they did not feel their views were sought, heard and acted upon. This did not enable people to influence and have a say in how the service was run. We also found at this inspection the improvements we required from our last inspection had not been acted upon such as staffing levels and the protection of people's rights.

Throughout the inspection multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations were found to be in breach. These breaches placed people at risk of receiving care and support that was inappropriate, unsafe and did not meet their needs.

Systems had not been established or operated effectively to assess, monitor and mitigate the risks to people's health, safety and welfare. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

Organisations registered with the Care Quality Commission (CQC) have a legal responsibility to notify us about certain events about incidents that had taken place. A statutory notification is a notice informing CQC of significant events and is required by law. During the inspection we became aware of incidents of potential abuse and Dols applications that had been authorised that had not been reported to CQC as required by law. The registered provider failed to notify the CQC of such incidents.

Failure to notify us of incidents as required was a breach of Regulation 18 Care Quality Commission (Registration) 2009 Notification of other incidents.

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 | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The registered provider had failed to notify us of incidents as required by law. |

**The enforcement action we took:**

We took urgent action to cancel the registration of the service.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The registered provider had failed to ensure that the care and treatment of people was appropriate, met their needs and reflect their preferences. The registered provider had failed to ensure people had access to meaningful occupation which would support their wellbeing and meet their individual needs and preferences. |

**The enforcement action we took:**

We took urgent action to cancel the registration of the service.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>People were not always treated with dignity and respect and people's independence and involvement was not respected or upheld. |

**The enforcement action we took:**

We took urgent action to cancel the registration of the service.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The registered provider was not ensuring that people's rights were protected |

**The enforcement action we took:**

We took urgent action to cancel the registration of the service.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The registered provider had failed to ensure people were safe. A failure to ensure that risks associated with people's needs had been assessed and plans developed and delivered to mitigate the risks placed people at risk of harm. |

**The enforcement action we took:**

We took urgent action to cancel the registration of the service.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>People had not been protected from the risk of abuse and improper treatment and systems had not been established to prevent the risk of abuse. |

**The enforcement action we took:**

We took urgent action to cancel the registration of the service.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>The registered provider did not have suitable arrangements in place to make sure people's nutritional needs were met. |

**The enforcement action we took:**

We took urgent action to cancel the registration of the service.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>The provider had failed to investigate and take appropriate action in response to complaints. |

**The enforcement action we took:**

We took urgent action to cancel the registration of the service.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |

| | |
|---|---|
| | The provider did not have robust systems in place to monitor the quality of the service.<br><br>The provider did not have effective systems in place to assess and monitor risks relating to the health, safety and welfare of people using the service. |

**The enforcement action we took:**

We took urgent action to cancel the registration of the service.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider had failed to ensure there was sufficient numbers of suitably skilled and experienced staff to meet people's care needs.<br><br>The provider had not ensured that staff received appropriate support, training and professional development as was needed so that they could carry out the duties to support people in the home. |

**The enforcement action we took:**

We took urgent action to cancel the registration of the service.