Care People Private Limited

The Orchards

Inspection report

13 Peaks Lane
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Grimsby
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Orchards is a residential care home providing personal care to up to 21 people aged 65 and over, including people living with dementia. There were 14 people living at the service at the time of inspection.

The care home accommodates people in one adapted building which has been extended over the years and is set over two floors.

People's experience of using this service and what we found
People at The Orchards did not receive a safe, effective and well led service. We identified concerns relating to people's safety which included poor oversight of fire safety issues by the provider. A lack of training and guidance for staff on how to support people in the event of a fire, and insufficient staffing levels during the night. This put people at significant risk of harm.

The provider did not ensure staff's competencies were checked in relation to training received. We have made a recommendation about this.

The provider had no oversight of the safety and quality of the service. Quality assurance systems were not established and operated effectively to ensure compliance with regulations. The premises were not well maintained, and areas were not fit for purpose. This included decoration and furnishings of the premises.

Medicines were not managed safely. Staff did not always have guidance to ensure they administered 'as and when required' medicines to people safely. Night staff had not been trained to carry out medicine administration.

Robust systems were not in place to monitor accidents and incidents which placed people at increased risk of harm. Systems did not give clear guidance to staff when to seek medical advice following an accident or incident. We have made a recommendation about this.

Safeguarding concerns had not been reported by staff and management. The registered manager was not clear of their role and responsibility in relation to safeguarding people.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; policies and systems in the service did not support this practice.

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

Why we inspected
This inspection was prompted by serious concerns we received about the service in relation to care

management, staff support and training and poor condition of the premises.

We have found evidence that the provider needs to make improvements. Please see safe, effective and well led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Orchards Care Home on our website at www.cqc.org.uk

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to fire safety, management of medicines, staff training and support, failing to operate effective monitoring systems to improve the quality and safety of the service, poor record keeping, notifications of incidents, and safeguarding people from risk of harm.

Full information about CQC's regulatory response to more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe.	**Inadequate**
Is the service effective? The service was not always effective.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

The Orchards

Detailed findings

Background to this inspection

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out over two days, one inspector attending on day one, and two inspectors on day two.

Service and service type
The Orchards is a 'care home'. 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.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection-
We spoke with one person who used the service, three relatives, two care staff, two team leaders, the chef, the cleaner, the registered manager and the provider.

We reviewed a range of records. This included four peoples care records and multiple medication records. We looked at four staff files in relation to recruitment and induction. A variety of records relating to the management of the service, policies and procedures were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
• People were placed at risk of harm because the provider had failed to fully mitigate risks relating to fire safety.
• Not all staff had completed full fire safety training as per the providers policy. This included attending fire drills and completing evacuation training using equipment to support people. This meant they may not know how to support people safely in an emergency.
• Personal emergency evacuation plans (PEEPS) were in place. However, they did not contain clear guidance for staff on how to support people in the event of a fire emergency situation.
• The PEEPs identified the amount of staff people would need to support them in a fire emergency. However, staffing levels on a night did not reflect those needs.
• Risks associated with people's care needs had not been fully assessed. The registered manager had also failed to seek the advice of relevant healthcare professionals when making decisions about how to provide safe care for people. This meant the support given by staff may not have been appropriate or safe for people living in the service.

The failure to adequately assess, monitor and reduce risks to people's health and safety is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Learning lessons when things go wrong
• Accidents and incidents were not properly monitored, recorded or investigated.
• There was no evidence that lessons were learned after incidents had occurred within the service.
• Accidents such as falls were not fully analysed to identify emerging patterns or trends.
• Records did not provide a clear description of injuries people had sustained. Records also failed to include accurate information about what actions had been taken following the incidents or accidents. This meant opportunities to prevent reoccurrence were missed.

The failure to assess and mitigate risk is a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
• Medicines were not managed safely.
• The providers medication policy was not always followed by staff. For example, the controlled drugs book

was not signed by two trained staff when medicines had been administered.
• Guidance for staff to administer medicines prescribed on an 'as and when required' basis (PRN) was not always in place. Records which were in place often lacked detail. This meant staff may not have full guidance to help them making decisions about when and how much medicine to give people.
• The provider had not ensured that staff on duty at night had been trained to administer medication. This meant people were at risk of not receiving their medicines when they needed them.

The failure to adequately manage robust medicine systems and practice was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014

Preventing and controlling infection
• People were not always protected from the risk of infection.
• During inspection we found areas of the premises were not clean or well maintained. Items of furniture was old and damaged and bathroom equipment was unclean. Flooring in the corridors was worn and taped together in areas.
• Area of the premises which had been identified in 2019 for repair had not been addressed. There were no plans in place to complete the works needed.
• Issues relating to maintenance which we found had not been identified via the provider's quality monitoring systems.
• Record relating to checks of the standards of cleanliness had not always been fully completed. There was no oversight of these records by the registered manager.

The failure to ensure the environment was clean, safe and well maintained was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• People were not protected from the risk of abuse.
• The registered manager did not understand their responsibilities in reporting all safeguarding concerns to the local authority.
• We identified safeguarding concerns which had not been reported to safeguarding.
• Staff had completed safeguarding training and told us they would report any concerns they had to the team leader or manager. One staff member told us they were unsure whether they would go straight to the safeguarding team if needed.
• Following the inspection, we reported our concerns to the safeguarding adult's team.

Staffing and recruitment
• The provider did not calculate staffing levels in line with people's needs. However, we observed there were enough staff on duty during the day to support people appropriately.
• Safe recruitment processes were in place.
• New staff completed an induction when they commenced in their role.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
• The provider had not ensured staff had completed refresher training to support people with specific areas of care. For example, enteral tube feeding.
• There was no information to show that staff's competency was checked after completion of training in areas such as emergency first aid, health and safety and infection control.
• Staff did not always ensure they used appropriate practices in relation to moving and handling. Where issues were identified in relation to poor practice, the registered manager had not ensured that staff's training was updated, and their competency assessed.

We recommend the provider reviews all refresher training for staff and complete competency checks where required.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• Staff did not consistently seek medical advice where changes in people's needs had occurred.
• The service had made some referrals when required in relation to people's health needs. However, improvements were needed.

We recommend the provider ensures clear guidance is in place for staff on when to seek medical advice.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet
• Staff assessed and documented people's needs in relation to their care. However, care plans were not always updated to ensure people's changing care needs were documented.
• People's nutritional needs were assessed on admission and the chef was aware of any dietary requirements that people had.
• People's nutrition and hydration needs were effectively met. However, food choices were limited and there was no information to show that people had been asked about their preferences.

Adapting service, design, decoration to meet people's needs
• The accommodation was arranged over two floors and the layout of the service met the needs of the

people who lived there. People were able to access all areas of the service easily, upstairs could be accessed by a lift.
• Rooms were personalised with people's own photographs and ornaments and staff supported people to make their rooms homely.

Ensuring consent to care and treatment in line with law and guidance
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.

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.

In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

• People were supported to make decisions and given choices.
• Staff had completed training on mental capacity and DoLS.
• DoLS applications were made appropriately and there were authorisations in place.
• Records relating to assessments of people's mental capacity were in place however, records in relation to decision making were not always recorded by staff.
• Where people needed decisions to be made in their best interests the registered manager failed to include the relevant professionals.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
• The registered manager did not understand quality performance, risk and regulatory requirements.
• Some quality assurance processes were operated, but they were not robust as they did not identify concerns we found. For example, poor standards of fire safety, low staffing levels at night and the lack of staff training in relation to medicines.
• Investigations and auditing of accidents and incidents was not robust, fully completed or managed appropriately to mitigate future risks to people.

The failure to operate robust quality assurance and safety monitoring systems was a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• A person-centred culture was not promoted within the service.
• Record keeping had not been properly monitored at the service and this impacted on the staff's ability to provide person-centred care. Care plans were not up to date and did not always reflect people's needs.
• During the inspection, we observed that records were not always stored safely and securely.
• The registered manager was unable to provide records we requested in a timely manner. This meant we had to request information to be sent to us after the inspection visit. We did not always receive information that we asked for.
• There were basic communication failings. Staff were unclear about where to record the support they gave to people, and their observations of people using the service.

The failure to operate effective systems for maintaining accurate records was a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others
• The provider had not been responsive to issues and concerns.
• There was a failure to report concerns in relation to safeguarding incidents which had occurred within the

service by the registered manager.
• The completion of investigations did not demonstrate an open and transparent approach had been utilised to investigate concerns within the service.
• Further development of working in partnership with key organisations including the safeguarding team and health professionals was required to ensure transparency and good outcomes for people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People and their relatives had not been contacted to request their views and wishes in relation to the service and the care given. Despite this, one relative told us, "The registered manager and staff are approachable. I would contact them if I had any concerns." Another told us, "I call regularly and staff are always knowledgeable about my family member."
• Regular staff meetings had not been held to allow staff to voice their concerns or views within the service.
• There were mixed views from staff in relation to support given by the management team. One staff member told us, "I do not always feel supported by the management team." Another told us they felt supported and could approach the registered manager with any concerns.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to adequately assess, monitor and reduce risks to peoples health and safety. The provider had failed to ensure that systems for the management of medicines were safe. 12 (1) (2) (a) (b) (f) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure that the premises were safe, clean and properly maintained. The provider had failed to ensure that equipment used to support people in the delivery of care and support was clean. 15 (1) (a) (c) (e) (2)

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 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective governance systems to ensure the safety and quality of the service. The provider had failed to ensure good standards of record keeping. The provider failed to seek and act on any feedback as a means to drive improvements within the service. 17 (1) (2) (a) (b) (c) (d) (e)

The enforcement action we took:

We issued a warning notice against the provider and the registered manager.