Lifeways Orchard Care Limited

216 Lightwood Road

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Good**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on the 28 October 2015 and was unannounced. At our three previous inspections we found that the provider did not have safe systems in place to manage people's medicines and records were not kept up to date. At this inspection we found that although some improvement had been made there were further areas of concern. You can see what action we have asked the provider to take at the end of the report.

The service provided accommodation and personal care for up to ten people with a learning disability.

The service had a registered manager however they were not available on the day of the inspection. We were supported by an area 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.

Summary of findings

People's medicines were not administered or stored safely. Some people did not always receive their prescribed medication. Storage of medication was not monitored to ensure that it was safe to use.

Care was not always personalised and did not meet people's individual needs and preferences. There were enough staff to keep people safe, however there were not enough staff to be able to support people in their chosen community activities.

Risks to people were not always acted upon when an incident had occurred to minimise the risk of it happening again.

People were protected from abuse as staff knew what constituted abuse and who to report it to if they suspected it had taken place.

The Mental Capacity Act 2005 (MCA) is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so. The Deprivation of Liberty Safeguards (DoLS) is part of the MCA. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The provider followed the principles of the MCA by ensuring that people consented to their care or were supported by representatives to make decisions.

Staff were supported to fulfil their role effectively. There was a regular programme of applicable training.

People's nutritional needs were met. People were supported to eat and drink sufficient to maintain a healthy lifestyle dependent on their specific needs.

People were supported to access a range of health care services. When people became unwell staff responded and sought the appropriate support.

Staff were observed to be generally kind and caring, however they did not always respond when people requested their support. They told us that were well supported by the registered manager.

The environment did not always support people to be independent. People struggled to negotiate themselves around the dining room. Risks and hazards were not always identified around the service.

The provider completed regular quality audits, however these were not always effective in identifying and acting on any necessary improvements.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not consistently safe. Medication was not administered or stored safely. Risks to people were not acted upon following an incident that had resulted in harm. There were sufficient numbers of suitably recruited staff to keep people safe within the service. People were kept safe as staff and management reported suspected abuse.	**Requires improvement**
Is the service effective? The service was effective. The provider worked within the principles of the MCA to ensure that people were supported to consent and make decisions with their representatives. Staff were supported and trained to be effective in their role. People's specific nutritional needs were met. When people required support with their health care needs they received it in a timely manner.	**Good**
Is the service caring? The service was not consistently caring. People were not always treated with dignity and respect. People were not as involved as they were able to be in their care, treatment and support. Relatives and friends were free to visit people. People's privacy was respected.	**Requires improvement**
Is the service responsive? The service was not responsive. People's needs were not assessed and regularly reviewed. People were not offered opportunities to engage in community activities of their choice. There was a complaints procedure and relatives knew how to use it.	**Requires improvement**
Is the service well-led? The service was not consistently well led. Systems were in place to monitor the quality of the service however action was not always taken to make required improvements. There was a registered manager in post. Staff felt supported and valued by the management team.	**Requires improvement**

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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 inspection took place on 28 October 2015 and was unannounced. The inspection was undertaken by one inspector.

We reviewed information we held on the service. This included notifications of significant events that the manager had sent us, safeguarding concerns and previous inspection reports. These are notifications about serious incidents that the provider is required to send to us by law. Prior to the inspection the provider had sent us a Provider Information Return (PIR)form. 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.

We spoke with two people who used the service and observed their care. We spoke with two relatives. We spoke with four members of care staff, an area manager and team leader.

We looked at three care records, medication administration records and staff rosters. We looked at the systems the provider had in place to monitor the quality of the service to see if they were effective.

Requires improvement

Is the service safe?

Our findings

At the last three inspections we found that systems to manage people's medicines were not safe. The provider had been in breach of the previous Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 – Management of Medication. At this inspection we found that although some improvements had been made, medicines were still not stored or administered safely. We saw that over the last six months one person on four occasions had not had their required medication as it had been found on the floor. Other people had also had missed medication over the same period of time. This meant that people were at risk due to not having their prescribed medication as nothing had been put in place to reduce the risk of this happening again. We had previously identified that temperatures of the fridge and room the medication was stored in was not being checked to ensure that the temperature was at an appropriate level to keep medicine safe for use. We found that there was one person's medicine being kept in a domestic fridge which was not being temperature checked, this meant that the medicine may not be safe for use. Although there were records saying the medicine cupboard temperature was being checked, staff could not find the thermometer they said they used to check the temperature.

Staff told us that one person had fallen unsupervised in their room trying to transfer out of bed. This was something the person had usually done independently. Staff told us that they had identified why the person had fallen, but no control measures had been put in place to minimise the risk of the incident happening again. The staff had supported them to visit their GP and hospital for a check-up following the fall as they were complaining of pain. This was impacting on the person as staff told us and records confirmed that the person had lost their confidence following the fall and now refused to do things they used to do independently. We saw that this person's room was dimly lit and had a lamp and wires loose on the floor, which could have put the person at risk and cause them to fall again.

The issues above constitute a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that some areas of the building and grounds were untidy and unclean. A bath that one person used was dirty and in the same bathroom we saw urine bottles soaking in buckets on the floor. In the kitchen an open bag of potatoes was sitting in a box on the floor next to a dirty bin. These could present an infection control issue and impact on the health and wellbeing of people who used the service.

People who used the service were unable to tell us whether they felt safe. We found that people were protected from abuse and the risk of abuse as staff we spoke with knew what constituted abuse and who they should report it to if they suspected abuse had taken place. One staff member said: "I would go up the line of management until I was satisfied it was dealt with, I might even have to contact the police". The manager had made safeguarding referrals to the local authority for further investigation in the past when an incident had occurred. This meant that the provider was following the correct procedure in ensuring people were kept safe from harm.

People who required specialist equipment such as wheelchairs and hoists for mobilising were provided with the equipment and support they needed. This equipment was regularly maintained to ensure they were safe for use. Staff had received training in moving people and we saw that they followed safe moving and handling procedures when supporting people to move using the hoist.

Staff told us and we saw that there were currently enough safely recruited staff to keep people safe in the service, however there were not enough staff to support people into the community. Staff had checks prior to being employed with the service including references from past employers and criminal background checks. Staffing levels at night had recently been increased as the provider had identified that the needs of people had changed and they required more support. We saw that when people required two staff to support them to move with the use of hoists there were enough staff available.

Good

Is the service effective?

Our findings

People who used the service required support to make decisions and to consent to their care, treatment and support due to their mental capacity. We saw that everyone's capacity to consent had been assessed due to their learning disabilities. We were told that two people had been referred for a Deprivation of Liberty Safeguards (DoLS) assessment. The Deprivation of Liberty Safeguards is part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

People were asked for their consent prior to any activity taking place, such as when having to use the hoist to support people to move, to come to the table for lunch and other daily activities. We were told that one person chose to stay in bed until the afternoon and then liked to stop up late. We saw this choice was respected by staff.

A relative told us: "The staff know my relative really well and have worked with them along time and are very good with them". Staff told us they received regular training and support to be effective in their role. We observed that staff knew people well. We saw there was an on-going programme of training applicable to the needs of people who used the service. For example staff had been trained in 'dysphagia' (some people with dysphagia have problems swallowing certain foods or liquids, while others can't swallow at all, so their diet has to be softened or taken through a tube) and caring for people with visual impairments. One staff member told us: "They blind folded us and walked us around and it made you realise how people must feel, we've been pushed about in wheelchairs too, so we can appreciate how that feels too".

People had their nutritional needs met. Staff knew people well and knew their likes and dislikes. We saw that people were offered choices at lunchtime and if they changed their mind this was respected. Some people required a fortified diet and some people required a specialised diet due to swallowing problems. Equipment such as lipped plates and straws for drinking were made available for people so they were able to eat independently. Food and fluid intake was monitored and people were regularly weighed. If someone had lost weight, action was taken to monitor and seek external support.

One person attended a health appointment supported by staff on the day of the inspection and they returned with new equipment which would help them sit correctly to eat. We saw evidence that staff recognised when people were unwell and sought professional advice. One person had been vomiting and refusing food, on-going health investigations had taken place and a diagnosis been made, treatment was now in the process of being planned. We saw people visited their GP, had input from community nurses, district nurses, physiotherapist, occupational therapists and the memory clinic. This meant that people were being supported to access appropriate health care resources.

Requires improvement

Is the service caring?

Our findings

We observed that one person who was fully dependent on staff for support was refusing to eat their lunch. A member of staff told us: “They [Person’s name] had been like this recently”. We heard the person indicate that they needed the toilet and staff responded by saying:” We will take you after lunch”. Consideration was not given to the fact that this person may had responded better to eating their lunch if they had been able to use the toilet first.

Two people indicated they were happy at the service when we asked them. We saw that staff knew people well and communicated with them at a level and pace they understood. People were supported to be as independent as they were able to be with the use of specialised equipment such as electric wheelchairs and equipment to help them to eat unsupported. However at lunchtime we saw that one person was having difficulty in moving themselves from the dining room as the area they had to move in was too small and they kept knocking into others and furniture. At one point they knocked into an open door and it shut on themselves which would have prevented them from leaving the room. The dining room did not allow people to mobilise freely around in their wheelchairs and was restricting people of their independence.

One person was asked if they wanted the radio on during lunch and this was then put on, however the other people in the dining room were not asked if they wanted the radio on. This meant that not everyone’s opinion was sought and respected.

A relative told us that they were made welcome to visit at any time and that the staff kept them informed of their relatives welfare. They said: “I attend any reviews that are held”. The area manager and team leader told us that there was limited contact with people’s family members due to distance and relative’s choice not to visit.

We could not see how people were involved in the running of the home and in how their care was being delivered. Care plans had not been recently reviewed with the person or their representatives and some information was out of date. We were told that no one had an advocate at present although they had been involved in the past with one person.

People’s care records and other confidential information were stored securely. Everyone had their own bedrooms and we saw that staff knocked on people’s doors before entering. Staff shut doors to bedrooms and bathrooms when supporting people with their personal care needs. We saw nothing through the day that compromised a person’s dignity.

Is the service responsive?

Our findings

One person asked to go out for a coffee and they also wanted to go shopping for clothes. They were told that they were unable to do this as there was not enough staff to be able to support them into the community. Another person put their coat on as an indication that they wanted to go out but again they were asked to take their coat off as they were not going out. Staff told us and we saw that people were unable to engage in community activities as much as they would have liked to due to their not being enough staff. A member of staff told us: “People get about once a week, we don’t think it’s good enough”. We were told by the area manager that it had been previously agreed that an extra member of staff from the agency, could be brought in during the day to facilitate community activities. However three members of staff told us that they had a directive from their manager that agency staff was not to be used due to the cost so the agency staff had not been used.

One person asked for a cigarette and on two occasions staff told them they couldn’t have one. We asked staff why the person couldn’t have a cigarette and both staff told us something different. One staff said: “[Person’s name] only smokes in the morning and then he doesn’t ask again”. We pointed out that it was still the morning and they told us: “[Person’s name] has had the agreed amount this morning. Another staff member told us when they told the person he couldn’t have one: “It’s his routine and there is no staff available now to go out with them anyway”. There was no care plan informing staff how to support this person in their chosen activity of smoking. This meant that this person’s choice to smoke was not being respected.

We saw one person was being supported by staff to do the hoovering, they told us they liked doing this. They also told us that they used to help cut the lawns but they didn’t do it now. A member of staff explained that the lawns were now cut by external contractors and that the service no longer had a lawn mower. The staff member said: [Person’s name] used to love cutting the lawns but we don’t even have a lawn mower now”. We saw another person wandered around the service without being offered anything to do, and they were asking staff if they could go out. Staff told us that this person was suffering from anxiety and was always asking to go out and even if they went they would still be anxious. However we saw records that stated that the person had recently been out for a coffee in the morning and then had been settled in the afternoon and evening. Other people were either asleep or watching the TV and were not offered activities to engage in during the day.

People’s care was not regularly reviewed to ensure that it was still relevant and met their needs. Goals had not been identified to ensure that care was good and on-going progress towards the goals was being made. Care plans and risk assessments did not always reflect people’s current care needs as they had not been up dated following a change in the person’s circumstances. However the area manager showed us that the registered manager had requested local authority reviews take place as these too were overdue.

The issues above constitute a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Handovers were conducted at every change of staff, to ensure the staff coming on duty were fully aware of the daily needs of each person. Staff told us they knew people well and were kept up to date with any changes through the handover process.

The provider had a complaints procedure. A relative told us and we saw records that they had complained and it had been dealt with. The relative told us that it was responded to and they were happy with the outcome. Another relative told us: “I would speak to any of the staff and they would act on it”.

Requires improvement

Is the service well-led?

Our findings

The registered manager was unavailable on the day of the inspection. We were supported through the inspection by an area manager. At our previous inspection we found that the provider was in breach of Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 – Records. Records were not up to date and did not contain relevant information to be able to care for people according to their current needs. We were told at that inspection that the task of reviewing and updating care records would now continue as a priority to ensure that people's current needs would be known and met. At this inspection records were still not up to date and reflective of people’s current needs.

We saw that the provider was still in the process of implementing their own style of care plans and information was still not current and up to date. For example, when someone had fallen their risk assessment had not been reviewed. Another person’s record stated they were on a ‘pureed diet’, however we saw that they had recently been assessed as being able to have a ‘fork mash’ diet. Staff told us that one person could only have up to five cigarettes a day and another member of staff told us up to ten. There was no care plan in place for this person to advise staff as to what the plan of care was in reference to them smoking. One staff member said: “We should all be doing the same thing”.

The manager carried out a regular medication audit and inputted all the information onto a computerised system that was seen by a member of the provider’s management team. We saw medication errors over a period of time that continued to happen with no action taken to minimise the risk of them occurring again. This meant that this audit was ineffective.

There was some confusion over the use of agency staff. Three staff members told us that they had been informed they could not use agency staff by the manager and team leader. However the area manager told us that it had been agreed that they could use agency staff. There had been mixed messages and miscommunication from the management team to the care staff. This had had an impact on the daily opportunities for people and was limiting them from accessing the community.

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

Staff we spoke with all told us that they felt supported by the manager and that if they had any issues they were approachable. Staff knew the whistle blowing procedures and told us that they would use it if they had concerns people were at risk.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The care and treatment of service users must be appropriate, meet their needs and reflect their preferences.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems or processes must be established and operated effectively to ensure compliance with the regulations.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users in relation to the proper and safe management of medicines.

The enforcement action we took:
We have issued the provider with a warning notice.