Buckland Care Limited

The Orchards Residential Home

Inspection report

1 Perrys Lane
Wrougton
Swindon
Wiltshire
SN4 9AX

Tel: 01793812242
Website: www.bucklandcare.co.uk

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 27 February 2018 and 5 March 2018. Breaches of legal requirements were found which included a breach of Regulation 12 relating to the safe care and treatment of people. After the comprehensive inspection, we took enforcement action telling the provider they must meet the legal requirements of Regulation 12 by 31 May 2018.

We undertook this focused inspection to check that they had met the legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Orchards Residential Home on our website at www.cqc.org.uk

We undertook an unannounced focused inspection of The Orchards Residential Home on 19 June 2018.This inspection was done to check that improvements to meet legal requirements had been made. The team inspected the service against one of the five questions we ask about services: is the service safe?

The ratings from the previous comprehensive inspection for the other four Key Questions were included in calculating the overall rating in this inspection.

The Orchards Residential Home is a care home supporting up to 44 people. At the time of our inspection there were 32 people living in the service. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service supports people with a range of conditions which includes people living with dementia.

There was a registered manager in post at the time of the inspection. 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.

We found that improvements had not been made in all areas and the service was rated inadequate in the key question. Is the service safe.

Medicines continued to be managed in a way that put people at risk of not receiving their medicines as prescribed. Medicines were not always stored in line with manufacturers guidance which put people at risk of receiving medicines that were not effective.

Risks to people were not always assessed and there were not always plans in place to manage the risks. Staff were not aware of the actions required to keep people safe and there were not always records to evidence that risks were being managed in line with people's care plans.

Accident and incident records did not include any evidence of accidents and incidents being investigated. Where people had experienced an accident or incident there was no review of their care records to look for ways to minimise the risk of reoccurrence.

Infection control procedures had improved and the home was clean and free from malodours.

We found a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection we met with the providers to discuss the concerns found. The provider has submitted an action plan detailing the action they will take to meet the regulations. We will follow up this action plan at the next inspection.

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.

Medicines were not managed safely which out people at risk of not receiving their medicines as prescribed.

Risks to people were not being effectively managed.

Accidents and incidents were not investigated and action was not always taken to minimise the risk of a reoccurrence.

The Orchards Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service,and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of The Orchards Residential Home on 19 June 2018. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 27 February 2018 and 5 March 2018 inspection had been made. The team inspected the service against one of the five questions we ask about services: is the service safe? This was because the service was not meeting some legal requirements.

This focused inspection took place on 19 June 2018 and was unannounced.

Prior to the inspection we looked at information we held about the service. We spoke with the commissioners of the service, who had been closely monitoring the service since our comprehensive inspection on 28 February 2018 and 5 March 2018.

The inspection was carried out by two inspectors, a pharmacist inspector, a specialist advisor in dementia care and an Expert by Experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection we spoke with ten people who used the service, the registered manager, the support manager, the area manager, a team leader, a senior care worker, a care worker and a housekeeper. We looked at three people's care records, medicine administration records, incident and accident records and other records relating to whether the service was safe.

Inadequate

Is the service safe?

Our findings

At our inspection on 28 February 2018 and 5 March 2018 we found that people were not supported by a safe service. We found concerns that resulted in a breach of Regulation 12 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was rated in inadequate in safe and the service was placed in special measures. At this inspection we rated the service as inadequate in safe.

At this inspection we found that although some improvements had been made there were still concerns regarding the safety of people living at the service.

At our previous inspection we found that medicines were not managed safely. Medicine administration records (MAR) were not completed accurately or in line with national guidance relating to management of medicines in care homes. Where people were prescribed as required medicines (PRN) there was not clear guidance for staff as to when people may require the medicines. Where people were prescribed topical medicines, there was not always information relating to the frequency of administration. Systems in place to ensure medicines were stored at the correct temperature were not effective.

At this inspection on 19 June 2018 we found MAR were completed accurately. There was guidance for staff to identify symptoms and enabled them to give 'as required' (PRN) medicines consistently. Records relating to the administration of topical medicines gave guidance to staff in relation to the frequency of administration.
Although we found that temperatures relating to the storage of medicines were being monitored and recorded, we found that medicines were not always stored in line with manufacturers guidance. For example, we found eye drops for three people which must be stored in the refrigerator that were stored at room temperature. Medicines may be ineffective or unsafe if they are stored at temperatures outside of the manufacturer's instructions.

Systems in place to ensure medicines were safe to use were not always effective. For example, we found a medicine for one person had gone past its expiry date. Staff had stored this with the person's current medicines in the trolley. This meant there was a risk that staff could give an out of date medicine to the person, leading to risk of harm.

Medicines were not always recorded on MAR. For example, we found for four people that staff had not recorded all their medicines held in stock on the MAR. This meant there was a risk that staff members may not give these medicines to people as they were not recorded on the MAR.

Some people were prescribed anticipatory medicines described as 'rescue' medicines to avoid hospital admissions. However, there was no guidance for staff in people's care plans when it might be necessary to administer these medicines. Some people were prescribed higher risk medicines such as anticoagulants. Anticoagulants are medicines prescribed to prevent blood clots. There was no guidance for staff in people's care plans to identify likely side effects of these medicines and information on how to manage them.

At our previous inspection risks to people were not always identified and where risks were known there were not always risk assessments or effective plans in place to manage the risks. At our inspection on 19 June 2018 we found people's care plans did not always contain up to date risk assessments and where risks were identified people were not supported in line with their care plan to manage the risk. For example, one person was identified at high risk of leaving the building unaccompanied and that it was not safe for them to do so. The person's care plan stated the person required "continual monitoring". Staff we spoke with were not able to tell us how the person was monitored and who was responsible for ensuring the person was safe. One member of staff told us that until three weeks before the inspection there had been a 30-minute observation chart to record where the person was, they added "but this petered out for some reason, don't know why". We spoke with the registered manager regarding the allocation of staff responsibilities. The registered manager told us that a member of staff was allocated "Lounge duty" each day. We looked at the allocation sheet for the day of our inspection and there was no allocation for "Lounge duty". We asked the registered manager who told us "They have printed off the wrong one (allocation sheet)". We asked a member of staff where the person was. The member of staff told us, "I would assume [person] is in the TV lounge, as that is where he likes to be". We could not be sure the risk of the person leaving the building unaccompanied was being effectively managed.

People's care plans contained conflicting information relating to risks to people. For example, one person's risk assessment relating to the risk of pressure damage stated they had restricted movement. The moving and handling risk assessment said the person was fully mobile. This meant we could not be sure the person was being supported in a way that managed the risk associated with pressure damage.

At our previous inspection systems in place to identify, investigate and monitor accidents and incidents were not effective. Recording of accidents and incidents was not accurate or consistent. There were no effective systems in place to enable lessons to be learned and themes identified when incidents and accidents occurred. At this inspection we found improvements had not been made. We looked at 20 incident/accidents that had occurred since the last inspection. There were no records of investigations being carried out and no evidence to show action was taken to reduce the risk of reoccurrence. For example, one incident form identified that four people had not received their morning medication as prescribed. The incident form stated the reason for this was that night staff had not been trained to administer medicines. There was no evidence that a health professional had been contacted in relation to the risks associated with people not receiving their medicines and there was no record of an investigation to determine what action could be taken to reduce the risk of a reoccurrence.

Another incident record identified a person had been found in a basement area, trying to leave the premises by a fire door. There was no investigation. There was no review of the person's care record or risk assessments as a result of the incident to look at ways to minimise the risk of a reoccurrence.

These issues were a continued breach of Regulation 12 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 28 February 2018 and 5 March 2018 we found infection control procedures were not always effective. There were areas of the service that were malodorous. At this inspection we found improvements had been made. The service smelt fresh and was clean. Records relating to cleaning schedules had been updated and enabled closer monitoring of the cleaning of the service.