Health & Care Services (NW) Limited

Orchid Lawns

Inspection report

Steppingley Hospital Grounds
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Ratings

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

Overall summary

This unannounced inspection took place on 01 June 2015. At our previous inspection in October 2014 we found that there was insufficient staff to provide for people's needs. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made to the level of staffing and additional improvements were planned.

Orchid Lawns provides nursing care and support for up to 24 older people with dementia and needs relating to their mental health. At the time of our inspection there were 16 people who lived at the home.

The home does not have a registered manager as required by the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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

Summary of findings

Regulations about how the service is run. At the time of this inspection the home had been without a registered manager for over 12 months and was being managed by a peripatetic manager from the provider's organisation on an interim basis.

During our inspection we found that people were safe at the home. Staff were aware of the safeguarding process. Personalised risk assessments were in place to reduce the risk of harm to people, as were risk assessments connected to the running of the home. These were reviewed regularly. Accidents and incidents were recorded and the causes of these analysed so that preventative action could be taken to reduce the number of occurrences. There were effective processes in place to manage people's medicines and referrals to other health and social care professionals were made when appropriate to maintain people's health and well-being.

There were enough skilled, qualified staff to provide for people's needs. Staffing levels had been calculated in accordance with current guidance and based on the dependency levels of the people who lived at the home. The provider had recently agreed to increase the staffing level above that calculated as being needed. Most care was delivered by permanent staff with the reliance on agency staff reduced significantly. Recruitment and selection processes were in place and the provider had taken steps to ensure that staff were suitable to work with people who lived at the home. They were trained and supported by way of supervisions.

People or relatives acting on their behalf had been involved in determining their care needs and the way in which their care was to be delivered. Their consent was gained before any care was provided and the requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met. Relatives were involved in the regular review of people's care needs and were kept informed of any changes to a person's health or well-being.

People had choice of good nutritious food that they liked and their weight was monitored with appropriate referrals made to the dietitian when concerns were identified.

There was an up to date complaints policy in place and a notice about the complaints system was on display in the entrance of the home. There were a number of other information leaflets on the notice boards around the home which included information about the service.

There was a very friendly, family atmosphere about the home. There was an open culture and staff were supported by the managers. Staff were aware of the visions and values of the provider. People, relatives and staff were able to make suggestions as to how the service was provided and developed. A quality assurance system was in the process of being introduced.

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 safe.

Staff were aware of the safeguarding process and appropriate referrals had been made to the local authority.

Personalised risk assessments were in place to reduce the risk of harm to people.

There were enough skilled, qualified staff to provide for people's needs.

Good

Is the service effective?
The service was effective.

Staff were trained and supported by way of supervisions.

The requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

People had a good choice of nutritious food and drink.

Good

Is the service caring?
The service was caring.

Staff were kind and caring.

Staff promoted people's dignity and treated them with respect.

Good

Is the service responsive?
The service was not always responsive.

People's care plans were reviewed and amended as their needs changed.

People were not supported to follow their interests and hobbies and there was a limited range of activities available.

There was an effective complaints policy in place.

Requires improvement

Is the service well-led?
The service was not always well-led.

There was no registered manager in place.

People, relatives and staff were encouraged to identify ways in which the service provided could be improved.

The quality assurance system had not been fully established or embedded.

Requires improvement

Orchid Lawns

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 01 June 2015 and was unannounced. The inspection team was made up of two inspectors.

Before the inspection we reviewed the information available to us about the home, such as notifications. A notification is information about important events which the provider is required to send us by law. We also reviewed information about the home that had been provided by staff and members of the public.

During the inspection we spoke with one person and three relatives of a person who lived at the home, four care workers, the cook, the acting manager, the regional manager and the administrator. We carried out observations of the interactions between staff and the people who lived at the home and also carried out observations using 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 with us.

We reviewed the care records and risk assessments for four people, checked medicines administration and reviewed how complaints were managed. We also looked at five staff records and reviewed information on how the quality of the service was monitored and managed.

Good

Is the service safe?

Our findings

When we inspected the home in October 2014 we found that there were insufficient staff to meet people's needs safely. During this inspection relatives told us they believed the service would benefit from additional care staff. At the start of the inspection we noted that the deployment of staff meant that people were left unattended. When we arrived the nurse in charge was in the office and the three care staff were supporting people with personal care, leaving those people already up unattended in the lounge/ dining area. This was later rectified when the nurse started to serve them breakfast. However, there was a visible staff presence during the rest of the inspection.

Staff also told us they believed that there should be more care workers. We spoke with the acting manager who told us that the staffing levels had been calculated in accordance with the guidance issued by The Regulation and Quality Improvement Authority based on people's calculated dependency levels. However, they had recently agreed with the provider that an additional care worker would be provided. Staff told us that the management always covered sickness with permanent staff prepared to do additional shifts, staff from a near-by home or agency staff. The duty rotas confirmed this and that the reliance on agency staff had dropped significantly.

Relatives of people we spoke with told us that they felt their relative was safe and secure living at the home. One relative told us, "[Relative] is safe but [they] doesn't walk or talk." Another relative said, "[Relative] is absolutely safe." They went on to say, "It is a good place for someone with challenging behaviour." A comment made following a recent survey of residents said that one of the best things about the home was, "Knowing the residents are safe and well cared for."

We saw that there was a current safeguarding policy, and information about safeguarding was displayed on a noticeboard in the entrance hall together with details of the telephone numbers to contact should people wish to. The staff we spoke with told us that they had received training on safeguarding procedures and were able to explain these to us, as well as describe the types of abuse that people might suffer. One member of staff said, ""I would report anything I thought was wrong. The safeguarding team are near-by and the number is advertised so if necessary I would go straight to the local authority." Records showed that the staff had made relevant safeguarding referrals to the local authority and had appropriately notified CQC of these. Staff also knew and understood about the provider's whistleblowing policy. One member of staff said, "We are told about the whistleblowing policy and encouraged to use it if we need to." This demonstrated that the provider had arrangements in place to protect people from harm.

There were personalised risk assessments in place for each person who lived at the home. The actions that staff should take to reduce the risk of harm to people were included in the detailed care plans. These included the identification of triggers for behaviour that had a negative impact on others or put others at risk and steps that staff should take to defuse the situation and keep people safe. Risk assessments were reviewed regularly to ensure that the level of risk to people was still appropriate for them. This demonstrated that risks were managed in such a way as to keep people safe.

The manager had carried out assessments to identify and address any risks posed to people by the environment. These had included fire risk assessments and the checking of portable electrical equipment. The service also had a Continuity plan in case of an emergency, which included information of the arrangements that had been made for major incidents such as the loss of all power or water supply.

Accident and incident forms were completed appropriately and a monthly analysis of these was produced to identify any trends or changes that could be made to reduce the numbers of these. This was used to identify ways in which the risk of harm to people who lived at the home could be reduced.

We looked at the recruitment files for four staff that had recently started work at the home. We found that there were robust recruitment procedures in place. Relevant checks had been completed to ensure that the applicant was suitable for the role to which they had been appointed before they had started work.

We saw that people received their medicines as prescribed and that medicines were stored and administered in line with current guidance and regulations. Staff who administered medicines confirmed they had received regular training updates. One person had been assessed as requiring their medicines to be administered covertly. This had been agreed with a GP and a best interest decision was

Good

Is the service safe?

formally documented. We observed a medicines round and saw that medicines were administered correctly. When a person requested pain relief medicine outside of the medicines round this was provided in a timely fashion.

We looked at the Medicines Administration Records (MAR) for all of the people living at the home and saw that these had been completed correctly and medicines received had been recorded. We checked stocks of medicines held which were in accordance with those recorded. Staff completed a daily audit of the medicines and the acting manager had robust processes for auditing medicines administration.

Good

Is the service effective?

Our findings

Relatives told us that staff had the skills that were required to care for them. One relative told us that staff were, "Very, very good." Another relative said that staff were, "Very capable." Feedback from a recent survey of relatives included a comment that the home should, "Maintain the high level of standards that are already in place."

Staff told us that there was a mandatory training programme in place and that they had the training they required for their roles. One member of staff said, "We get all the usual training and regular updates and we can ask for extra. For example, when we had someone with a catheter it was useful to have an update about catheter care."

We spoke with a member of staff who had been employed at the home for less than a month. They told us they had been provided with induction training when they commenced employment. They said that this ensured they were equipped with the necessary skills to carry out their role. They went on to tell us that the induction training was followed by a period of shadowing more experienced staff and said, "I could ask anyone if I did not know what to do." A senior staff member who was mentoring the new member of staff said, "I make sure they [the new staff] know to ask if they are unsure about anything."

Staff also told us that they received regular supervision and felt supported in their roles. They said that these sessions were useful and allowed them to discuss any training needs. One member of staff said that because the senior team had altered, the person providing their supervision had changed, but this had not altered the value of the sessions. Supervision records were kept in the staff personal files and a rota for supervision dates was displayed for the year ahead.

People's capacity to make and understand the implication of decisions about their care were assessed and documented within their care records. Staff had received training on the requirements of the Mental Capacity Act 2005, and the associated Deprivation of Liberty Safeguards and we saw evidence that these were followed in the delivery of care. We saw that best interest decisions had been made on behalf of people following meetings with relatives and healthcare professionals and were documented within their care plans. Applications for the deprivation of liberty had been made for all people who lived in the home as they could not leave unaccompanied and were under continuous supervision. This made sure that these decisions, which impacted on their rights to liberty, were made within the legal framework to protect people's rights.

Relatives we spoke with told us that when there were changes to the care that was to be provided, where their relative lacked capacity to make decisions for themselves, they were consulted and their consent was gained. One relative told us, "They talk about everything." Another relative told us that staff always asked people for their consent before delivering any care. They said, "They always talk to them before they do something." Staff told us of ways in which they gained consent from people before providing care. They explained that they used non-verbal methods of communication by using gestures, pictures and showing people items to gain consent and give them choices. Our observations confirmed that these methods were used effectively to gain consent and understand people's needs.

Relatives told us that the food was good. One relative said, "The food is okay. [Relative] has to have it liquidised, meat and stuff, but potatoes are always mashed." At lunch time we observed that a number of relatives supported the home by assisting people to eat their lunch. One relative said, "I know [relative] would be fed if I wasn't here but it is something I can do for [them] and to help the staff who work so hard." We spoke with staff who told us they worked with relatives to find out peoples likes and dislikes so they could offer suitable meals, particularly to those people who were unable to make choices. The head cook had worked at the home for a number of years and knew the people well and adapted the menus and portion size to their individual requirements.

All of the staff working in the home supported people at lunch time so that they received their meals in a timely fashion. We saw people were supported appropriately and the meal was very relaxed. For example music was played in the background and staff chatted with people. People were offered choices of food and being supported to make decisions. One person who was reluctant to eat their lunch was offered toast and jam which they ate well. Staff were patient with people when assisting them to eat their food.

People's weight was monitored and food and fluid charts were completed for people where there was an identified

Good

Is the service effective?

risk in relation to their intake that provided detailed information on what they had consumed. If people were identified as being at risk of weight loss their food was fortified and they were referred to the dietitian or GP.

Relative's told us that people were assisted to access other healthcare professionals to maintain their health and well-being. Records showed that people had been assisted to access optical and dental care and, where appropriate, referrals had been made to the local mental health teams and occupational therapists.

Good

Is the service caring?

Our findings

The relatives we spoke with told us that the staff were kind and considerate. One relative told us, "I am really happy with the care here. The staff are wonderful." Another relative said, "They [staff] treat all residents as family." In response to the most recent satisfaction survey one relative had written, "The dedication of the staff in caring for the residents is first class."

One relative said, "The staff are really good at knowing the people they care for." Positive, caring relationships had developed between people who used the service and the staff. Staff we spoke with were aware of the life histories of people who lived at the home and were knowledgeable about their likes and dislikes.

Another relative told us, "All of the carers are absolutely brilliant. They know people and pick up signs when they want something. They don't have any agency staff now." Another relative said, "They treat [Relative] very well. [Relative] is pretty calm. [Relative] is at home here and they know [them] better than I do. [Relative] is very happy and contented as much as [they] possibly could be." We observed the interaction between staff and people and found this to be friendly and caring. Staff told us that they also used body language and other non-verbal forms of communication, such as facial expressions, to understand people's needs, such as looking uncomfortable when they may require personal care. We observed that staff used a lot of smiles and touch, as reassurance when people became anxious.

Relatives told us that the staff protected people's dignity and treated them with respect. One relative told us their relative, "Gets their haircut every so often, never smells and is always suitably dressed." Staff had a clear understanding of the role they played in making sure people's privacy and dignity was respected. We observed that staff knocked on people's bedroom doors before entering. The staff told us they would ensure doors were closed when personal care was provided and would take care not to talk about other people or their own interests when providing care.

Staff told us they would observe people and report to the manager if they believed they were unhappy about something. One member of staff said, "I am an advocate for the people living here, particularly if they do not have frequent visitors."

There were a number of information leaflets on the notice boards which included information about the service, safeguarding, the complaints policy and fire evacuation instructions. The relatives we spoke with told us they were free to visit at any time during the day and evening. They told us that they visited at varying times and were always made to feel welcome. One relative we spoke with had bought their dog to visit which was appreciated by some of the other people living at the home. Staff told us that there were no restrictions on relatives and friends visiting the service.

Requires improvement

Is the service responsive?

Our findings

Relatives told us that they had been involved in deciding what care their relative was to receive and how this was to be given. They had been visited by one of the managers who had assessed whether the provider could provide the care they needed before they moved into the home. One relative told us, "[Relative] couldn't go to a normal home. [They] were heavily drugged but they have gradually reduced [their] medication."

The care plans followed a standard template which included information on their personal history, their individual preferences and their interests. Each was individualised to reflect people's needs and included clear instructions for staff on how best to support people with specific needs. One record we looked at showed that the person disliked being cared for by people they did not know and reminded staff to introduce themselves every time before providing any care for the individual.

We saw evidence that relatives were involved in the regular review of people's care needs and were kept informed of any changes to a person's health or well-being. One relative told us, "They talk about the care plans. If I have any concern they will address it." They went on to tell us that when their relative had been assessed as requiring an air bed with sides the staff had acquired one for them. Another relative told us how they had been involved in care plan reviews as their relative's condition had worsened to reflect their changing needs.

Relatives told us that there was little to keep people occupied. One relative said, "It is a pity they didn't have more activity but they are all at different stages [of dementia]. They are just sitting about, although they do have someone in who plays the guitar." Staff engaged whenever possible with people, an activity person did some one-to-one therapy with people such as hand massages and drawing and relatives and staff took people out into the gardens. The corridors of the home were decorated with pictures and posters relating to the past which may be of some significance to people who were living with dementia, such as newspapers reporting on Scott's death in 1913, the 1929 Wall Street crash and the 1945 VE day celebrations.

Relatives knew how to make a complaint. One relative told us that they had made a complaint about a member of staff and said, "The chap I made a complaint about, he's gone. They listened to me. Apart from that if I had any concerns I am not frightened to say anything. I would go to either [the deputy manager] or [the acting manager]." This demonstrated that the provider took action to resolve people's complaints to their satisfaction. There was an up to date complaints policy in place and a notice about the complaints system was on display in the home. We looked at the records of two recent complaints that had been received at the home and saw that these had been investigated and a full response sent to the person who had made the complaint by the provider's Chief Operating Officer within the timescale specified in the policy.

Requires improvement

Is the service well-led?

Our findings

There was no registered manager in post at the time of our inspection. A manager had been appointed but had failed to take up the vacant post. The provider was taking steps to recruit a replacement but in the meantime a peripatetic manager with the provider's organisation was acting as the manager for the home at the time of the inspection. They were supported by the regional manager and a recently appointed deputy manager.

We noted that there was a very friendly, family atmosphere about the home. There was a good rapport between staff and the people using the service which gave a very homely feeling and helped to stimulate people. One relative told us, "[Acting manager] maintains a good atmosphere and we work together. There is good communication and [acting manager] has the right way about [them]." Another relative said, "It is a good environment."

Staff told us that despite not having a regular manager they felt well supported. One member of staff said, "I could go to [name of peripatetic manager] about anything she is very approachable. Staff were aware of the visions and values of the provider to provide care and support that protected people's dignity and promoted their independence as much as possible.

The acting manager had recently been working with local community groups and had arranged for a coffee morning to be held fortnightly and for the local branch of the Alzheimer's Society to get involved with supporting people who live at the home.

The acting manager had started auditing the running of the home. We were shown initial audits of medicines management, the environment and care plans. All which had identified some areas for improvement and a plan of action had been put in place to address these. They told us that a full quality assurance system was to be put in place. We noted that an action plan had been devised following our last inspection in October 2014 and information on the actions taken were displayed on the noticeboard by the entrance to the home.

We saw that the results of a recent survey of relatives were 100% positive in most areas for example, nutrition, care health and safety but had identified concerns about staffing levels and social activities. These areas were currently being addressed by management.

People's records were stored in a locked cupboard with an office used by staff that was accessible only by using a key pad. This meant that people's records could only be accessed by persons authorised to do so.