Barchester Healthcare Homes Limited

The Orchard

Inspection report

189 Fairlee Road
Newport
Isle of Wight
PO30 2EP
Tel: 01983 520022
Website: orchard@barchester.com

Date of inspection visit: 9 and 12 June 2015
Date of publication: 24/07/2015

Ratings

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

Overall summary

This inspection took place on 9 and 12 June 2015 and was unannounced. The service provides accommodation for up to 60 people who have nursing needs and/or are living with dementia. There were 59 people living at the service when we visited.

The service had a registered manager in place. 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.

Most people and relatives praised the staff and care provided. However, they also raised issues about the lack of activities, lack of attention to individual needs and staff being rushed and very busy.

The provider's quality monitoring systems failed to ensure people received a safe, effective, caring and

Summary of findings

responsive service. Consequently, people were at risk of not having their health and other needs met, not being protected from abuse and having their rights compromised.

Staff were not following the provider's procedures for recording and reporting incidents, which meant senior staff were unaware incidents had occurred. Therefore incidents were not properly investigated and actions were not taken to reduce the risks to people, visitors and staff. This included a number of significant safeguarding concerns. The concerns we found in relation to the safety, effectiveness, caring and responsiveness of the service had not been identified by the provider's quality assurance systems. The provider had failed to ensure we were kept informed about all incidents which it is required by law to notify us about.

People did not always receive the health care they required. National Institute for Clinical Excellence (NICE) guidance for monitoring people who had suffered head injuries was not followed. Wounds were not always managed appropriately. Care plans contained some individual information but did not have all necessary information or had conflicting information.

Pain assessments were not in use. 'As and when necessary' (prn) care plans did not contain sufficient detail for people who were unable to state they were in pain. This failed to ensure they received consistent pain relief when they required it. Not all medicines were given safely as per manufactures guidance. Prescribed topical creams were not applied by care staff on a regular basis.

Staff did not always follow legislation designed to protect people's rights. Care records demonstrated that staff did not understand how to legally make decisions on behalf of people who lacked capacity. Mental capacity legislation designed to protect people's rights was not followed.

People were encouraged to eat well and most were positive about the meals provided, although some had to wait up to forty minutes before receiving their meals. People were cared for with kindness and compassion. People's individual preferences were not always met. Some activities were provided but people told us they were inadequate and they were bored.

There was not enough staff to meet people's needs safely at all times. Staff received appropriate training but not all received regular supervision and appraisals. The recruitment process was safe and ensured staff were suitable for their role.

There were no formal opportunities for people and relatives to express their views about the service. Information about the complaints procedure was available and people and visitors were able to make a complaint. However, these were not always recorded or investigated in a timely way. When people had raised issues they were not always aware of the outcome.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this provider is 'inadequate'. This means that it is in 'Special measures'. Special measures in Adult Social Care provides a framework within which CQC can use our enforcement powers in response to inadequate care and can work with, or signpost to, other organisations in the system to help ensure improvements are made.

Services in special measures are kept under review and, if we have not taken immediate action to cancel registration, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

You can see what action we have taken at the back of the full version of the report.

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 safe.

The provider had failed to ensure that appropriate action was taken when incidents occurred between people, placing people at risk of harm. Allegations made by people that they had been abused were not investigated.

Medicines were not all administered safely and systems were not in place to ensure consistency with the administration of 'as required' medicines. Prescribed topical creams were not applied as prescribed.

There were not always enough staff to meet people's needs. The recruitment process was safe and ensured staff were suitable for their role.

Procedures were in place to deal with foreseeable emergencies such as fire or when accidents or incidents occurred however, emergency information was not up to date.

Inadequate

Is the service effective?
The service was not effective

Where people lacked the capacity to make decisions themselves legislation designed to protect their rights was not correctly applied.

Wounds and other healthcare needs were not always effectively managed.

People were offered a choice of nutritious meals and appropriate support to eat and drink although records were not well maintained.

Staff were suitably trained but were not receiving appropriate support from the registered manager and management team.

Inadequate

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

People's dignity was not ensured by some care practices in the home.

People were not always supported to express their views or actively involved in making decisions about their care, treatment and support. Where people had a preference for the gender of care staff providing personal care this was not actively sought or recorded.

People's privacy was protected and confidential information was kept securely.

Requires improvement

Is the service responsive?
The service was not responsive.

Inadequate

Summary of findings

People did not always receive the correct healthcare and health monitoring they required. Action was not consistently taken following falls to monitor people and reduce the risk of subsequent falls. Systems did not ensure people would receive 'as required' pain medication consistently when they required it.

There was a lack of activities and people told us they were bored.

People and visitors were able to make complaints however these were not recorded or investigated in a timely way.

Is the service well-led?

Inadequate

The service was not well led.

The provider's quality monitoring systems had not ensured people received a safe and effective service.

Incidents that caused harm to people were not always reported to the registered manager or investigated appropriately.

People, relatives and most staff said the home was run well. However staff were unsure of the service philosophy.

The Orchard

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 9 and 12 June 2015 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor in the care of older people and an expert by experience in the care of older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service including previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

We spoke with 18 people using the service and nine family members. We also spoke with the provider's operations support manager, the registered manager, three nurses, 13 care staff, maintenance manager, administration staff, training staff and the chef. We looked at care plans and associated records for 15 people, staff duty records, five recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records. We observed care and support being delivered in communal areas.

Inadequate

Is the service safe?

Our findings

Safeguarding incidents were not recorded and reported correctly. People had reported concerns to staff and staff had observed incidents between people some of which resulted in injury. However, the provider's procedures for reporting and recording these incidents had not been followed. The registered manager told us the provider's policy was for all incidents to be reported to the registered manager so that protective action could be taken and trends could be identified. This would allow plans to be implemented to help prevent events in the future. However, daily records showed that not all incidents had been reported or recorded on incident forms or behaviour charts. This included incidents where one person had physically assaulted other people and incidents when people had told staff they had been abused. For example, we found a record where a person had stated they had been hit by a member of the care staff team. This was recorded in their care file but we could find no record of any investigation or action having been taken in respect of the allegation. On other occasions people living with dementia were recorded as having physically assaulted other people living with dementia but again there was no action recorded.

Because incidents had not been correctly recorded senior managers had been unable to undertake an analysis of the incidents and action taken to reduce the potential for future incidents. People remained at risk due to a failure to follow the provider's procedures. Incidents of abuse had not been reported to the local safeguarding team or the Care Quality Commission as required by law.

Staff told us they had received safeguarding training. Records confirmed this was included in the induction undertaken by all new staff. Staff were aware they should report any concerns to the registered manager and of how to contact external safeguarding teams. However, although staff had recorded and reported some incidents the registered manager was not aware of all of these. Procedures had not been correctly followed and people were not being protected from the risk of abuse.

The failure to identify when people were at risk of being abused and to take action to protect them is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines, including topically (applied to the skin) prescribed creams were not managed safely to ensure people received them as prescribed by their medical practitioner. The systems in place to manage topically prescribed creams did not always ensure people received these as prescribed. The task of applying these creams was delegated to care staff according to the Medicines Administration Records (MAR). Most topical creams charts contained inadequate information for care staff as to where creams should be applied. Most creams were to be applied at least twice a day and the topical cream records showed this was not occurring. Systems for monitoring the application of topical creams were inadequate. We found one topical cream which was dated as having been opened in September 2014 and others which had no date of opening or name of the person using them. Topical creams should only be used for a specified period of time, usually a maximum of three months but in some cases one month, once opened. We also found a topical cream left on a person's bedside table which stated it should be kept in a refrigerator. Records showed this had last been applied in March 2015. Topically prescribed creams are essential in maintaining older people's skin integrity and the failure to use correctly places people at risk of complications and skin breakdown.

We saw in the Medicines Administration Records (MARs) that some people were prescribed a medicine which is required to be given on an empty stomach, with water and no other food or drink (including other medicines) at the same time or for at least 30 minutes after it's administration. We saw that most of these people received this medicine at 09.00. This would be too close to breakfast or other medicines and would compromise the effectiveness of the medicine. The precautions in the manufacturer's guidance to prevent complications were not being followed. One person had been prescribed rectal enemas. They did not have an as required protocol or care plan. We saw staff had recorded that they had administered suppositories which are a different product. The nurse said "this is an error, I cannot see how they got from enemas to the suppositories but I have been away and perhaps they ran out". We observed one person's five medicines were being crushed. There was no record from the pharmacist that this was safe to do so. The crushing of medicines can

alter the way they are absorbed into the body and the combination of crushed medicines may have placed the person at risk. People were therefore not always receiving their medicines as prescribed or safely.

Medicines that had not been used or were waiting for disposal were recorded in a returns book and then placed in a container within the locked medicines rooms. In one medicines room there were three disposal bins, two of which were full. They were so full that items were bulging out of the top of one bin and the other was not shut securely. NICE guidelines state medicines for disposal should be secured in a tamper proof container within a cupboard until they are collected or taken to the pharmacy. Although the bins were insecure they were stored in a locked medicines room.

Most MARs were up to date, fully completed and some included as and when necessary (prn) protocols. This included personalised information about when as needed medicines should be given. However, other people's records showed they had been prescribed 'as required' medicines but there was no protocol on when they should be used. For example, four people living with dementia had been prescribed 'as required medicine' for agitation. Three of these people did not have an 'as required' protocol or care plans. The decision as to when this medication should be given could therefore vary between different members of staff. An 'as required' care plan or protocol would also have included guidance about other measures staff should try before using medication for agitation. Of sixteen people living with dementia who had been prescribed paracetamol 'as required' five did not have an 'as required' protocol or care plan. Another person had been prescribed a stronger 'as required' pain medicine but had no 'as needed' protocol or care plan. These people may not have received 'as required' medicines when they required them or had them when they did not need them.

The provider had a system for ordering medicines and stock control although we identified one pain relief patch which was not available following an increase in the dose several weeks previously. The nurse stated they had not chased this as the person did not seem in pain – however there had been no discussion with the GP about this or formal assessment of the person's pain. Where staff had added or amended prescriptions on MARs these had not always been signed by two staff. In one instance there was no signature to indicate who had amended a prescription or why.

The failure to ensure medicines were correctly managed is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines in use were stored securely. Staff administering medicines provided clear information for people, explaining what the medicine was for and how it could help people. Nurses told us they had received medicines training but not a medicines administration competency assessment.

People and relatives told us staff usually responded promptly when call bells were used. One person said "they seem to come quickly most of the time". One person said "the care staff are always in a rush". Another said "they are always so busy". We observed people in one part of the home waiting up to 40 minutes for their meal. They were sitting at a table and had watched other people eating who had already finished their meals. People and relatives also felt staff did not have time to sit and talk with people which may mean those who spent more time in their bedrooms could become isolated. Staff told us they used to have hostesses to undertake the afternoon tea rounds but now also had to do this themselves reducing time they could spend with people.

There were not always enough staff available to support people and keep them safe. One person had been assessed as requiring individual support to keep them and other people safe. We saw that on at least one occasion staff had had to intervene when other people were having a disagreement. This resulted in the person they should have been supporting being left unattended and becoming involved in an incident themselves. In another part of the home we heard a care staff say "I should have gone to lunch, but I can't leave [the person]". The person was trying to get up from their chair and was in danger of falling.

The provider had a dependency assessment tool which helped them calculate the number of care and nursing staff required. This had been completed in March 2015 with copies of individual people's assessments seen within care plan records. We saw the tool was no longer correct for several people as their needs had increased. The registered manager said the tool was still being developed and the

Inadequate

Is the service safe?

assessment had not been repeated since March 2015. The registered manager told us the staffing tool had identified that one section of the home was understaffed by three hours per day however, no action had been taken to address this deficit. The registered manager stated "the staff seem to manage". Staff told us they felt they had time to meet people's needs although they could be busy at times. We saw that when necessary existing staff undertook additional shifts to cover short term staffing shortfalls.

The failure to ensure there were always enough staff to meet people's needs and ensure their safety is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were plans in place to deal with foreseeable emergencies. Staff had undertaken first aid and fire awareness training. They were aware of the action they should take in emergency situations. Personal evacuation plans were available for all people. These included individual detail of the support each person would need if they had to be evacuated. The information in the emergency bag located near the front door was out of date. This contained names of people no longer in the home or in the room specified. The failure to maintain an accurate fire register places people and emergency staff at risk. We saw that in an emergency staff had to run along a corridor to seek assistance. They told us there were no emergency call bells within the corridors.

The failure to ensure plans are in place to deal with foreseeable emergencies is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most risks to people were recognised and assessed and when a risk was identified a care plan was created to advise staff as to how the risk should be managed. When people had been identified as having care and support needs relating to moving and handling the provider had ensured equipment such as hoists were available. Staff told us they had received training in moving and handling, including the effective and safe use of equipment used to assist people to mobilise or transfer from, for example, bed to chair. With the exception of one occasion we observed moving and handling procedures which were competent and safe with staff using the procedures and equipment correctly.

The process used to recruit staff was safe and helped to ensure staff were suitable for their role. Interviews included relevant questions to assess the applicant's knowledge and attitudes and were structured to the role people were applying for. Relevant checks were completed to make sure staff were of good character with the relevant skills and experience needed to support people appropriately. This included checking the registration of nurses with the relevant regulatory organisation, references from previous employers and criminal record checks. Staff confirmed this process was followed before they started working at the home.

Inadequate

Is the service effective?

Our findings

Staff were not following the principles of the Mental Capacity Act 2005 (MCA). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant. Many people's records did not contain decision specific mental capacity assessments in line with the MCA Code of Practice. The provider had a form which, if completed, would have contained all the necessary information and records to meet the legislation. However, this was not completed for many people living with dementia. Care records for people living with dementia lacked detail as to what decisions people required support with and how this support should be provided. In one person's records it stated "has no cognition". There was no assessment or information as to how they could be supported to make basic day to day decisions.

Where people were unable to make decisions best interest meetings had not taken place in accordance with the MCA. For example, in one person's care plan we found a best interest decision and risk assessment to use bed rails and bumpers. However, there had been no mental capacity assessment completed to determine that the person was not able to make this decision themselves. Another person was receiving their medicines crushed and placed in their food without their knowledge. This is called covert administration. Staff told us this was because they had been spitting out tablets. There had been no assessment of the person's mental capacity to determine if they were unable to make the decision to take or not take their medicines. Without an assessment of the person's ability to make the decision staff should not have been hiding the tablets in their food. For other people, staff had also made decisions without having first assessed the person's mental capacity. A nurse said "I was told I had to do all these (mental capacity assessments) but I am used to doing them as a team and then the system changed again, so I think you might find some that have not been done properly yet. There are some DoLs applications though".

The Deprivation of Liberty Safeguards (DoLS) provides a process by which a person can be legally deprived of their liberty when they do not have the capacity to make certain decisions and they may present a risk to themselves if they are able to leave the home freely. We were told that applications for DoLS authorisations had been made for some people living within the home. However, without first undertaking a mental capacity assessment a DoLS cannot legally be applied for. People's rights, therefore, had not been legally ensured.

The failure to follow the principles in the MCA is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always receiving the nursing care they required. People received healthcare from the trained nurses. This included wound dressings, blood sugar monitoring and insulin injections. However, records did not always show that action had been taken when routine observations identified a concern. One person was having their blood sugar levels checked twice a day prior to insulin being administered. Their care plan did not specify what action should be taken if readings were lower or higher than was normal and acceptable for the individual. Records showed that shortly before the inspection the morning readings had been low. There was no record of the action taken by nursing staff although the medication records showed insulin had been administered normally. There was no record that blood levels had been rechecked or other additional monitoring undertaken. On other occasions records showed blood levels had been high and again there was no record of what, if any, action had been taken.

Wound care plans and records did not demonstrate that people received correct wound care. The provider had a comprehensive wound management system, however this was not correctly used. For example, photographs were not always taken of wounds. Where these had been taken they were of poor quality and did not have a measuring rule to indicate the size of the wound. Records showed the wound was not being redressed with the frequency specified in the wound management plan. Other wound records also showed a failure to follow up or update the wound management plan. Where wounds had healed there was a failure to monitor the vulnerable skin to detect any early signs of further skin damage. For one person whose records showed the wound should have been redressed the

previous day the nurse said "this should have been done but in actual fact it has healed". The record did not state the wound had healed and there was no preventative care plan for this or other people whose wounds had healed.

One person had a urinary catheter. Their records showed they previously had several urinary tract infections (UTI) however there was no UTI prevention care plan. We saw the person's catheter drainage bag had been hung from their bed rails. The drainage bag was positioned higher than their bladder and this would have prevented free drainage increasing the risk of UTI. The home monitored routine observations of blood pressure, pulse and temperature on a monthly basis. However, we found that this was not always undertaken which meant changes in people's health needs may not be detected until they were significantly unwell.

We saw specialists such as Speech and Language Therapists (SALT) were consulted where staff identified a concern. However, when people had been assessed by SALT, their recommendations were not always followed. One person had been assessed by SALT and the recommendations were that they could have normal fluids but no straw or spouted beaker. We saw in their room a drink within reach in a spouted beaker with a straw in it. The person was at high risk of choking or aspirating on fluids.

Overall people's personal care needs were being met, however, we identified one person who had very long toe nails which would have impacted on their ability to walk. Their records showed they had had a lot of falls. Staff caring for the person stated "they hate having their toenails done (cut)". There was no reference to this in the person's care plan and no risk assessments relating to the nails or support the person should receive. The person was continuing to fall on a regular basis however they had not been referred to the falls clinic. Their care plan stated "needs to be observed while walking due to high risk of falls. Staff to be aware of whereabouts at all times". We observed that staff were busy and no one was allocated to observe the person who was restless and continually walking around. They had an unwitnessed fall whilst we were at the home. Staff said, in a matter of fact manner, "she is always falling, all the time".

Where necessary staff were recording the food and drinks people were receiving, however, these were not always fully recorded or recorded at the time people had food or drinks. This meant they may not have been accurate as staff said they "remembered what people had had". Fluid records were not always totalled to record the amount received over the day and there was no record that nurses had checked these. Within care plans there was no assessment to determine the desired daily fluid intake for the individual person. This can vary depending on the person's weight or medical needs.

The failure to ensure people received all the health and personal care they required is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were able to see GP's and were supported to attend hospital appointments.

The provider's policy was that staff should receive support through the use of alternate monthly one-to-one sessions of supervision and appraisals. These provided opportunities for them to discuss their performance, development and training needs. The provider had a monitoring system which showed that staff were receiving regular supervisions and appraisals. We spoke with trained nurses who should have been supervised by the deputy manager who had not been at work for the preceding 11 weeks. The nurses stated they had not received supervision since well before the deputy had been off work. However, the provider's records stated this had occurred. Nurses undertook supervision and appraisals for staff in their units. We were unable to view records of these as we were told the nurses kept these at their own homes as they "had no secure storage available to them in the home". We could not be assured that staff were receiving support in accordance with the provider's policy.

The failure to ensure staff receive regular supervision and appraisals is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people told us they were happy with the food and that there was plenty available and they had a choice. One person told us, "The food is good and you always get a choice". Kitchen staff were aware of people who needed their meals prepared in a certain way or fortified. They stated a range of alternatives could be provided.

A programme of induction training was completed by all new staff. In addition, new staff 'shadowed' experienced staff by working alongside them until they were confident

Inadequate

Is the service effective?

in their role. Training records showed most staff had completed all essential training required by the provider. Staff training was provided in a variety of formats, including face to face and by computer learning. New staff were positive about their induction and other staff said ongoing and refresher training had been of value. Other staff confirmed they had received all necessary training. There was an on-site trainer who ensured staff completed regular updates and any specific training required. Staff were also supported to gain qualifications in care. Non-care staff were also supported to achieve a relevant qualification.

Requires improvement

Is the service caring?

Our findings

One person told us the staff are nice but "at night they hardly speak a word of English, I couldn't even make them understand how to open the window and leave it on the latch – so it's either open too much or not at all". A family member said, "words do not describe how kind and caring the staff are, they are just wonderful." Another visitor said "I always bring the staff treats (like donuts) as they earn them, they work really hard and sometimes they do not get a break at all, they are all so kind and patient, I think they are wonderful and deserve all the praise they can get". We saw staff responded promptly to people who were requesting assistance and they did so in a patient and attentive manner.

However, we observed occasions when people's dignity was not ensured. For example, we saw one person who was in a lounge area wearing a thin cotton nightdress with no sleeves. The person was barefoot. The person's appearance was not dignified. In one lounge there were two small sofas. They both had thick covers on the seats, too thin to be blankets and too thick to be sheets. On one, partially covered by a thin blanket we could see the sofa cushions were covered in black bin liner bags. Staff told us "this is not right at all, it is not dignified, they could have used something else. Having said this I know [named person] likes to sleep on the sofa and can be incontinent so that is probably why".

We observed lunch in another part of the home. Eight people were sitting in one dining room. All were wearing large maroon clothes protectors. Another two people arrived and clothes protectors were immediately put on them. Nothing was said to the people nor were they asked if they wanted a clothing protector put on them. The arrangements for serving meals were not person centred but appeared to be about routine and convenience for kitchen and care staff. All people requiring their meals in an altered format such as liquidised or soft received their meals first. Then normal diets arrived and people received these. People awaiting normal diets had to wait, and observe others having their meal before they could receive their meal. Five people sat in the dining room wearing clothes protectors for forty minutes before they were given their meals. This occurred on both days of the inspection.

Where people required assistance some staff sat, whilst others crouched or stood to support people. One staff was reaching across a table to assist a person. This did not promote people's dignity or evidence respect.

We heard staff speaking over people about issues which did not relate to the person they were providing care for or assisting with their meal. Conversations included discussions about breaks and who else still required mealtime support. One care staff called across the room to another care staff, "who are you doing? You could do [name], they are over there". Later another care staff said "anyone left to be fed?" Where people were living with dementia, this conversation would have been confusing and possibly increased their sense of anxiety. There was very little conversation between people and care staff. We saw one person receiving full assistance with their meal from a care staff who did not speak to them during the meal. Some people received support from more than one care staff during their meal. These interactions demonstrated a lack of respect for people by staff and did not promote people's independence or choice.

In a care record we read that a person was observed by staff taking a chip from another person's plate. The staff member recorded that they had told the person they must not do that as "you are on a calorie controlled diet". Another person said they had been "told off" by staff about noise from their television at night. These interactions were not respectful and did not enhance people's dignity.

Staff told us people could request staff of a particular gender and were aware of one person who had a specific request for female staff. However, this information was not recorded in their care plan and we did not see any similar information in other care plans. The pre-admission assessment form did not contain any information directing the assessor to ask people about staff gender preferences. The failure to ask people may mean people would not realise a choice was an option. People's preferences may therefore not be known and they would not receive support with personal care as they wished.

The failure to ensure people were treated with dignity at all times is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's privacy was protected by staff knocking on people's doors before entering and ensuring doors were closed when they delivered personal care.

Requires improvement

Is the service caring?

Confidential information, such as care plans were kept in nursing offices and whilst not all were kept locked at all times information was not left readily available to people who should not have access to it.

Inadequate

Is the service responsive?

Our findings

People told us their wishes were not always met. One said ""I don't like that gravy on the meat – I told them, and when they remember, they leave it off. But I still have to scrape it off most of the time".

People's views were not formally sought on a regular basis by the provider. Resident meetings were no longer held with the most recent having been in September 2014. We were told these had been discontinued as not many people had attended. No other initiatives had been tried to encourage people to attend resident meetings or to seek people's views in other ways. A suggestions box was seen in the entrance area of the hall but the registered manager could not provide evidence that this had been used.

The failure to actively seek feedback from people is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems did not ensure people received 'as required' pain medication when they required it. People living with cognitive impairment such as dementia may not be able to express that they have pain. They may instead display different types of behaviours such as restlessness, agitation or aggression. We observed several people living with dementia who appeared to be agitated and restless. Staff did not assess the person with a view to pain management and had not explored the possibility that the person could have been in pain. The National Institute for Clinical Excellence (NICE) provides guidance for the assessment of pain in people living with dementia. There was no evidence this was being followed.

Where people were unable to express pain, a pain assessment tool was not in use even where their care plans indicated they may be in pain. For example, we saw in one person's records there was conflicting guidance for staff about what may indicate the person was in pain. "Ask [the person] if she has pain, look for non-verbal signs and loud moaning", also "[the person] suffers from a lot of pain and will often call out in pain". In another section of their care plan it stated "can verbally speak but unable to communicate needs, when they talk to you they may sound distressed, anxious, this is due to dementia rather than pain (although this is difficult to ascertain). I do not feel [the person] can understand what is being said and cannot respond appropriately". This gave a very mixed description of someone trying to communicate and who appears to show significant signs of pain. There was no attempt within the care plan to ensure the person was assessed for pain, how to do this, or ensure they are treated appropriately. Within the person's daily record it stated they were "agitated in personal care, saying in a lot of pain". There was no record that pain relief had been given.

People were not always adequately monitored in situations where their health may change such as following a fall. The National Institute for Clinical Excellence (NICE) provides guidance for monitoring people who have suffered a head injury. This specifies that neurological observations should be completed half hourly for two hours, hourly for four hours and 2 hourly for 24 hours. We were shown the provider's policy which was in line with the NICE guidance. However, staff had not followed this when people had fallen and injured their heads. The records viewed for three people who had suffered a head injury following a fall showed that neither the guidance or provider's policy had been followed. During the inspection a person suffered an unwitnessed fall. We heard them later tell staff they had a headache and were seen to be anxious and restless. Neurological observations were not commenced and the nurse told the person they would get them some pain relief. Potentially serious injuries may not have been identified and prompt action was not taken to prevent further complications in this or other incidents where people may have suffered a head injury.

Body maps were completed when care staff identified injuries or marks on people. However, it was not always evident that an investigation had occurred to establish how the injury had occurred or what action should be taken to reduce the risk of recurrence. Care plans had not been updated.

Care plans did contain a good level of individual detail about how some people wanted aspects of their care to be provided including information as to what they could do for themselves and what they required help with.

People who displayed behaviours that challenged were not supported appropriately. Care plans showed staff were recording behaviours in a variety of inconsistent ways. In some instances these were recorded in daily records in others staff recorded on behaviour charts. These did not direct staff to analyse the behaviour or identify what may have initiated the incident. One person was receiving individual support and had a behaviour monitoring form.

Inadequate

Is the service responsive?

This amounted to a description of what the person did rather than their behaviour. We found an entry that indicated an incident was written in the person's daily record and not on the behaviour monitoring form. The failure to have a consistent approach to recording behaviours meant senior staff were unable to monitor the level and complexity of incidents. It also prevented them designing individual approaches to supporting people and reducing the incidents of behaviours which challenged. We observed staff did not take action when people were becoming agitated and respond at an early stage. Consequently, people's anxieties had appeared to increase leading to incidents that could have been prevented if staff had recognised and responded to known behaviours.

A relative told us "I've come in here at all sorts of times, and I've never seen any activities happening when I come in". A person told us "It's so boring! I just want to get home". Another visitor said "[person] used to like gardening, but no-one is around to help her with it, which is a shame, as she needs more stimulation". During the inspection we observed one activity taking place which was attended by five people. The provider had undertaken a lifestyle survey in October 2014. This had identified that people were unhappy with the activities provided. Almost nine months later people continued to express dissatisfaction with activities.

Daily records did not list many activities which had occurred. This meant it was not possible to determine if people were receiving adequate mental and physical stimulation. A care staff told us "it's not in our job description to do activities" they added "anyway we don't have enough time".

The failure to ensure people received all necessary personal, health and social care is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they had raised concerns but that either these issues had not been addressed or they were unaware of the outcome of any investigation. The service had a complaints policy and a system to record and investigates complaints. We saw that one complaint had been received in March 2015 and was recorded on the complaints log. There was no further information to indicate what action, if any, had been taken to investigate the complaint. The level of information recorded did not specify what the actual concerns were. The complaint had not been investigated and responded to in a timely way.

The failure to have adequate systems to investigate complaints is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout the inspection staff responded promptly when we identified issues of concern to them. We observed a person sitting in a special wheelchair having breakfast. One foot was not on the foot rest but was pressed against and under the foot rest. The care staff assisting the person had not noted this. We pointed this out to the nurse who took immediate action to rectify the potentially dangerous situation. We also mentioned to staff where a person had forgotten to use their walking frame and were relying on unstable items of furniture to support them. These are examples of service responsiveness but we could not be assured they would have been picked up without us highlighting them.

Where necessary, people had been referred to occupational therapists for assessment to ensure they had the correct equipment including seating to ensure their safety and comfort. Staff said they felt they had access to all necessary equipment to meet people's care needs. Equipment in use such as pressure relieving mattresses was being used correctly.

Inadequate

Is the service well-led?

Our findings

The provider's quality monitoring systems failed to ensure people received a safe, effective, caring and responsive service. Consequently, people were at risk of not having their health and other needs met, not being protected from abuse and having their rights compromised.

The registered manager was responsible for managing this and another nearby service. They had a deputy in day to day charge at The Orchard. A senior representative of the provider was present throughout the inspection and stated they, and other senior managers, had been undertaking a range of quality monitoring visits to the home but these had not identified the issues we found.

The provider had systems for the reporting and monitoring of incidents however, staff were not reporting these and following the provider's procedures. There were no systems in place for senior managers to formally review daily records or to identify that incidents, which were occurring, were being reported according to the providers agreed procedures. This meant action was not being taken to reduce the risks to people, visitors and staff. Other information the provider used as part of its quality monitoring systems was inaccurate. Information about the number of staff who had received supervision and appraisals did not correspond with what staff told us.

The failure to ensure systems are operated correctly to ensure the quality of the service provided is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers and registered managers are required by law to notify the CQC about significant incidents and events Before the inspection visit we checked what notifications we had received. Staff and people told us about incidents of falls and where potential abuse had been identified. In some cases these had been recorded in the daily records for people. There were no reports of investigations into these incidents within care and staff records. We had not been notified about a range of these including potential abuse of people and when people had been injured due to falls or pressure injuries.

The failure to notify the Commission without delay of incidents is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Some people were unsure about the homes management arrangements. One person told us the home had "been without a manager for a long time – this has no impact on me directly, but it worries me that nobody 'carries the can'. Two visitors told us they felt the home was well organised and they knew the registered manager well because they did regular visits to the area of the home their relatives lived in. One told us "I know he is only part time but when he is here he makes his presence known. He always speaks to everyone and asks if everything is OK, it makes you feel he has his finger on the pulse". Another visitor said "I think things were a bit rocky when the manager left and maybe for a bit before, things were not as smooth but now you just know things are back on track".

One care staff told us the management team were supportive and thought "the senior managers are a good team". They were also complimentary about the nurse in charge of the unit they worked on who they felt "really understands and cared about everyone". However, another staff member felt that the manager did not listen. They said "when we raise things they are not heard and we, not just me but others like me, do not feel valued". They told us how they had raised a concern which had not been addressed by the location and providers management team.

Staff were unclear about the vision and values of the home. Staff said they thought it was about making sure people received the correct care and were happy. The provider's area manager listed the provider's values as providing high quality person centred care and promoting independence. It was not clear how these values were transmitted to staff or into the service provided.

Following the first day of the inspection we provided feedback to the registered manager. On the second day of the inspection they had already commenced responding to some of the more urgent issues we had identified. The area manager had undertaken a review of care plans in one part of the home and showed us a list of missing or incomplete information. Although this showed they were responsive to address issues we could not be assured that without our highlighting such issues, they would have been picked up and addressed by the provider themselves.