HC-One Limited

The Orchards

Inspection report

164 Shard End Crescent
Birmingham
West Midlands
B34 7BP

Tel: 01217302040
Website: www.hc-one.co.uk/homes/the-orchards/

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

At our last inspection on 7 October 2015 we found that people did not always receive their medications safely, effectively or as prescribed and the provider was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found that despite an increase in staffing levels following a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in June 2015, the deployment of the staff was not always effective to ensure that people's needs were met consistently and in a timely manner. At this inspection we found on-going concerns relating to these regulations.

This inspection took place on 8 and 9 September 2016. This was an unannounced inspection.

The home provides accommodation and support for up to 72 people who require nursing or personal care. At the time of our inspection, there were 60 people living at the home. The home is designed over two floors. The ground floor accommodates people on a permanent basis who require nursing and personal care, whilst the first floor accommodates people on both a permanent basis, but also people who require short-term, interim care for either respite or re-enablement purposes, whilst a long-term care plan is considered.

The service was required to have a registered manager in place as part of the conditions of registration. However, there was not a registered manager in post at the time of our visit because the person who was registered to manage the service had recently left. However, the provider had appointed a new manager who was in the process of applying for their registration with us. 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.
The service was not consistently safe, effective, caring or well-led because the provider had not always ensured that people received safe, person-centred care.

People did not always receive the care and support they required when they required it, because there was not always adequate numbers of staff available to meet their needs in a timely manner. Insufficient staffing levels also meant that people did not always receive their medications as prescribed and staff did not always have the time to get to know people or to spend time with people in order to provide person-centred care that was individual to people's specific care needs.

The provider's recruitment systems and processes were not always implemented effectively to ensure that staff were recruited safely.

Care records were not always complete and risks assessments were not always specific to peoples' individual care needs so staff did not always have the information to support people safely.

Not all people living at the home were actively encouraged and supported to engage in activities that were

meaningful and accessible to them. However, people were supported to maintain positive relationships with their friends and relatives.

It was not always clear that people received care and support with their consent because key systems and processes had not always been followed or documented to evidence this. However, most people were supported to make day to day choices and decisions, such as meal options. This meant that most people had food that they enjoyed and any risks associated with their diet were identified and managed safely within the home.

People were supported to maintain good health because staff worked closely with other health and social care professionals when necessary. jobs.

People were supported by staff that were nice, helpful and caring and most people were also cared for by staff that protected their privacy and dignity and respected them as individuals.

People were encouraged to be as independent as possible and were supported to express their views including the care and support that was provided to them, as far as reasonably possible. Most people felt involved in the planning and review of their care because staff communicated with them in ways they could understand.

Staff felt supported and appreciated in their work and reported the home to have an open and honest leadership culture. People were encouraged to offer feedback on the quality of the service and knew how to complain if they needed to.

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 always safe.

People were not always protected from risks associated with their care needs because risk assessments and management plans were not always specific to their individual care needs.

The provider's recruitment systems and processes were not always implemented effectively to ensure that staff were recruited safely.

People were not always supported by enough members of staff to meet their needs.

People did not always receive their medicines as prescribed and medication systems and processes within the home were unsafe.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights were not always protected because key processes had not always been followed or documented clearly, to ensure that people were not unlawfully restricted.

People received care from staff who had mostly received adequate training and had the knowledge and skills they required to do their job effectively.

People's dietary needs were assessed and monitored to identify any risks associated with their diet and fluid requirements and they had food they enjoyed.

People were supported to maintain good health because they had access to other health and social care professionals when necessary.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always receive the care they wanted based on

their personal preferences and dislikes because staff did not always have the time to get to know people.

People were supported by staff that were nice, helpful and caring.

People were encouraged to be as independent as possible and were supported to express their views in the care and support that was provided to them, as far as reasonably possible.

Is the service responsive?

Requires Improvement

The service was responsive.

Not all people were actively encouraged and supported to engage in activities that were meaningful and accessible to them.

People felt involved in the planning and review of their care because staff communicated with them in ways they could understand.

People were supported to maintain positive relationships with their friends and family.

People were encouraged to offer feedback on the quality of the service and knew how to complain.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had systems in place to monitor the safety and quality of the service but these had not always been used effectively to identify areas in need of improvement.

Staff felt supported in their work and reported the home to have an open and honest leadership culture.

The Orchards

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 was 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 unannounced inspection took place on 8 and 9 September 2016. The inspection was conducted by two inspectors, a pharmacy inspector, a Specialist Advisor and an Expert by Experience. A Specialist Advisor is a person who has specialist skills, knowledge and clinical experience in an area of practice relevant to the service being inspected. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection we looked at the information that we hold about the service. This included previous inspection reports that informed us of previous breaches of regulations dating back to 2013 as well as notifications from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also requested feedback from the local authority with their views about the service provided to people at The Orchards. A Provider Information Return (PIR) request had also been sent to the provider and returned. A PIR is a pre-inspection questionnaire that we send to providers to help us to plan our inspection. It asks providers to give us some key information about the service, what the service does well and any improvements they plan to make.

During our inspection, we spoke or spent time with 16 of the people who lived at the home, 11 relatives and 11 members of staff including the registered manager, operational lead, deputy manager, two nursing staff, three care staff, an activity co-ordinator, a member of the housekeeping team and a member of the maintenance personnel. We also spoke with two visiting health care professionals. Some of the people living at the home had complex care needs and were unable to tell us about the service they received. Therefore we used a tool called 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.

As part of the inspection, we also reviewed the care records of seven people, to see how their care was planned and looked at the medicine administration processes. We looked at training records for all staff and

at three staff files to check the provider's recruitment and supervision processes. We also looked at records which supported the provider to monitor the quality and management of the service, including health and safety audits, accidents and incident records and compliments and complaints.

Inadequate

Is the service safe?

Our findings

At our previous inspection in October 2015 we found the provider was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not receiving their medication safely, effectively or as prescribed. We issued a requirement notice and asked the provider to send us an action plan to tell us how they planned to improve, which we received in November 2015. In addition to this, in June 2015 we found the provider was in breach of Regulation18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because there was insufficient staff available to meet people's needs. Whilst we found that the provider had increased their staffing levels when we returned in October 2015, we found that staff were not being deployed effectively to ensure people's needs were being met in a timely manner. At this inspection we found that people were still at risk of not receiving their medication as prescribed, and people were still at risk of not having their care needs met as staff were not available when they were needed. Similar concerns regarding the management of medicine and staff had been identified at previous inspections going back to 2014.

At this inspection we looked at how medicines were managed which included checking the Medicine Administration Record (MAR) charts for 22 people, speaking to nursing staff and observing a medication administration round. We found that people's medicines were not always being managed or handled safely.

A relative we spoke with said, "They [staff] seem to leave them [tablets] in a pot and we have found them on the floor". We corroborated this with an observation whereby, we saw that one person had half of a tablet left on their bedside table at 15:00. They said, "It [tablet] was from earlier". When we checked the persons MAR chart, we found that this medication had been signed for as administered at 09:00.

We observed one nurse administering medicines on the ground floor. The nurse told us that they did not start the medicine round until 9am because they had other duties to fulfil including liaising with the GP surgeries, which took time every morning. Also due to the complex clinical needs of people, the nurse reported to feel 'pushed' and often had to ask for help from a nurse upstairs, who too felt under pressure. As a result, we found that the time of the morning medicine administration round did not finish until after 11.30am. This did not allow sufficient time between the morning and lunchtime medicine rounds for medicines to be spaced evenly throughout the day. The nurse explained to us that they would try to start the lunchtime medicines later, but that this would then impact on the timings of the tea-time and evening medication administration, for people who were prescribed medications four or more times a day. The manager explained to us that two senior care assistants were due to undertake medicine management training in order to support the administration of medicines. However, at the time of our inspection, people were not always receiving their medications as prescribed.

Medicines were not always available to give to people. We found two people were without pain relief and one person was without an inhaler for preventing breathlessness. This meant there was a potential for people to experience pain or to become unwell. The service knew about the missing medicines and we were assured that nobody had suffered any harm without their medicines. One person told us, "I have not felt breathless or needed my inhaler recently". However there was a potential risk that people could suffer pain

and/or difficulty in breathing due to the lack of availability of their medicine should they require them.

We were also shown copies of faxed Medication Request Forms to the GP to obtain prescriptions. The manager explained that there were ongoing problems and delays with the Electronic Prescription Service (EPS) which allowed the GP practice to send prescriptions electronically directly to the pharmacy. One member of staff also commented that, "It [unavailable medication] is a communication problem with staff as well". We found that there was a mixture of failings including poor communication between staff as well as system failures which meant that people did not have access to their medications that they required when they required them. We acknowledged that some of these problems were a system failure outside the service's control but explained the importance of ordering medicines in a timely manner with a procedure in place to chase prescriptions, which was the responsibility of the provider.

We could not always be assured that people were being given their prescribed medicines as intended because medication counts did not always match the MAR charts and we found gaps in three people's medicine administration records. This is when there is no staff signature to record the administration of a medicine or a reason documented to explain why the medicine had not been given. For example, we saw that one person was taking capsules prescribed for pain relief. 174 capsules were available at the start of the medication cycle and records showed that 82 capsules had been administered. This would suggest that 92 capsules should have been remaining. However, we found that there were 98 capsules remaining and further error was found in the stock balance, as this was recorded as 100 capsules remaining. Therefore, it was unclear whether this person had received all of the medication that had been signed for as administered.

We found that records for the amount of medicines available were not always accurate. This made it difficult to check that people had been given their medicines. For example, we looked at a MAR chart for one person prescribed a high risk medicine to prevent blood clots. Although the MAR chart documented that the person had been given the correct prescribed dose it was not possible to check that the person had been given their medicine as prescribed. This was because there was no date of opening on the medicine box, no record of receipt and no total balance recorded.

Arrangements were not in place to ensure that medicines with a short expiry were dated when they were opened. We found that a medicine with a short expiry date once removed from the refrigerator had not been dated when opened. It was therefore not possible to determine whether it was within the manufacturers recommended shelf life. There was an increased risk of medicines being used longer than the expiry date and the preparation may no longer be effective.

Handwritten MAR charts were written and checked by two staff. However, we found that this did not always ensure they were accurate. We found one person's handwritten MAR chart had numerous errors including missing strength, dose and form of medicine. Another person's medicine dose had been poorly written with the potential risk that it could have been misread and potential for significant overdose. On informing the manager the medicine dose was immediately re-written to prevent the risk of the wrong dosage been given to the person.

When people were prescribed a medicated skin patch to be applied on different parts of the body the available records did not always show where the patch had been applied. This is particularly important for people prescribed pain relief patches. This would ensure staff could check that the old patch was removed before applying a new patch and to ensure the site of application was rotated to reduce the incidence of side effects. Staff we spoke with were aware of the form available to them to record this information and that they should have been using it to record the site of application of the medication patch, however they

acknowledged that this was not always being completed.

Medicines were stored securely within the recommended temperature ranges for safe medicine storage. However, medicines stored in the medicine trolleys were not always well organised and we found more than one box of the same medicine in use and discontinued medicines still in the trolley.This increased the potential of a medicine error.

Supporting information for staff to safely administer medicines was not always available. In particular we looked at two people who were prescribed a medicine to be given 'when necessary' or 'as required' for agitation. Although staff were able to verbally explain when they would give the medicine there was no written person centred information available to enable staff to make a decision as to when to give the medicine. We further noted that when people were given a medicine prescribed for agitation there was not always a record to explain why the medicine had been given or what other methods had been tried primarily to support or reassure the person and potentially minimise the need for medication.

This is a continued and re-occurring breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to unsafe practice around medication management. You can see what action we have taken at the end of the report.

We found evidence to show that people were not always receiving the care and treatment they required in order to keep them safe..

For example, we found that one person was experiencing pain on their bottom they told us ,"I tell them [staff] I have an uncomfortable bottom and find it hard to sit properly without keep shuffling from side to side but they never look at it". Their relative told us that they had raised this as a concern with the staff on numerous occasions. "When we looked at the persons care file, we saw that despite the assessment documentation only being partly completed, it had indicated that she was at risk of developing pressure sores. However, there was no care plan on pressure sore prevention for this person, despite their relative having raised concerns to different members of staff on different occasions. We spoke to a nurse about this and they examined the area of discomfort. They identified that this person was at risk of developing a pressure sore because their skin was red in the affected area. They explained that barrier cream had not been applied previously because a chart had not been put in the person's room to indicate to staff that this was required as part of the assessment process. This showed that the person had not received the support they needed and had been left at risk of developing a pressure sore.

We were also told by a relative that the same person had been admitted to the home with anti-embolism stockings (used to prevent blood clots in the legs) and that these had not been changed in the three weeks that they had been there. The relative told us that they had complained to the staff on numerous occasions because there was a foul smell coming from the person's legs. We asked the nursing staff about this too, who removed the stockings and during which, found another area of broken skin on one of the persons legs. This had gone undetected because the staff had not previously changed the stockings, despite there being records of bruising to the skin upon admission. This showed that the person's needs were not being met and an identified risk had not been flowed up.

The relative told us that they were glad the problems were sorted but felt that the staff at the home should have listened to their concerns earlier and said that communication between staff at the home was 'poor'. Another relative confirmed this and said, "The care is ok, but nothing is consistent. They [staff] don't seem to communicate with each other and we have to keep reminding them and asking them to do things". Many of the people we spoke with told us that they felt important areas of care had been 'overlooked' because of

poor communication and recording.

This supports a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to safe care and treatment. You can see what action we have taken at the end of the report.

In October 2015, we found that the provider had increased the staffing levels but improvements were still required because staff had not been deployed effectively to ensure that people's needs were met consistently. At this inspection, we were told that people still had to wait for support and that staff felt 'under pressure' and 'pushed for time'. One person we spoke with said, "They [staff] seem to care but they are always busy and I get uncomfortable waiting for them". Another person told us, "If I press my buzzer, I can wait about 20 minutes...mind you, I could be dead by then couldn't I?" A third person we spoke with told us that they had experienced a fall and they had pressed their buzzer over six times but no-one came to their assistance. They told us that they were cold and wet because a jug of water had fallen on them during the incident and that it was only by chance a member of staff brought something to their room and found them on the floor, that they received assistance. A fourth person told us, "I feel safe when the staff eventually come to me, but I can wait over three quarters of an hour sometimes, which is hard when you are uncomfortable". A member of staff we spoke with told us, "The minimum [number of staff] is four; it's not too bad when there is five of us working, but it's a struggle when there is just four; [acting manager] does her best to get five, but it's not always possible". Another member of staff said, "We could do with an extra nurse really, it's very busy, especially with dressings (wounds) and medication". During our inspection we observed one person looked uncomfortable in their room in a state of undress. We noted that this person remained like this for over 20 minutes before we had to ask a member of staff to check on their well-being.

From speaking with people, relatives and staff, other than the time pressures associated with medication rounds which were evident on both floors of the home, the main concerns relating to staffing levels appeared to be on the first floor. One member of staff told us that they felt the first floor was 'very busy', especially with having the high turnover of residents in the intermediate care section. We found that staff did not always have the time to get to know people properly and were not always aware of their health conditions or the reason for their admission on to the unit. One relative we spoke with said, "They [staff] seem nice enough but they don't seem to be well informed about what people need". Another relative said, "The carers are friendly and kind but I am not sure they are all familiar with her care needs". During the inspection we saw that one gentleman looked frail, we asked a member of staff why this person had been admitted to the home and what their health and care needs were. They said, "He has only been here a short while as he is receiving intermediate care; I don't know much about him".

The nurse in charge on the intermediate care unit told us that they felt the home 'barely coped' with the complexity of patients coming out of the acute hospitals and that they now had to be 'very strict' on the admission criteria for the home. They told us that the majority of the nursing care was left to the nurse allocated to the first floor and they felt that they could really do with another nurse on duty.

We fed this back to the acting manager and the operational manager at the time of our inspection and discussed the staffing levels with them. They told us that the provider identified generic staffing levels for all of their care homes, based on the regulated activity that was being provided. For example, for a residential care home the ratio of staff to people is one to six, in nursing care there is one member of staff allocated to five people. However, we found that this did not always take in to consideration the varying complexities of people's care needs, especially on a unit where dependency levels changed on a daily basis. The acting manager acknowledged this and told us that the provider was looking at developing a dependency tool which would help them to ensure that the home was properly staffed and staff were deployed to meet the

needs of people based on their individual care needs. However, they were unsure when this would be implemented. This showed that the provider did not have an appropriate system in place to identify the numbers of staff needed to meet people's individual needs.

We were told that the provider had been successful in recruiting staff and the home was now fully staffed. They told us that they were still utilising temporary staff whilst they were waiting for the new staff to start work. On the day of our inspection, we found that a temporary nurse was in charge on the enhanced assessment unit and that they often covered shifts because work was always available at the home. They told us that it was a very busy and demanding service with a high admission and discharge rate and that consistency in staff was key. We looked at the staffing rotas for the last three months and found that the service was reliant on temporary staff and required at least one agency nurse to work almost every day. Some days we saw that the service relied heavily on agency nursing staff, with requests for up to three nurses per shift. This meant that the consistency of staff was not always assured.

We have found that concerns relating to staffing levels have been raised at previous inspections. However improvements have not been sustained to ensure peoples care needs are met consistently.

We found that the provider was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people did not always receive the care and support they

We found that the provider's recruitment systems and processes were not always implemented effectively. We saw that there were gaps in some staff members' employment histories without an explanation as well as some inconsistencies between the information that staff had provided on their application form and the information received from their referees'. Where there were inconsistencies, these had not been explored or explanations had not been recorded. We also found that in one staff members file, there was no Disclosure and Barring Service (DBS) number nor any identification documents for the member of staff. The Disclosure and Barring Service helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care. The acting manager told us that they had not yet had time within their new role to look at the staff files, but they assured us that they would perform an audit on all of the staff files to ensure that all of the information required is recorded and that staff have been recruited safely.

Records we looked at showed that people had risk assessments in their care files which related to generic risks around the home. These included moving and handling, falls and continence care. However, we found that people did not have risk assessments that were specific to their individual health and care needs, such as the risks associated with diabetes, dementia or behaviours that challenge such as physical or verbal aggression. It was clear from speaking to people, relatives and staff, that the staff were not always sure what people's health and care needs were and therefore were not always aware of the associated risks. For example, one person was at risk of developing a pressure sore but because there was no information in their file about the need for care staff to apply barrier cream, this had gone overlooked. We also found that the care home often relied on agency staff, who were not always familiar with the needs of the people living at the home and would be dependent on records for guidance on how to support people safely.

Staff we spoke with knew what action they needed to take in an emergency. One member of staff told us, "If a person was chocking, we would lean them forward and apply 'back slaps' in an attempt to dislodge the blockage, if this was unsuccessful we would call an ambulance for assistance". Another member of staff said, "If a person falls, we check them all over for injury before assisting them and if needs be we would call the paramedics to take them for an x-ray". During our inspection, we saw staff supporting people in ways that protected their safety, such as supporting people to eat and adhering to any specialist dietary needs to reduce the risk of choking. The previous manager had informed us in the Provider Information Return (PIR)

that all staff are trained to identify emergency situations and contingency plans were regularly reviewed and updated. Records we looked at showed that the maintenance team performed regular safety checks on equipment and facilitated random fire drills which involved staff and residents to ensure everyone was prepared in the event of an emergency.

Most of the people we spoke with on the ground floor told us they felt safe and well cared for at the home. One person said, "I feel very safe living here, its lovely". Another person said, "I feel safe, 100%". A relative we spoke with told us, "I am happy he is here; I know he is being looked after and kept safe". Another relative said, "I know she is safe here, they look after her well". A third relative commented, "We have peace of mind knowing she is safe here". Health care professionals we spoke with told us that they were confident that people were kept safe at the home and if they had any concerns they would report it straight away.

We found that staff had received training on what action to take to keep people safe from the risk of abuse and avoidable harm. One member of staff told us, "We have safeguarding training and we do a refresher course on this every year, we know what to look for and how to report any concerns". Another staff member said, "If I witnessed anything, I would speak to the person who was doing wrong and I'd report it to the manager, if nothing was done I would call the number we are given, you can report it anonymously". A third member of staff told us, "It's not nice having to raise a safeguarding, to think that someone may be at risk on your unit, but at the end of the day, it is there to protect people and that is what we are here for, so whatever it is, I always report it so that it can get looked in to properly and I know we are keeping people safe". This meant that staff had the knowledge and the skills they required to identify the potential risk of abuse and knew what action to take. The registered manager told us and information we hold about the service showed that, where safeguarding concerns had been raised, these had been reported and investigated appropriately by the relevant authorities.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People we spoke with told us that staff gave them choices and asked them what help they needed. One person said, "They [staff] ask us what we want" and, "They listen to me". Another person said, "We can do what we want, they are good like that, they give us choices and ask us what we need". A third person said, "They only do what we ask them to do, they are very respectful". Staff we spoke with were able to give examples of how they promoted consent and independence as much as reasonably possible, in all aspects of the day to day care and support they provided to people. For example, one member of staff told us, "It's important that we respect people's independence and try to promote that". Another member of staff said, "We talk to people before doing anything to get their permission". During the inspection, we observed the staff speaking to people and letting people know what they were going to do before supporting a person with any task, such as moving them and assisting them with food and drinks.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. This may include restricting a person's liberty in order to keep them safe. Under these circumstances providers are required to submit an application to a 'supervisory body' for the authority to deprive a person of their liberty. However, despite having training, staff we spoke with were not always sure about what could be seen as a restriction on a person's liberty and where an application for a DoLS had been made, we could not see or staff were unable to explain to us why or how they had made the decision to deprive a person of their liberty, if the restrictions were proportionate to the risk of harm and if other least restrictive options had been considered. One senior member of staff we spoke with told us that their understanding of the DoLS was limited and they needed additional training .

This was corroborated further by other records that we looked at and found that where applications had been made and people had been assessed, the outcome of these were not always available and the provider was not always able to explain to us whether any submitted applications had been agreed and people were being lawfully restricted in their best interests.

People we spoke with told us that they had a good choice about what they ate and they enjoyed the food the staff prepared for them. One person told us, "Oooooohhh the food is lovely, I can eat in the dining room or in here if I want to, it's my choice". Another person said, "Its lovely food, we get a good choice off the menu". A third person told us, "If we don't want what's on the menu we can ask for something else, like today it should be barbeque chicken but I'm not in to all that fancy stuff, so I have just asked for chicken, veg and gravy". Staff we spoke with told us that the kitchen staff prepared all of the meals on site and that people can have 'whatever they want'. One member of staff told us, "We get to know what people like, but we

always take the menu's round and ask them; we make sure they know all the options available". On the day of our inspection we saw people had a choice of different meals and that some people had requested a meal that was not on the menu, such as egg and chips, which had been accommodated. People were supported to eat either in their bedrooms or in the dining rooms, which were nicely decorated and the tables were laid, making for an inviting and relaxed atmosphere. Staff provided appropriate levels of support and encouragement to people who required it and offered adapted cutlery and plate guards to promote people's independence. The food was well presented and smelt appetising and people we spoke with told us they enjoyed their meals. One person said, "Lunch was beautiful, compliments to the chef".

We found that people had access to doctors and other health and social care professionals as required. One person said, "They have arranged different appointments with doctors and specialists whilst I have been here". Another person said, "I have been unwell, so they called the GP and I was prescribed antibiotics; I feel much better now". A relative we spoke with said, "She [person] has been assessed by a Psychologist, a Psychiatrist, she has visits from the GP when she needs one". A member of staff we spoke with told us, "Some people may need to be assessed by specialist professions, like if they have difficulty swallowing we will call the professionals to come and assess them and then follow the plan they recommend". On the day of our inspection we saw various health and social care professionals visiting the home including GP's, Social Workers, and District Nurses. Records we looked at confirmed that people were supported to maintain good health and to attend any medical appointments they were sent. We also saw that any health care concerns were followed up in a timely manner with referrals to the relevant services, such as speech and language therapists and dieticians.

Most of the people we spoke with, observations we made and records we looked at showed that staff had the knowledge and skills they required to do their job. One person told us, "They [staff] are very good". A relative we spoke with said, "They [staff] seem to know what they are doing". One member of staff we spoke with said, "The training is good; I had a good induction and worked through the Care Certificate; we do practical training too, like manual handling, when we get to use the different handling belts and hoists which was really good". A third member of staff told us they had difficulty reading and writing and that the support of their colleagues and the varying training methods promoted their learning. During the inspection, we also spoke with the provider's learning and development officer who told us about the different training options available to staff, including online learning, distant learning (using workbooks and DVD's), discussion groups as well as practical teaching sessions. We saw that the acting manager kept a training record which detailed when staff had completed various training as well as when the training had or was due to expire. This meant that the registered manager knew when staff were due any refresher or additional training and ensured that this was facilitated.

Staff we spoke with told us and records we looked at including the Provider Information Return showed that staff received supervision from either the senior staff or the acting manager to discuss any training needs or concerns. This allowed the acting manager to further monitor the effectiveness of the training and how staff were implementing their learning in to practice. We were also told by staff and records showed that the acting manager facilitated regular team meetings to discuss any outstanding training or service-related issues. One member of staff told us, "We have supervisions with the seniors and team meetings; [acting manager's name] is good at keeping on top of these so far and we always see her on the 'shop floor' walking round and monitoring things". The acting manager told us that they felt it was important to spend time on the units with people and staff to see what was going and to identify any issues as well as to support staff and acknowledge good practice.

Requires Improvement

Is the service caring?

Our findings

People, relatives and staff we spoke with, records we looked at and from the observations we made throughout the inspection, showed that the caring aspect of the support people received was dependent upon their location within the home. We found that people on the ground floor had a positive experience and staff appeared to know them well. However, people on the first floor appeared to have little interaction with staff and were under-stimulated within their environment. Staff did not have the time to get to know people or to talk with people about their care, hobbies or interests. One relative said, "The carers are friendly and kind but I am not sure they are familiar with all of her needs". They told us that their relative needed to wear a sling to support their shoulder and that sometimes the staff do not always put it on which made the person's arm and shoulder ache. They said, "I'm not sure if they just forget or I think some of them just don't know to put it on". Another relative said, "The care is ok, but nothing is very consistent. They don't seem to communicate with each other, and so we have to keep reminding them and asking them to do things". They gave an example of having to remind the care staff to add thickener to the person's drink because they were at risk of choking.

We found that some people's personal profiles had very little information about them as a person, their likes, dislikes and preferences. For example, we saw in one person's care file, who had lived at the home for a number of years, that their likes, dislikes, preferences and interests had 'not been expressed due to dementia'. However, it appeared that no attempt had been made to speak with the person's family or friends to elicit this information and staff had not updated the record as they had gotten to know the person whilst they had been living at the home so staff who were less familiar with the person could access this information too.

We also found on the first floor that due to the short-term stay basis of the service that room were un-personalised without any prompts or pictures to spark a conversation to enable staff to interact with people on a personable level. For example, we saw that one person had been admitted to the care home following a stroke and spent a lot of time in bed. They told us that they were 'okay' at the home and carers were kind to them, but only one actually spent time to talk with them. We found that this person had a history of depression, but we did not find a care plan relating to this in their care file and throughout the day, we did not see any member of staff sit with them or spend time with them engaging in any stimulating or meaningful activity. Staff we spoke with told us that there was an activity co-ordinator who visited this person and arranged activities for people living in the home, but throughout the day, we saw the activity co-ordinator mainly spent time on the ground floor, where people were less dependent.

Most people we spoke with told us and we saw that staff treated people with dignity and respect. One person said, "I'm not really bothered about that sort of stuff at my age, but they are respectful; I wash my own private parts!" Another person said, "The staff are very friendly and respect my privacy, they listen to what I want and let me do what I can". A relative we spoke with said, "I have never seen anything untoward; they are very mindful of privacy and dignity". However, some concerns were raised on the first floor about time pressures on staff not allowing them to pay attention to detail and important care needs being overlooked. A relative told us, "We had to complain about mom being told to go to the toilet in her pad if she

was desperate because they were too busy to help her to the toilet. Thankfully this has not happened since". We saw that one person spent a considerable amount of time in a state of undress. Their relatives told us that they had requested on a number of occasions for staff to ensure that this person wore pyjama bottoms and was covered because, "He has always been a proud man and he would be devastated if he thought everyone could see him". Despite requests from family, this person was still left unclothed when we went back to see them later in the day. Staff did not appear to notice this person and we had to ask a member of staff to support him in an attempt to protect his dignity. We have since been told that this was raised as a safeguarding concern and the home had taken appropriate action to ensure this did not happen again.

Nevertheless, most people we spoke with were consistently positive about the caring attitude of the staff. One person we spoke with told us, "The staff are lovely". Another person said, "They [staff] are kind and caring". A third person said, "They [staff] are all lovely, very pleasant". A relative we spoke with told us, "The staff are very friendly and approachable".

During our inspection we saw that staff adapted their communication and interaction skills in accordance to the needs of individual people. For example, one person responded well to humour with staff, whilst another person required reassurance and gentle contact.

Most of the people we spoke with on the ground floor told us that staff spent time talking with people and getting to know people. One person said, "I have been here a long time, so they know me well". Another person said, "Ooohh they play me up rotten [laughed]; it's a good job I know them!". A relative we spoke with told us, "The staff are very good, they seem to know her [person] well, they notice changes quickly; they called me the other day about a mark on her arm". Staff we spoke with on the ground floor were able to tell us about different people's likes and interests. One member of staff said, "[person's name] loves gardening, he used to have an allotment and he was in the paper once for growing the largest cabbage, so we have a vegetable plot outside and he helps us to grow vegetables; but we still haven't managed to grow any big ones!". This corroborated the information shared with us in the Provider Information Return (PIR). People were encouraged to maintain their individuality and we saw that bedrooms on the ground floor were personalised to their preference. One person said, "We can bring what we want in, to make it feel a bit more like home". Another person said, "It's nicely decorated but I brought my own chair, to add a bit of colour!"

We saw that some people were supported to express their individuality and staff were aware of how they could promote equality and diversity within the home. A staff member we spoke with said, "We respect people as individuals and encourage them to make their own choices and decisions as much as possible". We saw that people were referred to by their preferred names, their independence was promoted as much as possible and they were able to express themselves as individuals. People had access to culturally diverse foods and care records detailed peoples spiritual and religious beliefs which were incorporated in their end of life care plans, as reported in the PIR.

Requires Improvement

Is the service responsive?

Our findings

On the day of our inspection we saw some people were engaged in activities that they enjoyed. For example, we saw people going in and out of the garden, watching television, listening to the radio and joining in with a group activity facilitated by the activity co-ordinator. One person told us that they loved reading and that they always had a newspaper to read. Another person said, "She [activity co-ordinator] is very nice, she does as much as she can, she is still learning". A relative we spoke with said, "They asked us if we wanted to join them on a trip out too, which was nice".

However, we found that most of the people on the first floor with more complex care needs were not always supported to engage in stimulating or meaningful activities. One person said, "I spend most of my time in my room and look forward to my family visiting". A relative told us that their loved one spent a lot more time in their bed since moving in to the home and we saw this lady had very little interaction or stimulation during the day. During the inspection, we noticed that the activity co-ordinator spent much of their time on the ground floor engaging with people who appeared less dependent. We spoke with the activity co-ordinator at the time of the inspection and they told us that they had only been in post for a few months and had little experience of the role. They found it difficult to find the time to do group activities as well as spend time with people on an individual basis in their rooms. They also told us that despite their efforts, they found it difficult to identify low level activities for people who were more physically or cognitively impaired and therefore had a tendency to spend time with people who would actively engage in activities that they were confident in facilitating. We discussed their training needs with the acting manager. The acting manager assured us that the activity co-ordinator would be supported to develop their knowledge and skills in their new role and they would support them to develop a person-centred, activity led culture amongst all of the staff within the home, so that all of the people living at the home had access to activities of interest, meaningful interaction and stimulation.

We found that most people and/or their representatives were consulted about their care plans. One person told us, "I was asked a lot of questions when I first came". A relative said, "We can ask to speak to [acting manager's name] if we want to speak about [person's name]'s care". Records we looked at showed that relatives and health care professionals were invited to attend care reviews where appropriate, to ensure that all health and social care needs were reviewed regularly. We also saw that the home used a 'resident of the day' system which meant that on this day, the person identified would have all of their care plans reviewed with a member of staff. However, this was not always an effective system to ensuring people's records were completed and up to date because of the shortfalls we found during the inspection.

Everyone we spoke with and records we looked at showed that the provider asked for feedback on the quality of the service and people were given the opportunity to suggest improvements. One person told us, "We have residents meetings which I go to". A relative said, "We are invited to resident and relatives meetings, we can't always attend but it is good that they ask". We saw that the provider used an electronic system to collate and analysed the feedback and the acting manager had started to identify implement changes on the areas in need of improvement.

Most of the people we spoke with told us they knew how to complain. One person told us, "I know I can speak to [acting manager's name]". Another person said, "We have a new manager, I know who she is, I'd ask to speak to her if I needed to complain". A relative said, "I have complained and luckily I have not had reason to complain since". Another relative told us, "I don't know who the manager is, but I will be speaking with her because it's [the standard of care] not good enough". Another relative said, "I have met the manager she seems very nice, but I am not sure she knows all the issues yet as she is new". We saw that the provider had a complaints procedure in place and the acting manager was familiar with this. They told us that they led an open and honest service and would take all complaints and feedback very seriously. Records we looked at showed that complaints and feedback had been taken seriously and had been acted upon appropriately.

Everyone we spoke with also told us that their friends and relatives were always welcome to visit them and they were able to spend time with people that were important to them. One person said, "My daughters visit me every day, I look forward to seeing them". A relative told us, "There are no restrictions, I can come whenever I like and they [staff] are always friendly and make us feel welcome; we can help ourselves to a drink and they even invited us to stay for lunch once".

Requires Improvement

Is the service well-led?

Our findings

The service was required to have a registered manager in place as part of the conditions of their registration. There was not a registered manager in post at the time of our inspection because the person who was registered to manage the home had recently left to work at another location because they worked for the provider as a 'turn around manager'. However, the provider had appointed a new manager who was in the process of applying for their registration with us.

We were told that following our previous inspection in October 2015, the provider had identified The Orchards as a location that required intensive management support and had allocated it to their 'focussed home' portfolio. This meant that the service received the support from a 'turn around manager' (who was the previous registered manager) and additional, more intensive support from a team of operational managers. However, we were unable to see how any improvements that may have been made since our last inspection, had been sustained. We found that the provider had failed to implement effective quality monitoring systems and processes to enable them to assess and monitor any improvements and/or the sustainability of these, as well as to identify the on-going shortfalls of the service. Whilst we found that the new acting manager had made some attempt to improve the quality assurance systems and processes within the home, the service was still in the very early stages of change and further improvements were required.

We saw that there were systems in place to monitor the quality and safety of the service including audits of medication processes and care records, however these had not always been used effectively to identify the shortfalls found during the inspection and implement improvements. For example, we saw that two members of staff were required to check the medication at the end of each shift. However, this was an ineffective system as multiple errors and concerns were identified during the inspection. We also found that the medicines had been audited in August 2016 by the local pharmacist which informed the service of several issues relating to medicine management. The new manager had also undertaken an audit of the medicines on 10 August 2016, and found that both units had failed to meet the safe standards for medicines. The manager was therefore aware of the issues and agreed that improvements were needed. They had developed an action plan, however on the day of our inspection visit we continued to find significant areas of concern.

We found that there had been a fire risk assessment in March 2016 with an action plan for improvements to be made to enhance the safety of the service, however there was no evidence of the outcome of the action plan. Similarly, we saw that there had been a falls audit in February 2016 and that the action plan was required to be completed by May 2016. There was no evidence of the outcome of this action plan recorded. The new manager had also recently audited the care records. They had identified many of the shortfalls we found during our inspection and there was evidence that this had been communicated with some of the nursing staff during a team meeting. However, we continued to find areas in need of improvement in the record keeping systems and processes within the home which had been an on-going area of concern during previous inspections dating back to 2013 and therefore no improvement or sustainability of improvement was found.

We also found concerns relating to communication within the home. People and relatives we spoke with told us that they were concerned that they had to keep reminding staff about things that were important to them relating to their care needs and that they felt staff did not communicate with each other or information did not get shared or passed on effectively, either verbally or through effective record keeping. We were also told by staff that some of the main issues relating to the medication management systems within the home were due to poor communication.

The quality monitoring processes had also failed to recognise the concerns relating to pressure care, staffing levels, and staff files. Whilst we recognised that the acting manager was trying to implement more effective quality assurance checks since the appointment, the service had historically failed to improve or sustain any improvements to the quality monitoring systems which had ultimately led to the compromise of the safety of the service and the subsequent persistent breaches in regulations. Therefore, we found the service to be in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This breach had arisen before in a number of previous inspections dating back to 2013. You can see what action we have taken at the end of the report.

We found that the local authority clinical commissioning group had also recently assessed the safety and quality of the service and had requested for an action plan to be submitted to identify the ways in which the acting manager intends to improve the quality and safety of the service. We saw that this included some of the concerns we had raised during our inspection, including the need for mental capacity assessments and improved record keeping and care planning around best interest decision making and the deprivation of liberty safeguards processes. It also included actions to improve the care provided to people relating to tissue viability and pressure care, as well as person centred care planning and risk assessments that are specific to people's individual needs. Because the service was found to be rated as 'amber' over all, the clinical commissioning team will re-audit the home to monitor compliance and improvements within three to six months.

Information we hold about the service showed us that the provider had ensured that information that they were legally obliged to tell us had been passed on including the detailed completion of the Provider Information Return. However, not all of the information in the PIR was corroborated during the inspections, due to the shortfalls that we identified. Nevertheless, we found that the provider had acknowledged some areas for development in the PIR demonstrating some awareness of their strengths and limitations.

Staff we spoke with told us they felt supported in their work and that the service promoted an open and honest culture. One member of staff said, "I love my job, I enjoy coming to work; it's a lovely team". Another person told us, "It has been difficult over the years but I am optimistic with [acting manager's name] in post now". Everyone we spoke with confirmed that the acting manager was approachable, open and honest in their leadership style. One person said, "I know who the [acting] manager is, she seems nice and approachable". A member of staff told us, "She [acting manager] is always around, very hands-on, which is good". Another member of staff said, "She [acting manager] is very supportive and honest, she will tell you as it is, but always for the good of the residents; like the staffing levels, she tries her best to get us five [members of staff on a shift]".

Duty of Candour is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. People we spoke with, records we looked and observations we made showed that the acting manager was compliant with this requirement. We found them to be open in their communication with us throughout the inspection, and information we asked for, was provided to us.

Staff we spoke with were aware of the service having a whistle-blowing policy. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about risks to people's safety, malpractice or illegality without the fear of workplace reprisal. They may consider raising a whistle-blowing concern if they do not feel confident that the management of their organisation will deal with their concern properly, or when they have already raised a concern but the problem within the organisation or with the provider has not been resolved. One member of staff told us, "If I had any concerns I would go straight to [acting manager's name] but if I didn't think it was being dealt with I would report it myself using the whistle-blowing number, I know we can call anonymously if we want to". Information we hold about the provider showed that we had not received any whistle-blowing concerns recently and the provider assured us that no concerns had been raised with them directly.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive the care or treatment they needed, when they required it and people did not always receive their medicines as prescribed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The quality assurance systems in place were not always used effectively to identify the shortfalls found during the inspection and any improvements that had been made since our last inspection had not been sustained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People did not always received the care they required because staff were not always deployed effectively.