The Orchard Care Home Limited

# The Orchard Care Home

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
The Orchard Care Home is a residential care home providing personal nursing care to 5 at the time of the inspection. The service can support up to 6 people.

People's experience of using this service and what we found
Right Support:
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People were not always supported to take their medicines in a safe way. People were not always supported by staff trained to meet their needs.

Right Care:
Poor risk management meant people were not always safe. Staff understood they had a responsibility to protect people from abuse but systems and processes in places meant incidents were not recorded or investigated appropriately. Staff were caring, people told us they were happy with the support they received from staff.

Right Culture:
Governance and management at the service was not effective which placed people at risk of living in an unsafe environment. The culture of the service was not always empowering or dignified for autistic people or people with a learning disability.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 19 April 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

At our last inspection we recommended that the provider reviewed the culture and routines within the home to ensure they were supporting people in line with current guidance. At this inspection we found they had

not made improvements.

Why we inspected
We received concerns in relation to the culture and management within the home. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection. You can see what action we have asked the provider to take at the end of this full report. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Orchard Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to risk management, consent, staff training, culture and governance at this inspection. Please see the action we have told the provider to take at the end of this report.

Since the last inspection we recognised that the provider had failed to appoint a registered manager. This was a breach of regulation. Full information about CQC's regulatory response to this is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Inadequate

The service was not safe.

Details are in our safe findings below.

**Is the service effective?**

Inadequate

The service was not effective.

Details are in our effective findings below.

**Is the service well-led?**

Inadequate

The service was not well-led.

Details are in our well-led findings below.

# The Orchard Care Home

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 2 inspectors.

Service and service type
The Orchard Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Orchard Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 13 June 2023 and ended on 21 June 2023. We visited the service on 13 June 2023.

What we did before the inspection

We reviewed information we have received about the service since the last inspection. We sought feedback from the local authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used this information to plan our inspection.

During the inspection
We spoke with 2 people who were living at the home and observed interactions between people and staff. We spoke with 3 relatives of people living at the home. We sought feedback from 3 staff members. We spoke with the manager of the home. We reviewed 2 care plans and associated records. We reviewed medicines and medicine records. We looked at documentation related to running of the home, such as policies, audits and training data.

Inadequate

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks were not identified, assessed and monitored adequately in order to keep people safe. Staff were not provided with enough guidance on how to manage risks or support people with identified risks.
- We found significant concerns around the monitoring and management of water systems. This included a lack of regular checks and actions to reduce the risk of legionnaires (a serious water-based disease). Water temperature checks were not being carried out on showers; these were found to be over the recommended safe temperature placing people at risk of scalds.
- Where people had specific health conditions, we found there to be a lack of guidance for staff on how to support people with the risks associated with some of these.
- Whilst some environmental risks had been assessed and were being managed, we found some had not. For example, there were no window restrictors on the ground floor and this had not been risk assessed.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- People were supported by an adequate level of staffing on each shift to meet their needs. However, we had concerns regarding the training and skills of the staff supporting them, particularly at nights.
- According to the information from the provider, staff on nights had not been given the appropriate training to fulfil their roles and therefore there was no evidence they had the skills to keep people safe. For example, not all staff had medicine training and training specific to people's medical and wellbeing needs.

The provider failed to ensure they deployed suitably trained staff to keep people safe. This placed people at increased risk of harm and not receiving the correct support. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had been recruited safely; relevant pre-employment checks had been carried out. Including checks with the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely

- People were not always supported with their medicines in a safe way.
- We found staff had been supporting a person to chew their medicines. There was no evidence an

appropriate healthcare professional had been consulted to ensure this was safe way for the person to take their medicine.
● We were unable to review guidance around medicines which were administered as and when required (PRN). This is because protocols that had been in place were unavailable due to having been identified by the local authority as not adequate.
● We were concerned over the storage of insulin, which was being kept in a locked cabinet within the communal kitchen fridge. Best practice guides providers to avoid this where possible.

The provider failed to ensure the safe administration and management of medicines. This placed people at risk of harm. This was a breach of regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● There was a lack of systems and processes in place around potential safeguarding concerns and incidents.
● We found examples of incidents that had occurred with no evidence they had been logged, investigated, reported to the relevant bodies or any lessons learnt or shared.
● Not all staff had completed safeguarding training to enable them to be aware of their duty and responsibilities when it came to safeguarding people in their care.
● People and their relatives felt staff kept them safe. A person told us, "Staff always make me safe. They are good to me." A relative said, "I know my [relative] is in safe hands."

Preventing and controlling infection

At our last inspection the provider had failed to do all that was practicable to reduce the risk of infection. This was a breach of regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider no longer in breach regarding the risk of infection but as reported above remained in breach of regulation 12.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively pre-vented or managed.
● The provider's infection prevention and control policy did not reflect current government guidance.

Visiting in care homes
● People were supported to have visitors in line with current government guidance. Relatives we spoke with told us they were able to visit when they wished.

Inadequate

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance

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 MCA 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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At the last inspection we recommended the provider ensure all staff had completed relevant training and all decisions that are being made on behalf of someone are being assessed and documented in line with legislation. The provider had not made enough improvement.

- The home was not working within the principles of the MCA.
- Mental capacity assessments and best interest decisions were either poorly completed, not decision specific or they were missing altogether.
- Where mental capacity assessments had been carried out, people were deemed to be lacking in capacity despite it being documented they had a good level of comprehension around some decisions. People were not always given the opportunity to make their own decisions.
- Where decisions had been in people's best interest, it was not documented who had been involved in the decision-making process beyond the care home staff. This meant the decision may not actually have been in the person's best interest.
- The manager was unable to tell inspectors who had legal authorisation in place to be deprived of their

liberty. We found an authorisation for one person that had expired.
● Whilst training completion on Mental Capacity Act for staff had improved, nearly half of staff still had not completed it.

The provider failed to ensure they were working within the principles of the Mental Capacity Act and failed to ensure the correct legal authorisations and documentation was in place. This placed people at risk of being supported without consent. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● As described in the Safe section of this report, staff were not all provided with the relevant training to develop their skills to meet the needs of people living at the home.
● Staff had not all completed training in learning disabilities or autism, which is now a legal requirement for services supporting people living with learning disabilities.

The provider failed to ensure their staff received appropriate training. This was a breach of regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they felt supported and had received a good induction. A staff member said, "I feel supported within my role as a support worker because I feel that I am listened to and if there is anything I don't know or understand I can always count on the management team now to guide me."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

At our last inspection we recommended the provider reviewed the culture and routines within the home and ensure they were in individual people's best interests and were meeting current guidance and principles for supporting people with learning disabilities. The provider had made some changes however we recommend they continue to make improvements.

● Care was not being delivered in line with the Right Support, Right Care, Right Culture guidance.
● People demonstrated a good level of understanding around some specific decisions, however the home decided to make decisions that went against the persons wishes. This was not the least restrictive approach, nor did this promote what people were able to do for themselves.
● The home supported some people through the use of reward and behaviour charts. The use of these implicitly implied if a person did not act in a certain way there would be a punitive outcome. It is an undignified approach to use with adults. There was no evidence to demonstrate whether any healthcare professionals had been involved in this approach, whether the people consented to it. People did not have any best interest documentation relating to the decision to take this approach.
● People did have care plans in place that documented their preferences with reference to their protected characteristics. For example, their sexuality and spirituality.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● As described in the safe section of this report we had serious concerns around guidance for staff and training around people's healthcare conditions, such as diabetes.
● The home worked with the GP surgery and people had a ward round fortnightly with a nurse practitioner.
● People's care records showed evidence of a wide range of professional healthcare input, such as chiropodist, dentists and opticians.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported with their eating and drinking needs.
- Staff supported people to stay hydrated, particularly in hot weather. Where required, staff recorded people's fluid intake to monitor their risk of dehydration.
- People were offered a choice of meals and were able to ask for different options. We observed staff offering snacks, such as ice lollies, throughout the day.

Adapting service, design, decoration to meet people's needs

- People were able to personalise their rooms how they wished.
- People had access to a garden, which also had a log cabin which was being used as a bar and an area for activities.l

Inadequate

# Is the service well-led?

## Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider failed to ensure effective systems and processes were in place to assure themselves of the quality of service and care being provided. This was a breach of regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● As described in the Safe and Effective sections of this report we identified a number of serious concerns around risk management, medicines, consent and training. These had not been found by the providers quality assurance or auditing processes.
● Audits were minimal and ineffective to assure safe care delivery and environmental safety.
● There had been a lot of changes in management since the last inspection. The current manager had been in the role for 6 months; however they were still not fully aware of their roles and responsibilities. For example, they were not aware of who had a DoLs authorisation in place.
● A lack of good governance and effective management meant there was no evidence of learning. Incidents had not been logged or investigated adequately to explore where improvements could be made.
● The provider had not acted on recommendations made at our last inspection to make necessary improvements to ensure they were meeting regulations and best practice guidance.

The provider failed to ensure effective systems and processes were in place to assure them-selves of the quality of service and care being provided. This was a continued breach of regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● As described in the Effective section of this report we had concerns about the culture of the service.
● Outcomes for people did not reflect the principles and values of Right Support, Right Care, Right Culture. For example, people were not encouraged to have maximum choice and control over their support.
● People were not always supported in an empowering way to enable them have choice and be supported

in a dignified way.
● Feedback was not sought from people, relatives, staff or professionals that worked with the service in a formalised way. For example, no quality assurance tools such as surveys or questionnaires had been utilised.

The provider failed to ensure effective systems and processes were in place to assure them-selves of the quality of service and care being provided. This was a breach of regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives fed back to us they were happy with the care and were invited to be involved in care plan reviews annually.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others
● People's relatives told us the provider communicated with them well and were kept informed.
● A relative said, "I regularly check in and they ring me to let me know anything that needs to be known."
● Due to the poor record keeping around incidents it is not known whether the provider was informing the relevant agencies when required.

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider failed to ensure they were working within the principles of the Mental Capacity Act and failed to ensure the correct legal authorisations and documentation was in place. This placed people at risk of being supported without consent. |

**The enforcement action we took:**

We issued a Warning Notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. |

**The enforcement action we took:**

We issued a Warning Notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service.<br><br>The provider failed to ensure the safe administration and management of medicines.<br><br>This placed people at risk of harm. |

**The enforcement action we took:**

We issued an Urgent Notice of Decision

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider failed to ensure effective systems and processes were in place to assure themselves of the quality of service and care being provided.<br><br>The provider failed to ensure effective systems and processes were in place to assure themselves of the quality of service and care being provided. |

**The enforcement action we took:**

We issued a Warning Notice

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider failed to ensure they deployed suitably trained staff to keep people safe. This placed people at increased risk of harm and not receiving the correct support. |

**The enforcement action we took:**

We issue a Warning Notice