Broadoak Group of Care Homes

Orchard House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 8 and 9 February 2016. The first day of our inspection was unannounced. We told the provider that we would be returning for a second day.

Orchard House is a single storey purpose built care home located in Market Bosworth. The home provides accommodation for up to 30 older people who require assistance due to their age or people living with dementia or physical disabilities. There were 27 people using the service on the two days of our inspection.

There was a registered manager who was responsible for the service but at the time of our inspection they had not been away from the service for 10 months. 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. An acting manager was overseeing the day to day running of the service was in the process of submitting their application to become the registered manager.

At our last inspection of the service in November 2014 the service were in breach of one regulation, people were not always treated with consideration and respect. The provider sent us an action plan that detailed how they were going to improve this and we found that the provider had taken action to address this.

People felt safe at the service and staff had a good understanding of how to identify and report any concerns. Staff had not always taken appropriate action when people had sustained injuries and systems were not in place to ensure that staff responded immediately to any allegations or evidence of abuse. Where people had sustained injuries there was no investigation into how these had occurred.

Environmental risk assessments had been carried out but appropriate action to reduce identified risks had not always been carried out. This put people at the service at risk. Risks relating to people's care and support had not always been appropriately assessed.

There were some processes in place to ensure that people medicines were managed safely however some improvements were needed to ensure that people consistently received their medicines correctly and when they needed them.

People's capacity in relation to their care had been considered but information was not decision specific and therefore did not fully meet the requirements of the Mental Capacity Act (MCA) 2005 legislation.

People were provided with a balanced diet and varied diet. People were provided with appropriate assistance to eat their meals.

People had access to appropriate healthcare services. However, advice relating to people's healthcare was

not always acted upon without delay and shared with staff members effectively.

People told us that staff treated them with dignity and respect. Staff had a good understanding of people's likes, dislikes and preferences. Staff's detailed knowledge of people's preferences sometimes led to people not being provided with choices throughout the day.

People were involved in making day to day decisions about their care and support. People did not always receive person centred care that was responsive to their needs. Activity sessions were available but they did not reflect people's individual hobbies and interests.

People and their relatives told us that they felt able to raise any complaints. There were missed opportunities for the service to benefit from information within complaints that had been received.

Staff spoke highly of the manager. People and relatives told us that they were able to speak with the manager if they needed to.

Environmental audits had been carried out but these had failed to identify the environmental issues that we found. The provider had failed to ensure that actions put in place to improve their service had been carried out. The service had failed to act on the feedback provided to them to improve the environment for people that lived there.

We identified that the provider was in breach of three of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were not consistently protected from environmental risks at the service.

There had not always been an appropriate investigation to establish how people had received injuries. People had not always received appropriate care and treatment to safeguard them from harm.

Staff received an induction. There were some processes in place to ensure that people medicines were managed safely however some improvements were needed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider could not be sure that all staff members had received adequate training to enable them to meet people's needs.

People's capacity relating to their care had been considered but mental capacity assessments were not decision specific.

People had access to appropriate healthcare services. However, advice relating to people's healthcare was not always acted upon without any delay and shared effectively.

Is the service caring?

Good

The service was caring.

Staff respected people's privacy and dignity.

People were involved in making day to day decisions about their care and support.

Staff had a good understanding of people's likes, dislikes and preferences.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had not always contributed to an assessment of their needs. People did not always receive person centred care.

Activities sessions were available but they did not reflect people's individual hobbies and interests.

Complaints were not always responded to effectively or used as a learning opportunity.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People and staff spoke highly of the manager. Staff felt assured that anything they raised would be addressed.

Audits had failed to identify environmental risks to people using the service.

The service held meetings with people and their relatives to obtain feedback about the service provided. Feedback had not always been acted upon to improve the service.

Orchard House

Detailed findings

Background to this inspection

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

This inspection took place on 8 and 9 February 2016. The first day of the inspection was unannounced. We told the provider that we would be returning for a second day.

The inspection was carried out by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of caring for someone who used this type of service.

We looked at and reviewed the provider's information return. This is information we asked the provider to send us about how they are meeting the requirements of the five key questions. We reviewed notifications that we had received from the provider. A notification is information about important events which the service is required to send us by law. We contacted the local authority and who had funding responsibility for people who were using the service. We looked at information that we had received about the service and used this to inform our inspection planning. We spoke with a healthcare professional who was visiting the service on the day of our inspection.

We spoke with 13 people that used the service and relatives of people that used the service. We spoke with the acting manager, four care staff members, a domestic staff member and the cook on duty.

We observed the care that was being provided. We reviewed the records of 14 people that used the service. We looked at the incident and accident forms that had been completed for the past two months. We looked at documentation about how the service was managed. This included policies and procedures, four staff records and records associated with quality assurance processes.

Requires Improvement

Is the service safe?

Our findings

People were not consistently protected from environmental risks at the service. We looked around the general environment at the service and we identified some concerns. We found that four radiators in communal areas were not protected in any way. These were painfully hot to touch and within communal bathrooms where there was high risk that people's skin may come into contact with them. There was also as a risk that people may fall against them and be unable to either summons help or move away from them.

We found a risk assessment relating to the uncovered radiators at the service. It detailed that uncovered radiators were a high risk to people that used the service and that the action would be to put radiator covers in place. We saw that the risk assessment had been reviewed annually. The service had failed to mitigate identified risks that could have had an impact on people's health, safety and wellbeing. This was of greater concern as a person that used the service had actually experienced a burn that required medical attention from a radiator at the service approximately two years ago.

We found that in one of the communal toilets, that people at the service used, the toilet frame around the toilet which people used to assist them to sit down and stand up was unsecure. This meant that there was a risk that when people went to use the frame to support them there was a risk that it would move causing them to become unsteady and possibly fall.

We found that there was scale on showerheads and taps. We asked about the descaling and checking of them. We were told that water temperature checks were carried out but the descaling of the showerheads was going to be carried out by the domestic staff. We discussed this with a member of domestic staff who told us that this was something that they were going to be carrying out from the following week. This was a concern as the legionella risk assessment in place detailed that on a quarterly basis showerheads and hoses should be dismantled, cleaned and descaled. This had not been taking place. Legionella bacteria are commonly found in water. Health and Safety Executive guidance states that health and social care providers should carry out a full risk assessment of their hot and cold water systems and ensure adequate measures are in place to control the risks. This was not taking place and so people were not sufficiently protected from the risks of developing Legionnaires' disease of which the elderly are at a higher risk.

We found that one person who had recently moved into the service had a history of falls. There had been no risk assessments carried out in relation to this persons care. We saw that this person had experienced a fall during their time at the service but still no risk assessments relating to their care had been carried out.

We found that for another person who was staying at the service for a short period of time there was also no assessments of any risks relating to their care. This person had sustained fractures to both hips as a result of previous falls and yet there was no risk assessment carried out to reduce the risks relating to their health, safety and wellbeing.

During the early morning period people were left unaccompanied in the lounge area. People who were at risk of falls attempted to stand up and walk without any staff supervision. We observed one person who was

identified at high risk of falls and should walk with staff supervision. They got up to try and help two other people to reach to put their drinks down. An inspector had to intervene as there were no staff present. A short while later this person got up again to assist another person who needed a tissue, an inspector pulled the call bell to get staff to come and assist.

These issues constituted a breach of Regulation 12 (1) (2) (a) (b) & (d): Safe care and treatment. Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3).

We arrived at the service at 5.30am and we found that four people were up the lounge area, three of them were fully dressed but fast asleep. Two of the people were seated in wheelchairs and unable to move themselves. We spoke with these people, one of whom told us "I like to get up at about 7 -7.30am." We discussed this with the staff on duty, one of whom told us, "We get the doubles [meaning people that need two staff to assist them] up first as they are put to bed first." They told us that they got all six of the people that required two staff to get up before the day staff started their shift to help day staff out. We referred these concerns through to the local safeguarding authority.

We found two people at the service that had bruising on their hands. One of them also had scabs on their shin. We asked the acting manager about this. They were unsure how these had occurred and had not taken any action to investigate them. These injuries had not been recognised as potential signs of rough handling or inappropriate care. Effective systems were not in place to immediately respond to any allegations or evidence of abuse. We referred these concerns through to the local safeguarding authority who have opened safeguarding investigations into them.

We found that one person had fallen out of bed and sustained a carpet burn to their head. Staff were not medically trained and had assisted this person back into bed without seeking any medical attention although this was a head injury. Five hours later the staff sought further medical advice as the person's forehead had swollen and they had bruising to their cheekbones. Following a call to 111 the paramedics arrived and the person was taken to hospital. We reported this to the local safeguarding authority who have opened a safeguarding investigation to look into the concerns.

These matters were a breach of Regulation 13: Safeguarding service users from abuse and improper treatment. Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3)

People told us that they generally felt that there were enough staff to meet their needs although there were times when they needed more care staff on shift. People told us that they didn't have to wait for staff to respond if they needed them. One person told us, "When I press the buzzer it is attended to." Another person told us, "I am very fussy about cleaning, and it's been going down a bit because of staff, they can do with more staff, although they look after me." Throughout our inspections we saw that the majority of the time there were staff available to meet people's needs. However, we did find that while staff were assisting people to get up during the morning time people were left in a communal area of service without any staff present and this put some people at risk.

We discussed staffing levels with the acting manager who told us that the staffing levels had always been as they were. They told us that they ensured that they had staff on each shift with a mix of skills, qualifications and experience but in relation to the actual staffing levels this was just how it had always been. We discussed this with the acting manager and explained that they may wish to look at people's dependency needs to assess if they had the right staffing levels in place.

We looked at the recruitment files of four staff that worked at the service. We found that the staff had

received and induction at the service and that pre-employment checks had been carried out. However for one staff member these had not been completed before they started work. We discussed this with the acting manager who advised that they ensure that this would not happen again.

People told us that they received their medicines when they needed them. One relative told us, "The staff always make sure [my relative] has their medicines." We looked at the processes in place to support the safe management of medicines at the service. We found that photographs of people were not always in place with their medication administration record (MAR) charts but any known allergies that people had were recorded. We saw MAR charts clearly showed where medicines had been stopped by a GP. Where short courses of a medicine had been prescribed these were recorded appropriately and the amount of signatures of administration matched the amount of tablets supplied. There were appropriate measures in place to ensure that controlled drugs were kept and administered safely.

However where medicines were prescribed 'as directed when required', protocols were not in place to advise staff when and why these should be administered. Where variable dose medication was prescribed, for example, 'take one or two tablets twice a day' a protocol was not in place to advise staff how many tablets should be administered and why. Variable doses were not recorded on the MAR charts when staff administered them. This was a concern as staff would not be able to identify how much of a medicine a person had taken. We also found that where people had eye drops administered by staff there was no guidance in place to advise staff which eye they needed to be administered in. Staff had received training to support them to administer safely but there were no competency checks carried out to ensure that staff used safe practice. We discussed this with the acting manager who advised us that this was something they were going to introduce and showed us a form that they intended to introduce.

Requires Improvement

Is the service effective?

Our findings

People and relatives told us that the care staff had the skills and knowledge to meet people's needs. A relative told us, "They [the staff] understand [my relatives] needs and they know how to care for her." Another relative told us, "They are all really good, they know that need to encourage [my relative] to walk and they do just that."

Staff members told us that they had the right training and information to enable them to meet people's needs. One staff member told us, "I'm really quite happy with the training that we've had." Another staff member told us, "I have done quite a lot of distance learning, where we have workbooks to complete. I would like some training around end of life care, but the [acting] manager is looking into this for us." We looked at the staff training records of four staff members. We found that three staff members had completed training sessions within the last 12 months to provide them with skills and knowledge to meet people's needs but for one staff member we saw no records of any training other than an induction. This staff member had been employed by the service for five months and this was a concern as they were one of only two staff working overnight. This meant that they used equipment to assist people to move and the service had not ensured that they had provided them with adequate training to do this. We discussed this with the acting manager who advised us that the care worker had received training in their previous employment and that they were going to attend the next available training sessions. We saw that these were booked within the next two months following our inspection. However, the provider could not be sure that they had provided all staff with the necessary training to enable them to meet people's needs. Staff members also told us that they received regular supervisions and an annual appraisal. Records that we saw confirmed this. However the manager did not receive any formal supervision from the provider.

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 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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found that the service had considered people's capacity within assessments of their needs however these had not been done on a decision specific basis as is required by the MCA. We discussed this with the manager of the service who had an understanding of the requirements and showed us some new MCA assessment forms that were decision specific that they were beginning to implement.

The manager had identified that there were some restrictions in place relating to people's care and

freedom. They had followed the correct procedure and submitted an application to the 'Supervisory Body' for authority to have these restrictions in place. We saw that for one person this had been authorised and the service were still waiting for a response in relation to the others.

People told us that they were provided with plenty to eat and drink. One person told us, "The food is alright, and there is a choice. At breakfast we have cereals, porridge and at lunch there are two choices. The teas are good as the sandwiches and I have toasties." Relatives of people that we spoke with told us that the food was of a good standard. We saw that the majority of people ate their main meal in the dining room and sat on small tables of their choice. We saw that where people required liquidised meals these were provided and that people were supported with assistance to eat if they needed it.

Menus were produced on a four weekly cycle and the provided a varied and balanced diet. We saw that people were provided with choices of meals however these were done so verbally rather that in a pictorial format which some people may have benefitted from. We spoke with the cook who told us that there were always alternatives available if people did not like any of the options and that they provided two options at teatime and were able to have a cooked breakfast twice a week.

We saw the latest Environmental Health Inspection Report that had been carried out in September 2015. On the report it was recorded that fridge temperatures should be kept below eight degrees. We saw that all three of the kitchen fridges were recording temperatures of eight degrees. We discussed this with the cook and acting manager who told us that they were awaiting delivery of a new fridge that was due to arrive any day.

People told us that they were supported to access healthcare services when and if they needed them. One person told us, "Healthcare professionals are called if and when needed." Another person told us, "I only have to ask and I can see the doctor." The service had a weekly visit from their local GP to discuss as required people's healthcare needs. The acting manager told us that outside of the weekly GP visit they were able to contact the GP if required. A relative of a person told us that they knew the service had updated their care plan following a change in their health needs.
A visiting health professional told us, "I have no concerns, patients seem fine. Any concerns do seem to be addressed. I've had no comments or complaints from the patients."

However, on the first day of our inspection we found one person that had lost 3.8kg (6%) of their body weight within the period of a month. We discussed this with the acting manager who told us they would ask the GP to review them during the surgery that day. The GP requested that the service implement food and fluid charts and contact them the following week with another weight record. On the second day of our inspection we found that food and fluid charts had not been put in place for this person and there was nothing recorded in staff handover notes to make staff aware of this advice.

When Orchard House was first built it was to a purpose built design. The current décor, signage and lighting had not kept pace with the latest research about providing an environment that promoted stimulation and independence for people with dementia. Access to the garden was through an alarmed fire escape door which meant that access to the garden was not straightforward for people. At our last inspection we made a recommendation that the that the service found out more about adapting signs and decoration based on current best practice, in relation to the specialist needs of people living with dementia. We identified that the service had made some improvements by using pictorial signage in places and by introducing a pictorial activities board in the dining area. There was still room for further development in this area.

Good

Is the service caring?

Our findings

At our last inspection of the service in November 2014 we found that the service was in breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as people were not always treated with consideration and respect. This corresponds to Regulation 10 of the Health and Social Care (Regulated Activities) Regulations 2014.

During this inspection we found that people were treated with dignity and respect. People told us that staff treated them with dignity and respect. One person told us, "They do respect my privacy and dignity, I feel there is someone looking after me and I have a private room." A relative told us, "They [the staff] have been brilliant with [my relative] they are always friendly and they understand her." Another relative told us, "The care is definitely there with the staff, they are always pleasant." We saw that staff spoke to people with respect while they assisted them with daily tasks. For example, we saw that staff who assisted people to eat discreetly wiped people's mouths if they needed them to. We saw that staff referred to people by their preferred names and responded appropriately to people's needs. We saw that one person spilt a drink on their clothing and as soon as staff were aware they assisted the person to their bedroom to change. We also observed that when staff assisted people to the toilet they waited outside the door to provide people with privacy while they used the facilities.

People told us that they were involved in day to day decisions about their care and that they were listened to. One person told us, "In the morning they [the staff] wash and dress me and listen to me." Another person told us, "All I have seen is well looked after, and I have a choice in getting out of bed." Where people were able to express their own opinions they were involved in day to day decisions about their care. A relative told us, "The day staff are very helpful." They were unable to comment about the night staff because of the times of their visits.

Staff that we spoke with had a good understanding of people's likes, dislikes and preferences. For example they told us how one person preferred to have their meals in their bedroom. We confirmed with the person that this was the case. Staff's detailed knowledge of people's preferences sometimes led to people not being provided with choices throughout the day. For example, we saw that people's juices were poured out before they sat at the table to eat their meals and their preferred seating places were sometimes taken for granted. We found that information in people's care plans about their likes, dislikes and preferences was limited.

People's religious beliefs were taken into consideration. We saw that people's religions were recorded in their care plans and information about how these could be met. For example, one person received communion on a weekly basis as this was important to them.

Relatives told us that they were able to visit at any time but the service preferred them not to visit over mealtimes. We discussed this with the manager who told us that this was a preference to enable staff to focus on providing support to people who needed it however, if people wanted to stay over mealtimes then this was not a problem. People and relatives that we spoke with were happy with arrangement.

Requires Improvement

Is the service responsive?

Our findings

People told us that staff listened to them, however we were concerned as we found that people were told that the dining room was not open until 8am and that they were not allowed into the dining room before that time although one person had said four times that they were hungry. We were also concerned about the times that people were being assisted to get up. For example one person who was up fully dressed and in the lounge area when we arrived at the service at 5:30am told us that they liked to get up between 7am and 7:30am. These people had not received person centred care that was responsive to their needs.

Two people that had recently started to use the service did not have care plans in place. The acting manager told us that this was something that she was working on. However, at the time of our visit these people had not contributed towards their care plans. One of these people told us, "It is a bit of a shock as I am in a new environment. I have been moved in [amount of weeks ago], but nothing had been explained to me. They did speak to my daughter."

We saw that some people care plans included information about the times they liked to get up and go to bed and how frequently they liked to have showers. However this was not consistent, people's care plans did not always provided sufficient details to enable staff to meet people's needs. We discussed this with the acting manager who advised us that reviewing people's care plans was an ongoing process and she would ensure that people and their relatives where appropriate contributed to them.

People told us that some activities took place. There was a pictorial activities board available on display in the dining area that provided details of the activities on offer. During the first day of our inspection the morning session was advertised as a `Chinese New Year' event. We spoke to staff about this who advised us that they had been speaking to people using the service about Chinese New Year. We saw that music was played and people were provided with instruments to play if they wished to join in. This was not an activity that had been specifically chosen by people that used the service.

Activities that were available included sessions that were relevant to the time of the year, such as Shrove Tuesday (pancake day) and Valentine's Day but they did not reflect people's individual's hobbies and interests. People had not contributed to decisions about the types of activities that took place.

People and their relatives told us that they felt able to raise any complaints. One person told us, "I know where to complain, but do not know the manager's name but I know the faces." A relative told us, "I've no complaints but if I did I'd feel comfortable speaking with the manager." We saw that the complaints policy was on display with the service but it required updating to ensure that it included relevant details about external organisations and where people could refer their complaints to if they were not satisfied with the providers response.

We received mixed feedback from relatives about how their comments and complaints had been responded to. One relative told us that they had made a complaint and they were satisfied with the provider's response. Another relative told us, "Complaints are not effectively dealt with." We explored this with the acting

manager who told us that complaints were generally dealt with by the provider and so they were not always aware of information that had been received. This was a missed opportunity for them to use the information to further develop the service. We were also contacted by a relative of a person that had used the service and told that they had written to the providers head office in November 2015 to raise concerns but they had not received a response. We discussed these issues with the provider who assured us that they valued all information that they received about the service but acknowledged that there was sometimes a delay in them providing an official response. The provider told us that this was something they would address.

Requires Improvement

Is the service well-led?

Our findings

We saw that environmental audits were carried out but these had failed to identify the environmental issues that we found. These audits were not effective at assessing and monitoring the environmental risks to people's health and safety. They had failed to identify that people that used the communal toilet were being put at risk because of the loose toilet frame. They had failed to identify that there were radiators within communal areas of the service that were loose. They had failed to identify that there were painfully hot to touch radiators in communal bathrooms where people were likely to have exposed skin.

The action plan provided to CQC following the last inspection in November 2014 detailed that unannounced spot checks on night staff would be carried out and continued on a regular basis to ensure that night staff were respecting people's privacy and dignity. We saw that two of these checks had been carried out since this time. We discussed this with the acting manager who advised that more than checks than this had been carried out but they were unable to provide us with any documentation. The provider had failed to ensure that actions put in place to improve their service had been carried out.

Audits of incidents and accidents had failed to identify that appropriate action had not always been taken as a result. We discussed an incident with the acting manager who confirmed that staff had failed to follow the correct procedure. They told us that they had discussed this with staff but the incident form had been completed to show that staff had followed the correct procedure. We found records relating to another incident at the service where a person had experienced a fall and a few days later complained of pain. There had been no link made between the fall and the pain. The service had failed to identify that fall could have had an impact on the person's wellbeing.

Residents and relatives meetings were held every few months. Relatives that we spoke with and minutes that we saw confirmed this. These were used as an opportunity to share information and for people to provide feedback about the service they received. We saw from the minutes of a residents meeting that people had requested for a total of four bedroom windows to be replaced at a meeting nine months prior to our inspection. Windows had been replaced in several areas of the service but not in the rooms identified. These windows were showing signs of wear and rot. The service had failed to act on the feedback provided to them to improve the environment for people that lived there. We discussed this with the provider and showed them the windows. They advised us that they were unaware of this and would ensure that the windows were replaced.

These issues constituted a breach of Regulation 17 (1) (2) (b) & (e): Good Governance Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3).

People and relatives that we spoke with told us that they were able to speak with the manager if they needed to. One relative told us, "The manager is very approachable." Another relative told us, "I can always speak with [the manager] and she sorts things out."

Staff spoke highly of the acting manager. They told us that they were supportive and approachable. One

staff member told us, "[The manager] is approachable and she listens to you, you can always talk to her about anything, sometimes you might think that she's not addressed it but she has." Another staff member told us, "[The manager] is very good at what she does."

All of the staff members that we spoke with shared an understanding of the services values. They had a consistent vision of what the service was trying to achieve. There was a registered manager who was responsible for the service, but at the time of our inspection they had been away for 10 months managing another service run by the provider. There were no immediate plans for them to return to Orchard House. This had not been reported appropriately to CQC. The acting manager was aware of the responsibilities of their role and at the time of our inspection they had started the application process to become the registered manager of the service. The manager told us that although they received no formal supervision from the provider the provider did visit the service twice a week and they were available for them to talk to at any time.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had failed to adequately assess risks relating to the health and safety of service users. The service had failed to do all that is reasonably practicable to mitigate identified risks. Regulation 12 (1) (2) (a) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service had failed to protect people from abuse and improper treatment as systems and processes were not established for staff to investigate immediately upon becoming aware of any allegation or evidence of abuse. Regulation 13 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established and operated effectively to assess, monitor and

mitigate risks relating to people's health, safety and well being. The service had failed to act on feedback provided to improve the service and follow their own action plan to improve the service. Regulation 17 (1) (2) (b), (e) and (f).