The Orders Of St. John Care Trust

OSJCT Orchard House

Inspection report

Woodmans Way
Bishops Cleeve
Cheltenham
Gloucestershire
GL52 8DP

Tel: 01242672028
Website: www.osjct.co.uk

Date of inspection visit:
05 March 2017
06 March 2017

Date of publication:
27 April 2017

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 5 and 6 March 2017 and was unannounced. Orchard House provides accommodation for 50 people who require nursing and personal care. 47 people were living in the home at the time of our inspection. Orchard House is a large care home set over two floors. The home has two lounges, large dining room and small conservatory. The home also has hairdressing facilities on site.

There was no registered manager in place as required by their conditions of registration, however an acting manager was in position. 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. However a new manager had been appointed by the provider and would be applying to be registered with CQC immediately.

People and their relatives were mainly positive about the care they received. We observed the relationships between staff and people receiving support demonstrated dignity and respect at all times. Staff knew, understand and respond to each person's needs in a caring and compassionate way. However, whist we found most people's risks were mainly managed well, some people's risks
were not always being monitored in accordance to their needs. People and staff felt that the staffing levels had not always been consistent and there had been a high use of agency staff which had impacted on people's well-being. However we were assured that the home was actively recruiting permanent staff.

People received their prescribed oral medicines as required; however some people did not always have their creams applied as recommended. The safe management of sharps was not in line with current guidance.

The home was generally well maintained and clean; however the cleanliness of some areas had not always been upheld. We were told the level and deployment of housekeepers was being reviewed.

Safe recruitment practices were being used to employ new staff. Staff told us they felt trained to carry out their role; however we received mixed comments about the level of support they received. Not all new staff had received probation meetings at the start of their employment to ensure they were competent to carry out their role. The background and qualifications of agency staff had not always been checked and verified before they provided care in the home.

Staff were responsive to people's needs. People's care plans provided them with the guidance they needed to support people according to their needs and choice. Not everyone one received meaningful activities and social engagement, however an activities coordinator had been appointed to improve the range of activities in the home.

The acting manager and provider responded to people concerns and monitored the quality of the care provided. The home had been acknowledged for their achievements by the provider.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Care Quality Commission (Registration) Regulation 2009. You can see what actions we told the provider to take at the back of the full version of this 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

This service was not consistently safe.

People's risks had been assessed but their risk management plans were not always monitored.

On the days of our inspection there were sufficient numbers of staff to meet the needs of the people, however had been high use of agency staff and occasions when the staffing levels were not adequate.

People received their medicines in a safe and timely manner; however processes around the management of people's prescribed creams, safe management of sharps and the competencies of staff had not been consistent. The management of the cleanliness of the home was being reviewed.

Recruitment procedures were followed to ensure staff were checked and recruited safely.

Staff were knowledgeable about their role and responsibilities to protect people from harm and abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all new staff had received probation meetings in line with the provider's policy. The profiles identifying qualifications of agency staff had not been kept up to date.

Staff felt trained to carry out their role. A new support system was being introduced to staff.

Staff had a basic understanding of the principles of the Mental Capacity Act, however not all best interest decisions were fully documented.

People enjoyed their meals and were supported to eat a healthy diet.

Is the service caring?

Good

The service was caring

People are treated with kindness and compassion in their day-to-day care. Their bedrooms were personalised and decorated to their taste.

People received care and support from staff who knew and understood their history, likes, preferences, needs, hopes and goals.

Is the service responsive?

Good

The service was responsive.

Staff understood people's needs and responded to them in a timely way.

People's care plans provided staff with informant about how their needs should be met.

People enjoyed activities when they occurred. An activity coordinator had been recruited to enhance people's social well-being.

People and their relatives were confident that any concerns would be dealt with promptly.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The home had been without a permanent registered manager for some time, though the acting manager had been described as approachable.

Not all staff felt supported and alleged that communication across the home was not consistent.

The home had been monitored by the provider and had been acknowledge for their achievements.

OSJCT 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 the evening of 5 March and during the day of 6 March 2017 and was unannounced. The inspection team consisted of an inspector, a specialist advisor 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 and knowledge of caring for older people.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service as well as statutory notifications. Statutory notifications are information the provider is legally required to send us about significant events.

During the inspection we spent time walking around the home and observing how staff interacted with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with eight people and four relatives and visitors. We looked at the care plans and associated records of nine people. We also spoke with six care staff, the chef, the acting manager and a representative of the provider. We looked at staff files including the recruitment procedures and the training and development of all staff. We also checked the latest records concerning complaints and concerns, safeguarding incidents, accident and incident reports and the management of the home.

Requires Improvement

Is the service safe?

Our findings

People's personal risks had been identified, assessed and documented. Records showed that control measures had been put into place to help mitigate their risks. Staff were mainly knowledgeable about people's individual risks and were able to tell us the care people needed. For example, some people had been identified as being at risk of developing pressure ulcers. A risk management plan had been put into place to reduce people's risk such as the use of pressure relieving mattresses. Repositioning charts were in place for people who were unable to move themselves to relieve pressure from their skin. We found that information on the frequency people needed to be repositioned was shared with staff during handover.

However the monitoring of the control measures in place for some people's risks associated with their medical and safety equipment needs were not consistently carried out. For example, on inspecting some people's repositioning charts, we found that the majority of people had been frequently repositioned in accordance with their care plan; however one person's charts indicated that they may not have been turned for seven hours, when their care plan stated they should have been repositioned every four hours. We also reviewed the air flow mattresses of three people and found that settings of two people's mattresses were incorrect and that two people's bedrails, which were used in conjunction with deeper mattresses, were not at the correct height in line with national guidance.

We reviewed the care records of one person who had a catheter in place and whilst we found that this person's catheter care was being managed well and information about the management of their catheter had been documented, the information did not include how often the catheter required changing and how the catheter should be cleaned.

We raised our concerns with the acting manager who said that they would immediately review people's medical and safety equipment and risk management plans in accordance with their needs.

However, we found a lot of good practices when supporting people with their other personal risks such as monitoring people who had become unwell or lost their appetite. Relatives also told us people's health and well-being risks were managed well and they were always notified of any concerns.

There were safe medication administration systems in place and people received their medicines when required. We observed safe practices in the management and administration of people's medicines, such as checking the stock of medicines which could be misused between each shift. People were given their medicines on time and appropriately. Nurses responsible for administering medicines had received training. Medicines Administration Records (MAR charts) had been completed appropriately with no gaps in the recording of administration on the MAR charts. Individual detailed protocols were in place for medicines prescribed to be given as necessary. Medicines were stored and disposed of in line with current guidance. People's medicines care plans generally provided clear guidance about people's medicines and when they should be administered. However, the management and prescription of one person who required oxygen was not clearly recorded and some people had not had their medicinal creams applied as prescribed.

We had been made aware of recent medicines error regarding the administration of one person's controlled drug (medicines which could be misused by others) by an agency nurse. There are national guidelines around the storage and administration of people's controlled drugs to ensure that they are not misused by another person. We reviewed the home's systems regarding the management of people's controlled drugs and the incident that had occurred and we were satisfied that the incident had been investigated and immediate actions had been taken. However, we found that staff were not always clear about their role and responsibilities when assisting and witnessing the registered nurses with the administration of people's controlled drugs. We were told by the Area Operations Manager that care staff had been trained but this would be addressed again with all staff to ensure they were aware of the correct practices.

All nurses were required to carry out the provider's 'medication administration' training. However the training matrix indicated that this had not been completed by all nurses. Records also showed the skills and competencies of all the nursing staff to safely store, administer and dispose of medicines within the home had not been consistently checked. At the time of our inspection, the acting manager was not aware if the agency nurses had been assessed as competent in managing people's medicines as they did not always have an up to date profile. We also found that the safe management of sharps was not in line with current guidance to prevent or minimise the risk of accidental injury.

Whilst we found elements of good and safe care, some people's risks were not being monitored effectively and people were at risk of receiving care and treatment from staff that may not be competent in their role. This is a breach of Regulation 12, Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

During our evening walk around the home, we found some bathrooms were cluttered with equipment such as hoists, for example one hoist had been left in front of the bathroom sink which would have prevented people to wash their hands. We also found some toilets were dirty with dried faecal matter in the bowl and on the toilet seats during the evening. Two relatives raised concerns about the cleanliness of the home including the toilets and the passenger lift. We were told that an additional new housekeeper had been employed and they would be reviewing the working hours of housekeepers to ensure the home's environment remained clean at all times.

We recommend that the service seeks guidance from a reputable source to ensure the safe and effective management of and arrangements for preventing and controlling the spread of infection.

Concerns had been raised with CQC before this inspection around the staffing levels and the high use of agency staff in the home. During this inspection we spoke to several day and night staff about the staffing levels in the home. Most staff felt that people's needs were being met in a person centred and unrushed manner when the required levels of staff were on duty. However, they shared with us that on occasions there had not been adequate numbers of staff on duty and this had impacted on people's care.

Some people told us that on occasions their needs had not always been immediately met especially during busy periods of the day such as at breakfast time or in the evening. One person said, "They are very nice here, though there have been a lot of staff changes. They can be low of staff at times but I can mostly manage by myself so I try not to bother them." Another person said, "They are sometimes short staffed but I know they try their best. I have to be the legs for some of the residents in here (pointing to people in wheelchairs in the lounge) and get staff for them." Relatives were mainly positive about the staffing levels in the home but some felt that the staffing levels were noticeably lower in the afternoon.

Staff told us some shifts had been difficult but they had pulled together and worked as team. A staff member explained that staffing levels especially at night had been a concern. They went on and said, "It's been tough

at times, we have been very busy, but it's the residents that keep you going, we can't let them suffer." We reviewed the call bell system records for a few days which indicated the response time of staff when people had used their call bell to request assistance. In the majority of times, most people received a response from staff in a timely manner. However there was no recorded evidence of regular call bell monitoring checks or investigations since the previous registered manager had left, although the acting manager stated they would frequently check the call bell display panels for staff response times but this was not recorded.

Where there were known shortages of staff, the acting manager had tried to plan ahead and had asked staff to carry out additional shifts or they had used agency staff. We reviewed a sample of the recent staff rotas during a three week period leading up to this inspection and found on three occasions when there had been a shortage of staff and that agency staff had regularly been used. The acting manager explained that they had recently experienced staffing problems but they were currently recruiting new staff to help reduce the need of agency staff. They shared with us the details of new staff that had been offered positions but they were waiting for their recruitment checks to be completed. We were told that recruitment had been a huge challenge and they still had some vacancies to fill. We concluded that there had been recent periods where there had been frequent use of agency staff and there had been occasions when there had not been enough staff on duty to meet people's needs; however the home was proactively recruiting new staff to overcome these issues.

Where accidents and incidents had occurred these were reported and recorded. The acting manager reviewed all the incidents to identify any patterns and to implement any actions to be taken to reduce any further risks. The area operations manager also reviewed the accident and incident reports before their visit to the home to recognise and follow up on any concerns or trends.

People were protected from abuse by staff with the knowledge and understanding of safeguarding policies and procedures. Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. They were aware of their responsibility to whistle blow and report any poor practices or issues. Staff told us how they would recognise signs of abuse and harm and would immediately report them to the acting manager or the provider and also external agencies such as the local authority safeguarding team or CQC if they felt the or provider had not responded. Where safety related incidents had occurred, these had been documented and staff had carried out reflected practices to ensure the incidents did not reoccur.

The home generally followed safe recruitment practices. Most new staff had completed an online application form. Records relating to the recruitment of staff showed the majority of relevant checks had been completed.

People and their relatives told us they had no concerns about the safety of Orchard House and they were happy with the quality of care being provided. For example, we received comments from relatives such as "I have been impressed by the staff and their care" and "I have only seen kindness."

Requires Improvement

Is the service effective?

Our findings

People in Orchard House were sometimes cared for by agency staff if there were staff shortages. The home had been provided with profiles of the skills and qualifications of potential available agency staff; however the information about some agency staff was not available or kept up to date. Therefore the acting manager was not always assured that people who received care from agency staff had up to date training and the relevant employment checks. However, we were told that agency staff never worked alone and they received a brief induction before they worked with people. Agency staff were always introduced to staff members who provided support and advice during their shift.

The acting manager acted on our concerns about the agency staff profiles immediately and requested up to date profiles of all agency staff used in the home to ensure that people were being cared for by staff with the appropriate skills and knowledge. Some people and staff told us that some agency staff were not always effective when they were on duty especially if they were unfamiliar with the home. For example, one staff member said, "We often have to carry the agency staff (metaphorically) as they don't know what they are doing. It can be hard work at times. Others are good and will use their initiative." The acting manager explained if this came to their attention then it would be fed back to the agency organisation and the agency staff member would no longer be used in the home. Another staff member also said, "We have a lot of agency staff on these days and sometimes we have been a staff member down. It's been hard on us and it impacts on the residents as they have to wait longer for us." Experienced staff carried out an induction check list with any agency staff on duty at the start of each shift which included explaining the fire procedures, call bell systems and housekeeping arrangements of the home. Records showed this induction had been consistently carried out however there were very few recorded comments about the competencies and knowledge of the agency staff which may impact on people. For example, agency staff were asked if they had received manual handling training but the records did not state their last training date or if they were familiar with moving and handling equipment used in Orchard House. However, one agency night staff member said they felt the induction was quite thorough and provided them with the information they needed.

Permanent staff told us they had the training and skills they needed to meet people's needs. A matrix was in place to monitor the training of staff and when their mandatory training was about to expire. The matrix showed that the majority of staff were trained to carry out their role. Staff had access to the provider's training system to undertake on line courses. Additional training for staff to undertake face to face training in relevant subjects such as first aid, fire training and moving and handing training had been planned. Staff were also expected to attend the provider's dementia awareness training and consider national qualifications in health and social care. All staff were positive about the training they had received. One nurse praised the unqualified care staff and said, "The carers here are brilliant, they have the skills to cope with the residents here. They are very helpful."

All new staff were required to attend the provider's four day induction course. They received a 12 week induction period to shadow other staff, complete the providers mandatory training and be mentored by a key experienced staff member. The senior staff and acting manager observed their practices and approach

to people before they were allowed to work as part of team. New staff were required to do a series of e-learning courses and complete the care certificate. However, we found that new staff probation meeting had not always consistently occurred in line with provider's requirement.

The Orders of St John Care Trust had recently implemented a new process to supervise and support staff across the trust called 'Trust in Conversation'. We were told that all staff would have a mid and end of year review to reflect on their work practices and discuss their learning needs. Objectives and expectations would be set and reviewed with staff. Information from previous meetings and compliments would also inform the meetings and assist with setting objectives. Staff would benefit from at least two other regular support meetings such as one to one meetings, group supervisions and staff meetings throughout the year. This new system was about to be implemented at Orchard House and staff were being asked to prepare for their mid-year conversation with their line manager. However, some staff did not have a sound understanding of this new process and felt that they hadn't received the support that they expected, although there was no negative impact on people as staff could talk to the managers informally. This was raised with the area operations managers, who explained that they were aware of this issue and were working with staff to help them understand the changes of the principles and systems of staff performance development.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 and whether any conditions on authorisations to deprive a person of their liberty were being met. 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. We found that staff were aware of the principles of the MCA and applied them to their care practices. For example, we heard staff offering people choices regarding their care or meals and found their decisions were respected. Where people were unable to express their views, staff provided them with care in their best interests based on the knowledge and previous preferences of people such as their choice of drink.

From discussions with staff we found that best interest decisions were being made on behalf of people if they were unable to express their views and that people's relatives had signed their care records on behalf of them; however there was no recorded evidence of these best decision making processes or limited evidence that some people had consented to the use of bedrails.We raised this with the acting manager who told us they were aware that people's consent to their care was not always correctly or lawfully recorded and would be addressed when people's care needs were reviewed.

The acting manager was aware of their responsibility to recognise when people may be deprived of their liberty. People can only be deprived of their liberty to receive care and treatment when this 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). They had applied for authorisation to the supervisory body (local authority) for those people who were being deprived of their liberty. They were waiting for some people to be assessed by the supervisory body and in the mean time we found that people were being supported in the least restrictive way.

People and their relatives told us they enjoyed their meals and praised the kitchen staff. For example, one relative said "The cook has been great and has suggested foods to encourage mums appetite." People could choose where they wished to eat their meals, although most people chose to sit in the dining room at lunchtime. Pictorial menus were displayed on each table. People were offered a choice of two hot meals and desserts and a choice of drinks at lunchtime. Alternative options could be requested from the kitchen if

people did not like the options of the day.

Peoples nutritional needs, like and dislikes, were identified and known by staff. For example, one person enjoyed and was given a beaker of milk before their meal. People who required support to consume their meals, were mainly supported with dignity. Staff encouraged and informed people of what they were eating at an appropriate pace and manner. People were given adapted crockery such as beakers, padded cutlery or a plate guards to encourage them to be independent with their meals. However we found the plate guards were not always correctly positioned for some people. Whilst most people were encouraged and prompted to eat their meals, we observed two people sat for long period of time with their meal in front of them without being prompted to eat.

Staff adapted their approach to encourage people to eat, for example a person with advanced dementia was admitted with poor dietary intake and weight loss. They refused help to eat from staff and wished to remain independent. This was initially managed by cutting up their food and providing finger foods, with lots of encouragement. They had also liquidised meals some meals so they could drink independently from a cup with minimal prompting. As a result their weight was being maintained and we observed they were content and relaxed during their meal.

The home had good contacts with the local surgery and the GPs visited regularly to review the needs of people. Records showed that other health care professional visited the home when people required additional treatment or support. Relatives told us that they were kept informed of any changes in people's health and well-being. Health care professionals were being asked to compete a short questionnaire on the staff approach when they visited the home and whether they were provided with the information they needed to help drive quality and meet the people's needs.

Good

Is the service caring?

Our findings

People were supported by staff who were kind and put the needs of the people first. We observed staff interacting with people throughout the day of our inspection. Staff cared for people respectfully. We saw many warm exchanges between people and staff. Staff addressed people by their first names in a friendly and respectful way. They knew people well and when possible staff had time to stop and chat with people. People appeared relaxed and comfortable around staff.

People were positive about the care and support they received from staff. We received comments such as "I'm very happy, the carers are nice and the food is good. What more do you want", "I am happy here" and "The staff are kind." Relatives also praised the caring nature of staff and told us they often go the extra mile where they can to help people. They told us they were welcomed into the home at any time and were informed of any changes in their loved ones well-being. People had personalised their own rooms with photographs and objects of interests.

We saw examples of staff caring for people where a gentle, compassionate and respectful approach was adopted. For example, one member of staff gave one person reassurance by talking gently to them. The person did not respond to the member of staff verbally but showed their well-being by holding onto the member of staff's hand and stroking it whilst walking with them. Staff demonstrated good listening skills and allowed people time to speak at their own pace. Volunteers helping with activities also demonstrated good communication skills and showed they were genuinely interested in what the people had to say. They spoke to people in a respectful manner and gave them time to initiate conversation.

People's dignity and privacy was valued. Staff knocked on people's bedroom doors before they entered and helped people with their personal care behind closed curtains and doors. We saw staff talking to people in a confidential manner if they were amongst other people. Staff provided us with examples of how they supported people with dignity and encouraged them to be independent where possible. Some people were staying in the home for a short period before they returned home. They told us they were enjoying their stay at Orchard House and staff were helping them to get the strength to return home.

Where known, people's cultural and religious needs were supported. We were told that staff had spoken to their relative and researched people's religion to gain a better understanding of their beliefs such as the refusal of certain medical treatments or diet preferences. People were supported to maintain relationships with their family and friends or to develop a relationship in the home, however people's sexuality were not always explored with people unless they raised it with staff.

At the time of our inspection, no one at the home was receiving end of life care. However, some staff felt that the communication about how to support people during the end stages of their life to ensure they were kept comfortable was not always clear. We raised this with the acting manager who showed us they the majority of staff had competed end of life training and plans were place for further training in the next few months. They also planned for this topic to be discussed again at staff meetings. Records showed that some people had been consulted about their end of life care planning and funeral arrangements.

Good

Is the service responsive?

Our findings

People's needs were assessed prior to their admission to make sure they could be met by the home. Care plans were developed based of this information and discussions with people and their relatives and contained a good description of their needs. For example, people's care plans stated the support they required and how they preferred their care to be delivered, such as their personal care, mobility and nutritional support to achieve the best possible outcome for the person. Staff told us people's care plans contained all the information they needed to be able to meet people's needs. A system was in place to prompt staff to review people's needs. Most changes in people's care had been updated and recorded in their care plan. We were told the nurses were working through everyone's care needs and had spent time with people, their relatives and staff. Nurses were also reviewing all records and monitoring charts to ensure they correctly recorded the person's current needs.

We observed that staff worked well together and effectively communicated when people's needs had changed. An informative handover system with daily handover notes occurred between shifts to ensure that all staff were fully informed of people's progress and needs. We were told by staff that the handover sheets were very useful especially for agency staff as sometimes the quality and detail of the verbal handovers between shifts was variable. Information in the nurse's office provided staff will information about people's clinical needs such as dates for dressing changes, medicines reviews and resident of the day. Daily records were completed at the end of each shift for each person showed that people's needs had been met, although these were mainly task orientated and did not always include information on people's emotional well-being.

People's social and recreational needs were not always being consistently being met. At the time of our inspection, the home was without an activity coordinator to plan meaningful activities for people who lived in Orchard House. We found that there was limited information about people's recreational preferences, life history and their social requirements. People and their relatives told us about some activities held in the home and trips out. They said, "I love the quizzes"; "Mum loves the activities, we wish there were more things for her to do" and "The activities have been good when they are on". One relative expressed concern that without an activity coordinator the activities in the home were 'sparse and not daily'. We were told that an activity coordinator had recently been appointed and would start to work at the home after their induction. However, the home had an active team of volunteers who supported people with the activities such as quizzes and art and craft sessions. During an art session we observed the volunteers actively engaging with people and encouraging them to participate. The activities volunteers had provided and sourced excellent resources and had developed activities to engage all people. People clearly enjoyed the activities when they were provided.

The provider and staff valued people's opinions and acted on any concerns. People and their relative's felt their day to day concerns and complaints were encouraged, explored and responded to in good time. One relative felt that any concerns were dealt with promptly and satisfactorily. They said, "We had a concern about laundry, this was resolved swiftly." Concerns and complaints were used as an opportunity for learning or improvement. We reviewed the home's compliments and complaints log and found that complaints had

been documented and acted on within the guidelines of the provider's policy. The acting manager also logged people's compliments and shared them with staff.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there had been no registered manager in post at Orchard House for approximately six months. During this time the head nurse had been delegated the role of acting manager. They received regular support from the area operations manager and another peripatetic manager who visited the home weekly. The acting manager told us the position had been challenging at times and they had been required to occasionally carry out some clinical shifts if they were short of nurses. Some staff explained that not having a permanent home manager had had a detrimental effect on the staff morale and communication across the home. Staff generally praised the acting manager but some felt that a permanent manager would have more autonomy and be more responsive in their decision making. We received comments such as "They have had a rough few months without a manager but I can see things getting better"; "The temporary manager is very easy to talk to", "It has been difficult but the deputy did a grand job" and "I hope the new manager is like a breath of fresh air." Staff explained that there were concerns regarding the communication across the home. They went on to explain that the paperwork relating to people's care, staff rotas, staff remuneration and benefits was not always clear or consistent and had affected staff spirits.

During our inspection we received mixed views from staff about the support they received. Some staff felt they were well supported well and could speak to senior staff and the managers in confidence about any concerns and these would be acted. However, others felt that their concerns were not always listened to or acted on by the nurses or managers. Staff also raised concerns about the low staffing levels and the use of agency staff on some shifts; although we were reassured that new staff were being proactively recruited. From our observation during our two days of inspection we found staff responding to people's needs in a timely manner. However some staff stated that not all nurses assisted care staff with non-clinical duties when the staffing levels were low which had resulted in feelings of discontentment amongst some staff. We found that a recent incident which had occurred during the night shift had also raised some concerns about the support and communication with night staff. We raised this with the acting manager who showed us copies of staff meeting minutes, however we found that the meetings mainly discussed expected practices and procedures and did not always capture staff concerns or views. Records also showed that not all staff had attended the meetings that had been set up. Minutes of the nurses meetings indicated that nurses had met frequently to discuss people's care plans and issues around clinical and medicine practices and that actions had been stated but there was a generic response to who was responsible for implementing any actions and the time frames. There was no evidence that these actions had been followed through and acted on.

We recommend that the service seeks guidance from a reputable source regarding the support and management of staff.

However, the provider had recently appointed a new manager who had just started their induction process during our inspection. The new manager told us they were excited about their new position and would use our inspection and comments to bench mark how the home was doing. We were told that they would be submitting an application to CQC to be the registered manager in the near future. The acting manager and area operation manager recognised that there had been some inconsistencies in the frequency of meetings

with people, their relatives and staff. However, we were assured that this would be immediately addressed by the new manager who had immediate plans to set up a series of meetings with all staff, people and their relatives to introduce themselves and listen to people's views and experiences of Orchard House. The provider was also preparing to end out a staff survey for 2017 to capture their views and thoughts.

The provider monitored the home to help drive improvements to service being delivered. They carried out regular quality assurance processes to monitor the quality of service such as monthly catering and health and safety audits. In the summer of 2016, the provider carried out a resident survey. We were told whilst there was a limited response from people who live at Orchard House, the learnings from all the surveys of the providers' homes would be applied to each home such as addressing laundry issues to ensure a standard of care and practices across all their homes. Records showed that Orchard House had scored well in the provider's internal audit carried out in October 2016. An action plan was in place to be addressed the identified shortfalls. The home had received an accreditation for medicines management from the provider due to no medicines errors occurring in the year prior to the audit. They also received a letter from the provider recognising that they had succeeded in 'zero home acquired pressure ulcers' in the last 12 months. The acting manager was acknowledged and praised for these achievements.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Some people's risks were not being monitored effectively and people were at risk of receiving care and treatment from staff that may not be competent in their role.