HC-One Limited

The Orchards

Inspection report

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22 February 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

At our last inspection in September 2016 we found that people did not always receive their medicines safely, effectively or as prescribed and the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found that despite an increase in staffing levels, the deployment of the staff was not always effective to ensure that people's needs were met consistently and/or in a timely manner and a further breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was identified. In addition, we found that the provider's quality monitoring systems were not always implemented effectively so that they were able to identify shortfalls within the service and a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was also identified. We asked the provider to send us an action plan to inform us of what action they planned to take in order to make the required improvements and become compliant with the regulations, which we received in October 2016. At this inspection, some improvements had been made but we continued to find on-going concerns which meant further breaches of regulations were identified.

This inspection took place on 08, 15 and 22 February 2017. All of the inspection visits were unannounced including an evening inspection visit which was conducted on 15 February 2017.

The home provides accommodation and support for up to 72 people who require nursing or personal care. At the time of our inspection, there were 54 people living at the home. The home is designed over two floors. The ground floor accommodates people on a permanent basis who require nursing and personal care, whilst the first floor accommodates people on both a permanent basis, but also where people require short-term, interim care for either respite or re-enablement purposes, whilst a long-term care plan is considered.

The service was required to have a registered manager in place as part of the conditions of registration. There was not a registered manager in post at the time of our visit because the person who had registered to manage the service since our last inspection had recently left. The provider had re-deployed a 'turn-around manager' who was employed by the provider to support homes that required 'restabilising'. The 'turn-around manager' had been registered for the management of this location previously back in 2016 and was in the process of re-applying for their registration with us. We have received an application for us to consider. 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.

People did not always receive their medicines as prescribed and poor quality assurance and record keeping systems meant that medicines were not always managed or recorded effectively. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had some systems in place to monitor the safety and quality of the service but these had not always been used effectively to identify areas in need of improvement or to sustain the improvements made. Record keeping and governance within the service were also found to be ineffective. Records were not always complete, recorded accurately and some information was missing. Staff did not always have the information or time to get to know people to ensure that people received care that was personalised and that met their individual needs. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always feel involved in the planning of their care and they felt that the assessment processes did not always ensure that the staff had all of the information they required to provide person-centred care to them as individuals.

People were encouraged to offer feedback on the quality of the service but were not always sure that their suggestions had been acted upon. People were not always aware of who the manager of the service was but told us that they would inform the care staff if they had any concerns or wanted to complain.

Not all of the people living at the home were actively encouraged and supported to engage in activities that were meaningful and accessible to them. However, people were supported to maintain positive relationships with their friends and relatives.

The provider's recruitment systems and processes were implemented effectively to ensure that staff were recruited safely and staff felt supported and appreciated in their work.

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

People received care and support with their consent because key systems and processes had been followed. People were supported to make day to day choices and decisions, such as meal options. This meant that people had food that they enjoyed and any risks associated with their diet were identified and managed safely within the home.

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

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 always safe.

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

People's needs were not always me in a timely manner because staff were not always available when they needed them.

Staff knew how to keep people safe from abuse and avoidable harm and were aware of the reporting procedures.

The provider's recruitment systems and processes were implemented effectively to ensure that staff were recruited safely.

Is the service effective?

Good

The service was effective.

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

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

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

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

Is the service caring?

Good

The service was caring.

People were supported by staff that were lovely, helpful and caring and that treated them with dignity and respect.

People were supported to express their individuality and staff were aware of how they could promote equality and diversity within the home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

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

People felt involved in the planning and review of their care but were not always confident that the assessment process or communication systems within the home meant that staff had all of the information they required to provide person-centred care.

People were encouraged to offer feedback on the quality of the service and knew how to complain but were not always confident that their feedback or suggestions would be acted upon.

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

Is the service well-led?

Requires Improvement

The service was not always well led.

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

Record keeping systems were not always effective and information was not always available or recorded accurately.

The Orchards

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 08, 15 and 22 February 2017 which included an evening inspection to check how the service operated at night time. The inspection was conducted by three inspectors, a pharmacy inspector, a Specialist Advisor and an Expert by Experience. A Specialist Advisor is a person who has specialist skills, knowledge and clinical experience in an area of practice relevant to the service being inspected. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection we looked at the information that we hold about the service. This included previous inspection reports that informed us of previous breaches of regulations dating back to 2013, as well as notifications from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also requested feedback from the local authority with their views about the service provided to people at The Orchards.

During our inspection, we spoke or spent time with 20 of the people who lived at the home, two relatives and 18 members of staff including the 'turn-around' manager, an operational lead, the enhanced assessment unit manager, four nursing staff, six care staff (including senior care staff), and a member of the housekeeping team. We made general observations around the home during our inspection.

As part of the inspection, we also reviewed the care records of eight people to see how their care was planned and looked at the medicine administration processes. We looked at training records for all staff and at three staff files to check the provider's recruitment and supervision processes. We also looked at records which supported the provider to monitor the quality and management of the service. These included health and safety records such as fire safety and maintenance checks, accidents and incident records, compliments and complaints, medicine administration audits as well as records used to monitor staffing levels and assistance response times and associated audits.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in September 2016 we found the provider was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not receiving their medicines safely, effectively or as prescribed. This demonstrated a repeated breach of this regulation because the provider has a history of not being able to sustain safe medication practices. In addition to this, in September 2016 we also found the provider was in breach of Regulation18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because there was insufficient staff available to meet people's needs in a timely manner. The provider has a history of not having enough staff or not deploying them effectively to be able to meet people's needs. We issued requirement notices for both of these breaches of regulations and asked the provider to send us an action plan to tell us how they planned to improve, which we received in October 2016. At this inspection we found that people were still at risk of not receiving their medication as prescribed, and people were still at risk of not having their care needs met as staff were not always available when they were needed.

At this inspection we looked at how medicines were managed, which included checking the Medicine Administration Record (MAR) charts for 10 people, speaking to nursing and care staff and observing a medication administration round. We found that there were some improvements; however we also found that some people's medicines were not always being managed or handled safely.

We found that the provider had introduced nursing assistants to help with the administration of medicines alongside the nursing staff. The nursing assistants had been given the responsibility of administering less complex medicines to people, which allowed the nursing staff to concentrate on those people who had more complex needs. This meant that people were getting their medicines closer to the times specified on their MAR charts and allowed medicines to be evenly spaced throughout the day.

We found the provider had a system of counting tablets on a daily basis following administration and comparing the quantity found against the record to determine whether the medicines had been administered as prescribed. We found this had improved the accuracy of the records however the provider could not always be assured that people had been given their prescribed medicines as intended because medication counts did not always match the MAR charts. For example, we saw that one person was taking capsules prescribed for pain relief. 28 capsules were available at the start of the medication cycle and records showed that 18 capsules had been administered. This would suggest that 10 capsules should have been remaining however; we found there were 22 capsules remaining. Therefore it was unclear whether this person had received all of the medicine that had been signed for.

Medicines were not always administered as prescribed. We found one person had not received the correct dose of their blood pressure medicine. We found that out of the 24 days that had been signed for on the MAR chart an audit showed that the prescribed dose had not been administered for nine days. We found that another person had not received the prescribed dose of their inhaler for seven days as there was not one available. We were told that the person concerned had been discharged from hospital and the inhaler had not arrived with the rest of their medicines. We were concerned that it took five days before the issue was

raised with the person's doctor and a further two days before the inhaler arrived at the service. We spoke with the person concerned and they recalled a time when, "They [staff] were waiting for the inhaler to come from the pharmacy, but I had my other inhaler (pointed to a purple round one on bedside table) that kept me going, so I was ok". This raised further concerns as this inhaler was not listed as a current medicine on their discharge letter from the hospital.

We also found that systems were not in place to monitor people who were self-administering their medicines and therefore the service could not be sure that these medicines were being administered as they were intended to be.

We looked at the records for people who were having medicinal skin patches applied to their bodies. We found that these records were not robust enough to demonstrate where the patches were being applied to the body. As a consequence the provider was not able to demonstrate that the patches were being applied in line with the manufacturer's guidance. We spoke to two people about the application of the patches and one person said, "Oh they hurt me when they put them there [pointing to her left and right chest]". We asked the person where the staff placed the patches and they said, "I think they put them there and there [pointing to her left and right chest]". We asked if the staff placed them anywhere else and she said "I don't know, these are the places I know about because they hurt".

We found that where people needed to have their medicines administered directly into their stomach through a tube the provider had not ensured that the necessary information was in place to ensure that these medicines were administered safely. We spoke with an agency nurse who confirmed that they had administered medicines through a tube that morning and had not seen any information on how to prepare and administer the prescribed medicines. The agency nurse gave an account of how they had prepared and administered these medicines and described crushing and placing all of the medicines into 100ml of water and flushing the mixture of medicines through the tube. This method of administration contravened the accepted practice and place people's safety at risk.

We also found that people who had been prescribed ointments were not always having these applied by staff as prescribed. For example, we saw that one person had been prescribed an ointment to be applied for seven days and then reviewed. However, the MAR chart showed that this ointment had been applied for a total of 23 days without any evidence of a review taking place. We also found that records were not robust enough to demonstrate when ointments had been prescribed, the frequency and duration they should be applied for or where on the body they should be applied. For example, for one person, we saw that their MAR chart stated 'apply to affected area' but there was no body map attached to MAR to show where the 'affected area' was. A Senior carer said, "We just know where to apply it". We also found that the same person was prescribed another ointment according to their MAR chart, which also instructed, 'to be applied to the affected area'. The nurse in charge was unsure of where the 'affected area' was and thought it was for a rash on the persons back. They stated, "The senior carer should know". The senior carer told us that the cream was actually prescribed for the person's legs and that this information should be available in their care records. However, we checked the persons care records thoroughly alongside the senior carer and we could not find any information about when the cream had been prescribed, what the cream had been prescribed for, where it should be applied to, or how often and for how long it should be administered for. We found a body map in a separate folder that simply stated the cream was to be applied to both legs but did not indicate where about on the legs it needed to be applied and omitted all other details regarding the initiation date, frequency and duration of application.

The shortfalls we found during our inspection had not been identified by the provider's quality monitoring systems and processes and the 'turn-around' manager was not always aware of the medicine errors we

found.

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

Most of the people we spoke with during our inspection told us that they felt that there was not always enough staff available to meet their needs. One person said, "They are always short of staff, I have had two years of this, some of the staff rush me". This person gave us an example and explained that they wanted to get out of bed early but had to wait till 11.40am because there was not enough staff available to assist them. Another person said, "There are not enough of them to get everyone sorted in the morning. I cannot get out of bed on my own so have to wait for them. I like to get up reasonably early but several days I have had to wait until late morning, then by the time I am dressed they take me straight into dinner, it is that late. I don't like it". Another person told us, "Sometimes they [staff] leave you on the toilet and forget to come back". A fourth person said, "There is never enough staff they are always very busy. I don't ask for very much because I know how busy they are and other people are probably worse off than me and need their [staff] help more".

Staff we spoke with told us that the home was 'busy' but they reported to 'manage' on the current staffing levels most of the time. One member of staff said, "It is busy, most places are and it can be difficult when staff call in sick at the last minute or when we are short-staffed, but we manage". During our night inspection we observed staff working over and leaving late after their shift had finished. They told us that this was because they had not had time during the day to do what they needed to do and that this happened 'not always, but quite often'. Another member of staff we spoke with said, "It is always difficult during handover periods [the change-over of staff] to make sure information is shared but also that the floor is covered and people's needs are met; it often means we [staff] have to either wait until the handover has finished which makes us late leaving or we start work without a handover; I rarely leave on time, a twilight shift would be a good idea".

We discussed these concerns with the 'turn-around' manager and the regional manager at the time of our inspection and they reported to be 'shocked' that people were sharing these concerns with us. They said, "If you look at our dependency tool, you will see that we are actually over-staffed, so I don't know what more we can do". We saw that the provider used a spread sheet called a 'dependency tool' to help them to calculate the number of staffing hours they required based on people's needs to ensure they had enough staff available. However, they were unable to explain why people were still reporting these experiences and considered whether the deployment of staff remained an issue. The 'turn-around' manager told us that allocation sheets were now being used to ensure that all members of staff were allocated specific roles and responsibilities during each shift. However, we observed two of the handover's that took place during our evening visit [a 'hand-over' is the terminology used by staff to describe the exchange of information during the changeover of staff]. We saw that staff were not allocated specific tasks to complete and no records were available to show that this took place at other times. The provider's quality monitoring systems and processes had not supported them to identify that this was an on-going issue or to analyse the potential root-causes for why people continued to experience this service deficiency, despite the increased staffing levels. The turn-around manager assured us that this would be addressed as a priority.

We also saw that following our last inspection, the provider had implemented an audit tool which looked at the response times of staff to people when they had activated their call assistance alarms. We saw that the monthly averages were consistently below the provider's target of seven minutes, however there was no further analysis of the data and the audit failed to look at incidences when response times took longer than

seven minutes. For example, we saw evidence of a time when it took staff up to 34 minutes to respond to a person. The 'turn-around' manager explained that sometimes the alarms are not deactivated by staff which can affect the data. However, people we spoke with confirmed that they were often left waiting for long periods of time when they press their call assistance alarms. One person said, "Sometimes when I press my buzzer they come quite quickly but other times you do have to wait quite a long time. I just have to sit here and wait but it can be quite distressing if you need something". Another person we spoke with confirmed this and told us, "I pressed my buzzer the other day and I waited over an hour. When they came they were not very nice to me as I complained about waiting. They [staff] said I had not been waiting that long but I had my watch on so I knew I had". Whilst we were unable to corroborate the length of time that this person had reported to us, we recognised that this incident had had a significant impact on their experience of care. They went on to give another example and said, "They put me in this dayroom the other day and gave me the mobile call buzzer [alarm]. I pressed it but no-one came. Eventually someone went past so I called them. They came and said the buzzer was not working and hung it back on the wall – where it is now?!" During our inspection we also pressed a call bell and no one came. We were told that this was not working. We fed back to the regional manager at the time of our inspection and this was reported to the maintenance team who repaired the alarm; however it was not clear how the maintenance of the call assistance alarms were checked and monitored to enable the provider to identify these issues proactively.

We also saw that where people had sensor mats installed in their rooms (which are used to alert staff when a person gets out of bed to help to prevent falls), they did not have access to a call assistance alarm because only one alert system could be plugged in to the device at any one time. This meant that if a person was in bed and needed assistance, the only way they could alert someone would be to try and get out of the bed which would then activate the mat. One person we spoke with who had one of these sensor mats told us, "I don't know how I would call for help". The turn-around manager told us that this had been considered previously, but had been told by the manufacturer of the call assistance alarm that dual 'splitter' connections were not available for that particular system. The provider had not considered any alternative systems or implemented any other creative ways of addressing this issue.

We were told that the provider was continuing to recruit staff to the home and in the meantime, they employed regular temporary staff. We looked at the staffing rotas for the last three months and found that the service was reliant on temporary staff and required at least one agency nurse or carer to work almost every day. This was evident on the days of our inspection. Some days we saw that the service relied heavily on agency nursing staff, with requests for up to three nurses per day. This meant that despite the service requesting regular agency staff, the consistency of staff was not always assured.

We have found that concerns relating to staffing levels have been raised at previous inspections dating back to 2014 and whilst improvements in staffing levels had been made, the way staff were deployed continued to require improvement.

At our last inspection, we found that the provider's recruitment systems and processes were not always implemented effectively. We found that improvements had been made and that the provider was following safe recruitment practices. Staff we spoke with and records we looked at confirmed that the provider had facilitated a range of employment checks before staff started working at the home which included identity checks, a review of employment histories, employment and personal references as well as consulted the Disclosure and Barring Service (DBS). The Disclosure and Barring Service helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care.

Most of the staff we spoke with knew what action they needed to take in an emergency. One member of staff told us, "If a person was choking, I would call for assistance immediately and pat their back or [gestured the

Heimlich manoeuvre] in an attempt to dislodge it [blockage]". Another member of staff told us, "We are lucky to have nurses here so we can always get their assistance but if in doubt we always call 999 for emergency assistance". We found that staff had received training in emergency first aid and knew what action to take in an emergency situation including how to initiate and perform cardiopulmonary resuscitation ('CPR' is an emergency treatment used to restart a person's heart and breathing if they stop). Some of the people living at the home had a DNACPR' [Do Not Attempt Cardiopulmonary Resuscitation] in place which is a record of an advanced medical decision that has been made and recorded to instruct CPR not to take place. These are implemented when cardiac or respiratory arrest is an expected part of the dying process or whereby CPR will not be successful or in the person's best interests and will help to ensure the person dies in a dignified and peaceful manner. Two of the care staff we spoke with were aware of people who had an advanced decision (DNACPR) in place and knew not to initiate CPR. However, the nurse in charge of the shift was unsure who had a DNACPR in place and told us that the information in relation to who had a DNACPR in place was included on the handover sheet. The nurse went to get the handover sheet in order to tell us. This meant that in an emergency situation this could potentially cause a delay in a person receiving CPR or could result in a person receiving CPR against medical advice and against their best interests. Staff we spoke with felt that a better system was required. We fed this back to the 'turn-around' manager at the time of our inspection and they assured us that immediate action would be taken to ensure that all staff are aware of who has a DNACPR in place. They told us, "We will look at putting red folders in people's rooms to help staff to distinguish straight away who has a DNACPR".

Records we looked at showed that the maintenance team performed regular safety checks on equipment and facilitated random fire drills which involved staff and residents to ensure everyone was prepared in the event of an emergency. An agency member of staff told us that as part of their induction to the home they were told about the fire safety procedures. However, they acknowledged that because they work in lots of different places it is easy to forget the specifics of each home but they were able to provide us with an appropriate account of how they would respond in the event of a fire in order to protect the safety of people using or visiting the service.

Some of the people we spoke with told us that they felt safe living at the home and were happy with the care they received. One person said, "I am very happy here and they [staff] look after me well". Another person told us, "I am ok here".

Records we looked at showed that people had risk assessments in their care files which related to generic risks around the home. These included moving and handling, falls and continence care. We also found that some improvements had also been made to include risk management plans that were more specific to people's individual health and care needs, such as wound management. We looked at three risk management plans where people had been assessed as high risks of developing a pressure sore. Advice was sought from the Tissue Viability Nurse to inform the care plan and prevent skin damage. Wound management plans were in place informing staff how to prevent further damage and the action to take if further medical intervention was required. Records showed that reviews were held to monitor the treatment prescribed and establish if alternatives treatment was needed. We saw that people had been assessed for suitable beds and pressure cushions to prevent further damage to people skin.

We found that staff had received training on what action to take to keep people safe from the risk of abuse and avoidable harm. One member of staff told us, "We have training which covers the signs to look out for if we are concerned such as someone becoming withdrawn, if they act differently like start flinching or look nervous when you approach them, or if I notice bruises; I would report it straight away to a senior and manager. If nothing is done, I know I can contact the safeguarding ream myself". Another staff member said, "If I witnessed anything, like rough handling, shouting or if I noticed bruises or any changes in a person's

behaviour or emotional state, I would report it straight away to management". This meant that staff had the knowledge and the skills they required to identify the potential risk of abuse and knew what action to take. The registered manager told us and information we hold about the service showed that, where safeguarding concerns had been raised, these had been reported and investigated appropriately by the relevant authorities.

Good

Is the service effective?

Our findings

People we spoke with and observations we made during our inspection showed that care was provided to people with their consent, as far as reasonably possible. One person told us, "The staff are very kind; they always talk to you and ask you what you want or need". Another person said, "We are treated with respect here, they always ask before doing anything, they knock before they come in to your room and ask us what we would like; we have a good choice at meal times for instance".

The Mental Capacity Act (MCA) 2005 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 so that they can receive care and treatment when this is in their best interests, for example, to keep them safe and when it had been legally authorised under the MCA 2005. The application procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Records we looked at showed that most of the staff working at the home had received training on the MCA and DoLS and that most of the staff we spoke with were aware of their roles and responsibilities to ensure that people were cared for lawfully. We also checked whether the provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. For example, we also looked at records in relation to people using bed rails. We saw that where people lacked the capacity to consent to this restriction and were under constant supervision due to their care needs, best interest's assessments had been facilitated and applications and/or authorisations had been completed. We saw that some people who had capacity to make this decision had requested bedrails as they felt more comfortable knowing that the bedrails were in place. One member of staff told us, "I always ensure they [people] agree". Another member of staff said, "I always give people options and seek their consent before doing anything with them". Staff we spoke with confirmed that training had been completed and the registered manager showed us that further training had been arranged.

People we spoke with told us that they enjoyed the food available within the home and that they had a choice about what and where they ate. One person told us, "I can't fault the food; we get a good choice and it's lovely". Another person said, "The food's really nice, it's well cooked". Observations we made during our inspection showed that people had a choice of whether they preferred to eat in their rooms or in the dining room. Staff also asked people what they wanted to eat from a menu and where personal preferences were made, these were accommodated. For example, one person asked for the roast dinner but did not want the sage and onion stuffing. Another person asked for ice cream instead of rhubarb and custard whilst another person requested bananas and custard; all of which were accommodated. We found that the meal time experience for people in the dining rooms was pleasant. The dining rooms were nicely decorated and the tables were laid, making for an inviting and relaxed atmosphere. Staff introduced people that had not met before and regularly checked that people were satisfied with their meals. The food was well presented and smelt appetising and people we spoke with told us they enjoyed their meals. People were supported to eat

their meals where required and adaptive aids were available to promote independence.

We found that most of the people who chose to eat in their rooms, received their meals in a timely manner and staff supported them where required. However, we did see one person that looked slumped in bed with their lunch tray in front of them. Staff we spoke with told us that this person had declined to eat their lunch in their chair and told us that the person required two members of staff to reposition them and they went to get another member of staff to assist them. However, when we returned a little while later, we saw the person was again slumped in their bed and had started to fall asleep with their meal in front of them. We raised this with a passing member of staff who told us that this person had 'good and bad days' and for this reason their dietary intake is supplemented with nutritional drinks via a PEG tube directly in to their stomach. However, we suggested that on 'bad days' the person may benefit from additional support from staff, which was acknowledged by the member of staff who proceeded to sit with the person to encourage them to eat.

We found that people had access to doctors and other health and social care professionals as required. One person said, "They have arranged different appointments for me, although I was supposed to go for an X-Ray today but I couldn't go because they [staff] forgot to arrange transport for me; hopefully they will re-arrange it and I won't have to wait too long". A member of staff confirmed this and was in the process of re-arranging the appointment. A member of staff we spoke with told us, "We get to know people well, if we think they need to see a doctor we will request a GP visit or maybe they are having difficulty eating and we would refer them to a dietician or a Speech and Language Therapist (SALT)". On the day of our inspection we saw various health and social care professionals visiting the home including GP's, Social Workers, and District Nurses. Records we looked at confirmed that people were supported to maintain good health and to attend any medical appointments they were sent. We also saw that any health or social care concerns were followed up in a timely manner with referrals to the relevant services, such as Tissue Viability Nurses, District Nurses, Dieticians or SALTs. People we spoke with told us that they regularly had visits from the chiropodist, physiotherapist and had access to the hairdresser.

Most of the people we spoke with, observations we made and records we looked at showed that staff had the knowledge and skills they required to do their job. One person told us, "They [staff] are all very kind and look after us well". Another person said, "They [staff] are all very good, they do their best there's just not always enough of them". A relative we spoke with said, "The staff are pleasant and provide physical care ok; they seem to know what they are doing". However, some concerns were raised about the consistency of staff knowledge and competencies. One person said, "The nursing care varies from day to day depending on the nurse on shift. Often there are different staff who don't always seem to know much about me or my leg dressing". They said, "I am not sure all the staff are trained to do everything so you have to wait until someone comes on [shift] who can".

Staff we spoke with and records we looked at showed that staff received adequate training to do their jobs effectively. One member of staff we spoke with said, "The training is excellent; I have been in care for many years but since coming here, I have learnt so many new things and we are recognised for our efforts and enthusiasm; we are encouraged to develop here". Another member of staff said, "This was my first care job and I must say the training and support has been really good; I had a really good induction and did lots of training either practical or e-learning which was good and then I had time to shadow other staff until I felt ready to do it alone". We saw that the provider kept a training record which detailed when permanent staff had completed various training as well as when the training had or was due to expire. However, when we asked about how they monitored the learning and development needs of temporary staff, the 'turn-around' manager told us that this was primarily the responsibility of the agency that employed the staff. The 'turn-around' manager said, "When a member of staff is sent here for the first time we get their profile which has

all of the recruitment and training checks, we usually keep this in a file". However, we were told that they could not locate the file with this information in and had started a new one for new agency staff. The 'turn-around' manager also told us that they did not routinely, re-check, supervise or perform spot checks on agency staff as part of their quality monitoring processes but they recognised that this was an area for development.

Staff we spoke with told us and records we looked showed that permanent staff received supervision from either the senior carers or the 'turn-around' manager to discuss any training needs or concerns. This allowed the 'turn-around' manager to further monitor the effectiveness of the training and how staff were implementing their learning in to practice. We were also told by staff and records showed that they attended regular team meetings to discuss any outstanding training or service-related issues.

Good

Is the service caring?

Our findings

People, relatives and staff we spoke with and observations we made during the inspection showed that people received their support from staff that were kind and caring. One person said, "They [staff] are all lovely, very kind and always treat us with respect". Another person told us, "They [staff] look after me very well". A third person said, "They are all very kind and they look after us well, it's nice to see a smiling face". Most of the staff we spoke with, particularly those who worked predominantly on the ground floor (where people were permanent residents) were able to tell us about the people they cared for and appeared to know people well. One member of staff said, "We get to know people really well; what they like, dislike and things they need". They gave us an example of a person who was visually impaired and required additional support and reassurance when the fire alarms were being tested because the staff member knew that this worried them. The staff member said, "When I know there is going to be a [fire] test, I go straight to [person's name] room and let them know and I sit with her to reassure her throughout it". Another member of staff we spoke with told us, "I am agency [staff] so I am not always familiar with everyone, but I make sure I take the time to get to know people as best I can; for example, if I am caring for someone for the first time, I will strike up a conversation with them to help them feel relaxed and more comfortable". They gave an example of how they did this by observing what a person was wearing and commenting on how nice they looked and asked whether the colour of their jumper was their favourite colour to initiate conversation.

Staff we spoke with told us that getting to know people on the first floor, where people only stayed for a short period of time, was more difficult. One member of staff said, "We do our best but it is harder because people come and go and rooms aren't as personalised because people aren't staying so they don't bother bringing stuff in from home". We found that people's care records had very little information about them as a person, their hobbies, interests, personal histories, likes, dislikes and preferences. This information is pertinent in promoting person-centred care. We fed this back to the registered manager at the time of our inspection. They told us that they had recognised this and had started to look at 'life history' work and was working with an Occupational Therapist from the intermediate care service to look at how they could adapt their initial assessment process to capture more person-centred information and improve their person-centred approach to care.

Most of the people and relatives we spoke with told us and we saw that staff treated people with dignity and respect. One person said, "They [staff] are very respectful" Another person said, "It [personal care] doesn't really bother me, but they do keep things private you know, keep me covered [during personal care]". A relative we spoke with said, "I have never had cause to complain about the staff, they seem to look after her [person] and treat her well and she is happy which is the main thing". Staff we spoke with were mindful about protecting people's privacy and dignity. One member of staff said, "We [staff] knock before we go in to people's rooms, talk to them before doing anything to make sure it's ok, shut doors and curtains to keep things private and I'd be discrete when speaking to people in communal rooms". Another staff member told us how some people are afraid of falling and like to know that staff are nearby but also need some privacy when using the toilet for example. They said, "I will support [person] to the toilet and make sure they are safe, then I explain that I will just wait outside the door if they need anything; I make sure that I 'check-in' with them throughout so they know I am still there and make sure that they are ok". Another member of staff

said, "I treat people in the way that I would want my family to be treated, with kindness and respect".

We saw that people were supported to express their individuality and staff were aware of how they could promote equality and diversity within the home. A staff member we spoke with said, "We treat people equally and fairly but respect people as individuals too because everyone is different". They went on to tell us that they weren't aware of anyone living in the home from the lesbian, gay, bisexual or transgender community but they were confident that there would be no discrimination within the home. They said, "It's a nice home and we do our best to make everyone feel welcome and help them in any way they need; we have people who are blind, so we adapt our approach to them, people who are Asian and have specific diets like halal meat, and one lady had someone come in for a prayer reading the other day". However, some of the people we spoke with were not always aware of how the staff could support them to meet their cultural or religious needs. One person we spoke with who had lived at the home for many years said, "I used to go to church when I was at home. No-one has ever taken me from here or asked about my religion. I have never seen a vicar or church person. It would be nice to have a little service or to see the vicar occasionally; I suppose now you mention it, I do miss it". We fed this back to the registered manager at the time of our inspection and they assured us that this would be looked in to and addressed.

We saw that people were referred to by their preferred names, their independence was promoted as much as possible and they were able to express themselves as individuals. People had access to culturally diverse foods and care records showed that people's spiritual and religious beliefs had been incorporated in their end of life care plans. Staff we spoke with told us about how important it was to respect people's end of life wishes and to care for people and their families when the time comes with 'tender loving care (TLC)'. One member of staff told us, "A lady was at end of life and we made sure someone was with her at all times for two days because we didn't want her to be alone when the time came and we wanted to make sure she was comfortable; she passed away at 19:45 but I asked if I could stay [as the staff member's shift was due to end at 20:00] to help care for her afterwards; I felt proud that I was able to do that for someone".

We were also told about how the provider accommodated people's wishes with regards to funeral plans; they recognised the location as people's homes and therefore supported families to have their relatives' funeral's to leave from the home and held 'wakes' in the lounge areas. One of the staff members we spoke with said, "It happens quite often, we will all stand outside to show our respects as they [funeral procession] leave and some staff will go and sometimes take other residents [people] to the service; when families ask to have the wake here, it's nice because staff and residents who aren't able to attend the service are able to pay their respects and be a part of it that way". The registered manager said, "In a way it shows that they [people and families] do view this as their home and us as their extended family and I think it is a way of recognition of that; relatives will also share their appreciation with the staff during the wake too which is good for the staff too".

Requires Improvement

Is the service responsive?

Our findings

On the day of our inspection we saw some people were engaged in activities that they enjoyed. For example, we saw one person independently playing pool on their own in one of the lounge areas, whilst other people were seen to be watching television or listening to the radio in their rooms. We also saw that on the first day of our inspection, the provider had arranged for a singer to come in to the home to entertain people but they had not turned up. To compensate, one of the staff members facilitated a singing session in the lounge which people appeared to enjoy. When we spoke to this member of staff afterwards, we found that they worked as part of the house keeping department but was interested in becoming an activity co-ordinator, since the previous one had gone back to being a 'carer' and the post was now vacant. The 'turn-around' manager told us that they were actively recruiting to the post and any existing staff members that were interested in the post, were invited to apply. In the meantime, all staff were responsible for fulfilling this role.

Everyone we spoke with and observations we made throughout our inspection showed that there was a lack of social and occupational engagement within the home. One person told us that before their illness they had been very active and enjoyed painting and playing tennis. No-one had asked her about this before and when we asked if this was something they would like to do, they replied, "I don't think it would be possible here because they [staff] wouldn't like the mess". A relative we spoke with told us that the staff were 'pleasant' and provided 'good physical care', but the care lacked 'mental stimulation' which they attributed to time pressures within the home. They said, "I have never seen her [person] out of this room and yet she enjoys speaking to other people; there is definitely something lacking". Observations we made within the home confirmed this. We saw most people spent a lot of their time in their rooms. Whilst we recognised that this may be some people's personal preference, it was not always possible to determine this because not all of the people living at the home were able to speak with us. From speaking to some relatives, there was a general consensus that more could be done to encourage social engagement in the communal areas.

We found that the home had ample space and the facilities to provide meaningful and stimulating activities but from the observations we made and from speaking with people we saw that that these were rarely used, such as a bar area and large lounge areas. Further observations we made, particularly on the first floor were that despite people spending much of their time in their rooms, people's rooms were bland and lacked visual stimulation. This was an on-going concern from our last inspection back in September 2016. We continued to see limited interactions between people and staff outside of task-led engagement and we saw that many of the rooms did not have chairs for staff or visitors to sit in and spend time with people.

We fed our concerns back to the 'turn-around' manager at the time of our inspection who acknowledged that this was an area in need of improvement and that they were in the process of actively recruiting an activity co-ordinator. They also told us that they had recognised the need to improve the recording of activities that were being facilitated within the home as they knew more activity was happening but it was not being documented or recorded. However, they acknowledged that this was not the experience of people who were sharing their views with us or of our observations during the inspection. Following discussion, the 'turn-around' manager recognised that whilst the recruitment of an activity co-ordinator would be a positive development for the home, it required all staff to be supported to develop their knowledge and skills within

this area in order to promote a person-centred, activity led culture within the home, so that all of the people living at the home had access to activities of interest, meaningful interaction and stimulation.

We found that some people and/or their representatives were consulted about their care plans but most people felt that initial assessments, care reviews and communication within the home required improvement. One relative we spoke with told us, "It seems like assessments and communication is lacking; when she [person] was in hospital she was in a bed with a ripple matrass [pressure relieving matrass] and 'cot-sides' [bed rails]. She had neither when she came here; they put her in an ordinary bed and she fell out, we also had to ask for a pressure matrass; surely they should have picked up these things on assessment?" A person we spoke with said, "I don't know where I would be without my relatives who speak upon my behalf because I am not sure the staff really know or understand people's individual needs". Another person said, "Communication is a big problem because staffs' responses to things are often very vague, as though they don't know or are unsure". It was evident from speaking with people, staff and from the records we looked at, that person-centred care was compromised. This was due to the lack of personable, in-depth, holistic assessment and review processes that ensured people's emotional, psychological, social, cultural and occupational needs were considered as well as their physical care needs. We found that information about people's abilities, likes, dislikes, preferences, hobbies, interests, aspirations and goals had not always been considered. The 'turn-around' manager told us that this was an area that they recognised required improvement.

Everyone we spoke with and records we looked at such as the meetings from residents/relatives meetings showed that the provider asked for feedback on the quality of the service and people were given the opportunity to suggest improvements. We also saw that the provider used an electronic system which was readily available within the entrance of the home, for people to provide feedback and suggestions. However, some of the people and relatives we spoke with were not always confident that these had been acted upon. One person told us, "They [staff] do have meetings for residents and relatives because my daughter has attended; I know she made some suggestions for improvements, but I am not sure they have ever done any of them, I think she would have told me if they had". A relative said, "We have been asked about things and they do respond [to suggestions/queries] but this is often very vague".

Most of the people we spoke with told us they were unsure who the manager was but would tell the staff if they were unhappy or wished to complain. One person said, "I would speak to the staff if I had a problem". Another person told us, "I know I could tell the staff if I was unhappy but I don't know who the manager is". We saw that the provider had a complaints procedure in place and the 'turn-around' manager was familiar with this. They told us that they led an open and honest service and would take all complaints and feedback very seriously. Records we looked at showed that complaints and feedback had been recorded, but it was evident from speaking to people that further improvements were required.

Requires Improvement

Is the service well-led?

Our findings

The service was required to have a registered manager in place as part of the conditions of their registration. There was not a registered manager in post at the time of our inspection because the person who had registered to manage the home since our last inspection had recently left. The provider had re-deployed a 'turn around manager' to the location who worked for the provider to support services that required 'restabilising'. The turn-around manager was familiar with the service as they had been registered before in 2016 and was in the process of re-applying for their registration with us. As part of our inspection, we looked at the registration history of the location and found that this would be their sixth manager to register with us since June 2014. This shows that the service has had an unstable management structure and has lacked consistency and sustainability in its leadership. This was reflected in the feedback that we received from people who used the service. One person we spoke with said, "Any organisation is only as good as its leadership and it is clear here that they are not very good; who are they anyway?" A relative we spoke with told us, "Leadership seems to be the problem here; there is not proper communication or consistency with what's going on". Another relative confirmed this and stated, "Communication is not very good and no-one really seems to know what is going on".

Staff we spoke with were aware of the service having a whistle-blowing policy. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about risks to people's safety, malpractice or illegality without the fear of workplace reprisal. They may consider raising a whistle-blowing concern if they do not feel confident that the management of their organisation will deal with their concern properly, or when they have already raised a concern but the problem within the organisation or with the provider has not been resolved. Information we received from the local authority showed that a whistle-blowing concern had been raised which also shared the concerns relating to management and leadership within the home, including the lack of consistency and poor communication.

We were told that following our previous inspection in September 2016, the provider had identified The Orchards as a location that required intensive management support and had re-allocated it to their 'focussed home' portfolio. This meant that the service received the support from a 'turn around manager' and additional, more intensive support from a team of operational managers. This process had also been implemented previously, following our inspection in October 2015. However, whilst some improvements were noted previously, we were unable to see how these improvements had or will be sustained. We found that the provider's quality monitoring systems and processes (used to assess and monitor any shortfalls, improvements and/or the sustainability of these within the service) continued to be ineffective due to the on-going issues that we identified during our inspection. Whilst we found that the new turn-around manager had made some attempt to improve the implementation of quality assurance systems and processes within the home, the service was still in the stages of yet another cycle of change and further improvements were required.

We saw that there were systems in place to monitor the quality and safety of the service including audits of medication processes and care records, however these had not always been used effectively to identify the shortfalls found during the inspection and to drive improvements. Call assistance alarms had also been

audited but the information was only used to identify the average response times and had not been analysed further to consider shortfalls or areas for improvement, themes or trends in the data collated. We saw that information that we asked for as part of the inspection could not always be found which further supported our findings of poor governance within the service. For example, Medication Administration Records (MAR) were not always readily available when required and staff were not always sure where they would find archived information. Professionals visits/communications were not always recorded to inform staff about how to provide care to people safely and effectively, care files were difficult to navigate and in one record we saw that records leading up to an incident where a person experienced a fall was missing. We also found that where concerns regarding a person presenting with dehydration had been raised, records from around the time of the concerns including fluid charts could not be found. We asked to see information about the recruitment and competency checks undertaken on agency staff, but this could not be found.

Thus, we continued to find areas in need of improvement in the record keeping systems and quality monitoring processes within the home which had been an on-going area of concern during previous inspections dating back to 2013. The lack of sustainability of any improvements that had been made over the years together with the on-going improvements required, meant that the safety of the service continued to be compromised and subsequently, persistent breaches in regulations had been found. We found the service to be in continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what action we have taken at the end of the report.

Staff we spoke with told us they felt things had improved since our last inspection in September 2016 and they felt supported in their work. One member of staff said, "Things have definitely improved; the management is firm but fair". Another staff member told us, "We [staff] get a lot of support, especially from senior care staff and the nursing assistants". Staff we spoke with told us and records we looked at showed that they received regular supervision and that the 'turn-around' manager also spent time 'on the floor' making observations. We were also told and records we looked at confirmed that staff engaged in regular team meetings which they found useful and informative and staff we spoke with told us that they felt valued and listened to. One member of staff told us about the provider's staff development schemes and how this had helped them to progress in their career. They said, "I have worked in care for over 20 years and have never had the opportunity to progress, but within six months of starting here, I have been recognised for my hard work and potential and have been given the opportunity to progress to senior care and hopefully will become a nursing assistant". One of the regional operations managers also told us that the provider was involved in the 'Kindness in Care awards' whereby staff are nominated for their work, which demonstrated their commitment to recognising, supporting and valuing staff contributions.

Duty of Candour is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. People we spoke with, records we looked and observations we made showed that the 'turn-around' manager was compliant with this requirement. We found them to be open in their communication with us throughout the inspection, and information we asked for, was provided to us, where available. They were forthcoming in recognising their limitations and were confident in their plans for development within the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment People living at The Orchards Care Home were not always protected against the risks associated with the unsafe use and management of medicines.

The enforcement action we took:

We issued a Warning Notice to the provider. We asked them to send us an action plan informing us of how they planned to ensure that people were protected against unsafe medicine management and how they would become compliant with this regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had some systems in place to monitor the safety and quality of the service but these had not always been implemented effectively to identify areas in need of improvement or used to drive improvements. Record keeping systems were not always effective and information was not always available or recorded accurately.

The enforcement action we took:

We issued a Warning Notice against the provider. We asked them to send us an action plan informing us of how they planned to make the required improvements to ensure that people received a safe and quality service.