ONH (Herts) Limited

The Orchard Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 21 and 22 December 2015. Breaches of legal requirements were found. We took enforcement action to ensure people were safe. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to Regulations 9, 12, 13, 14, 16, 17 and 18 of the Health and Social Care Act (Regulated Activities) 2014 Regulations.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Orchard Nursing Home on our website at www.cqc.org.uk

The Orchard Nursing Home provides accommodation and personal care for up to 63 people. There were 43 people living at the home on the day of our inspection.
The service had a manager in post who had not yet registered with the Care Quality Commission (CQC) . A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run.

The systems in place to monitor and review the service were not always effective. Although there had been improvements in regards to the management of the home, this was not always effective as there were some areas that still remained in breach of regulation.

People had been put at risk due to the process around removing bedrails when new beds were supplied. Although this was responded to promptly, there were a high number of falls and there remained some people without the equipment they needed to make them safe.

Staff had improved knowledge and awareness of individual risks. However, we noted that pressure reliving cushions were not always used when they were needed and one person's fall risks were not consistently mitigated.

Medicines were not always managed safety. We saw improvements in regards to the records held. However, stock quantities were wrong and this was not detected by the auditing tool.

Staffing levels had improved and staff were recruited through an effective process. People, relatives and staff were positive about the calibre of new staff members. Staff received the appropriate training and supervision for their role.

People were supported to eat and drink sufficient amounts and staff made mealtimes an enjoyable experience. People's care needs were met and their care plans were written with their involvement and

included appropriate information to enable staff to support them safely.

People and their relatives were aware of how to give their feedback and make a complaint to the management. These were responded to appropriately.

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

We found that some action had been taken to improve safety, but the service was not always consistently safe.

Individual risks in relation to falls was not always mitigated.

People's pressure care management was not consistent in regards to the use of equipment.

Medicines were not always managed safely.

Staff were safely recruited and staffing levels were improving.

Is the service effective?

Requires Improvement

We found that action had been taken to improve the effectiveness of the service.

People were supported by staff who received the appropriate training and supervision.

People were supported to eat and drink sufficient amounts.

Is the service caring?

Requires Improvement

We found that action had been taken to make the service caring.

People were treated with respect and as individuals.

People were involved in planning their care.

People were supported by staff who were aware of their choices.

Is the service responsive?

Requires Improvement

We found that action had been taken to make the service responsive.

People's care needs were met.

People's care plans included information to enable staff to

support them in accordance with their needs.

Complaints were responded to and people's feedback was sought.

Is the service well-led?

Requires Improvement

We found that actions had been taken to make the service well led, however these were not consistent.

Governance systems were not always effective.

Leadership arrangements needed to be reviewed to ensure all necessary improvements could be made and sustained.

Staff were positive about the manager and the changes in the home.

The Orchard Nursing Home

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 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of The Orchard Nursing Home on 29 March 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 21 and 22 December 2015 inspection had been made. The team inspected the service against the five questions we ask about services: is the service safe, is the service effective, is the service caring, is the service responsive and is the service well led. This is because the service was not meeting some legal requirements.

The inspection was undertaken by three inspectors.

During the inspection we spoke with five people who used the service, six relatives, 11 staff, the catering manager for the provider, the manager, the clinical manager and a peripatetic manager. A peripatetic manager is someone who is employed by the provider to give support to a service or management team. We viewed nine people's support plans and reviewed records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

When we inspected the service on 21 and 22 December 2015 we found that people were not receiving safe care in relation to moving and handling, use of equipment, pressure care management, risk management and management of medicines. We also found that there were insufficient numbers of skilled staff available to meet people's needs and that concerns in relation to abuse were not reported or investigated. At this inspection we found that there remained a shortfall in relation to the management of medicines and some areas of pressure care management. However, staffing levels and consistency had improved and staff were aware of individual risks and how to work safely.

Where potential risks to people's health, well-being or safety had been identified, these were assessed and reviewed regularly to take account of people's changing needs and circumstances. Risk assessments were in place for areas such as trips and falls, use of wheelchairs and mechanical hoists. These assessments were detailed and identified potential risks to people's safety and the controls that had been put in place to mitigate risks. For example, a care plan in relation to the risk of a person falling from bed stated, "I have a low profile bed with bedrails on each side and also bumpers."
We noted that staff were aware of individual risks, including those at risk of falls. We tracked a number of incidents which had occurred in care records and found that these had been reviewed by the manager. Risk assessments had been updated to reflect the event and associated care plans developed to reduce the risks. We asked staff about the incidents and they said the incidents had been discussed to try to find the cause and that they were familiar with the changes made to care plans as a result.
Examples included a re-referral made to a speech and language therapist for a person at high risk of choking and a review by a physiotherapist and occupational therapist for a person identified at high risk of falling due to mobility issues. However, in another case we noted that a person whose at high risk of falls needed to wear their glasses and well-fitting shoes at all times. We observed this person for almost three hours during the morning without their glasses and shoes being worn. Staff told us that they normally provided them with personal care after breakfast so they had not yet received support when asked about this during breakfast. We saw from the person's accident care plan that it had been noted that many of the person's falls occurred during the morning which indicated that an absence of their glasses and shoes may have been a factor.

Following an incident in the home it had been identified that wooden bedrails in use were defective and therefore people were potentially at risk. The provider had taken immediate action to remove all similar bed rails from the home in order to prevent recurrence of this and to protect people's health, safety and well-being. However, the provider sourced new beds for people that were not suitable for use with bedrails, this had been a deliberate decision taken by the provider in order to remove the restrictions created by use of bedrails.

However, people's needs had not been assessed in this regard and consequently some people experienced a significant number of falls from their beds. The beds were adjustable in height and people rolled from low level beds so did not sustain injuries. Records we viewed showed there had been 22 instances of people falling from their beds in a period of two weeks. Once this had been identified the provider took action to re-

instate bed rails for those people assessed as high risk from falling from their beds subsequent to a full assessment and consultation with people and their families.

The manager told us that there were now 11 or 12 new bedrails in place and that these had been introduced from 17 March 2016 and we noted that incident reporting had ceased from this date. The manager told us this may be a combination of the rails reducing falls and staff stopping reporting these incidents due to the frequency of occurrences.

People's medicines were not always managed safely. We saw that medicine records were completed consistently, there were care plans for people who required medicines on an as needed basis and handwritten entries were countersigned to reduce the risk of an error in recording. However, we counted 15 boxes of medicines and found that six of these boxes contained a different amount than what was expected according to the medicine records. For example, in some cases too many tablets remained which indicated that doses of medicines had been missed and in others too few remained, indicating too many doses may have been administered. This meant that people were at risk of ill health as they may not have received their medicines in accordance with prescriber's instructions.

People who were at risk of developing pressure ulcers had care plans in place to help staff reduce the risks them developing. We saw that where people needed assistance to change their position and use preventative creams, this was recorded. We also saw that, where appropriate, people had pressure relieving mattresses set to the correct setting for their weight. However, we also noted that three people assessed at high or very high risk of developing had not been supported to use pressure cushions in accordance with their care plans. We noted that two of these people sat in wheelchairs without any sort of cushion for long periods of time. This meant the risk of them developing a pressure ulcer was increased.

This was a continued breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People told us that they felt safe. One person said, "Oh Yes I am safe here." Relatives also told us that they felt people were safe. One relative said, "I have no concerns about my relative's safety." Staff were able to confidently describe how they would report any concerns both within the organisation and outside to the local authority safeguarding team. Information and guidance about how to report concerns, together with relevant contact numbers, was displayed in the nurse's station and in the reception area of the home. We noted that any concerns had been documented and reported appropriately.

Safe and effective recruitment practices were followed to help ensure that staff were of good character, physically and mentally fit for the role and sufficiently experienced, skilled and qualified to meet the needs of people who used the service. A recently recruited staff member was able to describe the process and said that they had not been able to start to work at the home until the manager had received satisfactory references and criminal record check. People and their relatives told us that the staff recently employed to work at the home were of a high calibre. One person said of a newly recruited care staff member, "They are a really good carer, so kind."

We also noted that issues in relation to numbers of skilled and suitable staff available to meet people's needs had been addressed. We saw that people had their needs met in a timely fashion and the atmosphere was calm and unrushed. The manager told us that they were continually recruiting to fill all staff vacancies, particularly nursing vacancies which were covered by agency nurses. We spoke with some agency nurses who told us they had been at the home regularly since January and they knew people well.

Requires Improvement

Is the service effective?

Our findings

When we inspected the service on 21 and 22 December 2015 we found that staff had not received the training and supervision they required to carry out their roles safely. In addition we found that people had not received sufficient support to eat and drink enough to maintain their health and wellbeing. At this inspection we found that training and supervision had been provided and the staff told us they felt supported. We also found that people were provided with appropriate levels of support to help them to eat and drink.

Staff told us that they received training which enabled them to care for people safely. One staff member told us that this had improved in recent times and said, "We have much more training now, it helps make us a more professional team." Relatives also felt that staff were more equipped for their roles. One relative said, "The management seem to be much more on the ball, there are some very good carers and they seem to do a lot more training now."
A newly recruited staff member told us that they shadowed established staff for weeks and undertook a range of basic core training during this period before they were able to work with people unsupervised.

Staff confirmed that they had regular supervision. This used to be from their floor leader but was now being undertaken by a member of the provider's management team that had been seconded to the home to provide additional assistance and support. This meant that staff felt supported.

People were supported to eat and drink and there was varied menu for them to enjoy. We sampled the food on each floor of the home and food it to be tasty, fresh and hot. We observed breakfast and lunch in the home. We saw that people were given sufficient quantities and were encouraged to drink during their meals. Staff sat with people and assisted them to eat where they were unable to do so independently. This was done respectfully and staff stayed with people, giving them full attention, throughout the duration of the meal. We also noted that staff took care making sure food was not too hot before giving a spoonful to people. For example, we observed a staff member cooling soup by transferring it between two cups repeatedly.

People were offered choices of what they wanted to eat and, on one floor where most people lived with dementia, they were shown both plates so they could choose which they fancied. We noted in one case that a person had a bit of both options and in another a relative asked on their behalf for an omelette. This was immediately called through to the kitchen and the chef arrived a short while later with an omelette and a side salad. We saw that nutritional and risk assessments were completed and staff were familiar with these. Food which had been pureed for those requiring a soft diet was well presented. Individual risks were displayed in the kitchen areas and we heard staff discussing who needed what type of support.

Where people were at risk of malnutrition and dehydration a record of what they had been offered and consumed was recorded. Amounts of fluid was totalled at the end of the day and staff told us if they were worried a person was not eating or drinking enough, they would contact the GP. We saw in medical notes that these referrals had been made. People's weights were monitored and this was used as part of a

screening process. However, we discussed with the manager that at times, when there had been changes in a person's weight, it was not always clear when the changes were reviewed. We saw throughout the inspection that drinks were available and people were prompted to drink regularly.

Requires Improvement

Is the service caring?

Our findings

When we inspected the service on 21 and 22 December 2015 we found that people were not involved in planning their care and they were not treated respectfully or as individuals. For example, the focus in some people's care plans was put on the fact that people may 'hit out' or be 'aggressive' but guidance was not provided about addressing triggers to that behaviour or considering what may help a person. At this inspection we found that people and their relatives were involved in making decisions about their care and staff were aware of people's preferences, individual needs and wishes.

People and their relatives were positive about most of the staff team. Comments from people about staff included, "Very kind", "caring" and "Lovely." Relatives also described staff as, "Great", "Attentive", and that they "Try their hardest.", One relative told us, "The staff team have a great deal of empathy, they are very caring." However, other relatives told us it could depend on which staff were on duty as to if it was basic care delivered or staff took time to doing, "All the little bits."
Care plans, which demonstrated people and their relatives involvement, included what was important to the person and what their strengths were. We noted that when we asked staff about a person who was known to display behaviour that challenged, staff told us that they were a jolly person and loved to dance. This reassured us that staff were looking for the positives in people rather than those characteristics that may have made supporting the person more difficult.

Staff were more attentive in their approach and this was seen across the permanent staff and the agency staff. We observed the agency nurse during lunch service on middle floor and saw they were very kind and gentle, touching people lightly on the arm as they talked with them and bending down to talk quietly with people who were hard of hearing as opposed to shouting from above.

People were relaxed and comfortable to approach and talk with care staff, domestic staff and management alike. We observed all staff interacting with people in a warm and caring manner; listening to what they had to say and taking action where appropriate.

People`s right to privacy was promoted. We saw that staff knocked on people's doors before entering their rooms. Staff acted on people`s preferences to have their bedroom doors open or closed and we saw staff closed bedroom doors when personal care was delivered.

Relatives and friends of people who used the service were encouraged to visit at any time and we noted that there was a regular flow of visitors into the home throughout the day.

Requires Improvement

Is the service responsive?

Our findings

When we inspected the service on 21 and 22 December 2015 we found that people's care needs were not being met appropriately and safely. We also found that care plans were not completed or accurate. At this inspection we found that in most areas care needs were met, care plans were completed accurately and staff were able to describe people's different care needs to us.

People's care needs were met. We saw that people received support with going to the toilet, getting washed and dressed, eating and drinking and in relation to their mobility. Care was given in a way that was described in the care plans. Care plans included evidence of reviews involving the people who used the service and/or their relatives where necessary and appropriate. Staff were familiar with people's likes and dislikes and we saw detailed accounts in the care records of people's preferences around many areas of their lives. We saw for example thorough information about peoples' lives, their families, careers and individual preferences in the way they would like to spend their time. We saw people's preferences were listed which included, for example, their favourite colours, perfume and make up preferences as well as details of lifestyle choices and preferences with regards food, drink, sleep, activities and favourite music.

People's care plans were sufficiently detailed to enable staff to provide their care needs. Staff members were clearly knowledgeable about people's individual likes, dislikes and needs. A staff member recently recruited to work at the home demonstrated an in depth knowledge of a person's nutrition and hydration needs and explained to us how the person could appear completely different from one day to another. The staff member explained that this meant that a different approach was required from staff to ensure that the person had their needs met.

The service encouraged feedback from people, their relatives and friends. One relative told us, "I have had to raise concerns and I understand that not all suggestions can be taken up. There has to be some compromise." We saw that a feedback booklet called, 'We value your opinion' was widely advertised and available for people and their relatives to use. In addition relatives told us that there was a regular meeting arranged to meet with and receive feedback from relatives. A monthly newsletter had been published which updated people and their relatives about developments with recruitment and any other key events.

The manager told us that issues raised by relatives were responded to, but not always by letter. The manager had not yet developed a robust system for managing complaints and was not able to show us a clear pathway about how they were resolved. There was 'Grumbles book' in the communal reception area for relatives to be able to enter any specific issues that they wished to be attended to. Examples included incidences of people being left without their call bells, hearing aids without batteries and no straws that person needed to help them drink from a beaker. These issues were commented on in the margin of the book by staff to indicate what had been done.

Requires Improvement

Is the service well-led?

Our findings

When we inspected the service on 21 and 22 December 2015 we found that systems in place to identify, address and resolve any issues in the home were ineffective and as a result this impacted on the safety and welfare of people who lived at the service. At this inspection we found that although there had been improvements made, there were still areas that were not fully rectified.

Since our last inspection the provider had put additional management support into place. This consisted of peripatetic managers who worked with and supervised staff on each floor and a clinical manager who oversaw care and nursing practice. Although there was mixed views on the effectiveness and the consistency of this from relatives, staff told us it had been positive. One staff member said, "We have seen big changes in the last several months and we are really settling now and have some stability." We found that care records were completed and this had been part of management team's role. In addition, we found that staff morale had improved. However, where we had found issues that continued as a breach, it was not clear that the current structure was effective.

There was a clinical governance system in place used to update the provider about progress and performance in a number of areas. However, we found this was not always accurate. For example, it had not reflected that there had been any infections in the home during a three month period, wrongly reported that an inadequate health and safety audit was good and had the wrong dates of safeguarding incidents. This system did not ensure that incidents were monitored effectively or that all remedial actions had been taken. In addition, it did not ensure that the provider was fully aware of all events in the home to enable them to monitor themes and trends. We also found medicines audits did not include adequate stock checks of medicines. This meant that the manager could not be sure that the audits were effective and identified all areas of shortfalls or risk.

This was a continued breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Most people and their relatives were positive about the changes made in the home since our last inspection. One relative said, "I am not saying it is perfect but they do seem to have taken on board the CQC comments and it is moving in the right direction." Another relative told us, "Things have improved in recent months, I can't criticise the care [relative] receives now."

Staff told us that their morale was "Improving" and that they felt engaged with developments in the care home. All staff commented positively about the availability of their manager and how approachable they were. One staff member said of the manager, "[Name] is phenomenal." We saw that the manager was visible and available. Staff told us that the manager was available and often assisted them in the delivery of care and support to people. Staff told us they felt able to report incidents, raise concerns and make suggestions for improvements. Staff were clear about their expected roles and responsibilities.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to individuals safety were not always mitigated and medicines were not managed safely.

The enforcement action we took:

Notice of proposal to impose positive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not effective or robust.

The enforcement action we took:

Notice of proposal to impose a positive condition