ONH (Herts) Limited

The Orchard Nursing Home

Inspection report

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Date of inspection visit:
18 April 2017

Date of publication:
05 June 2017

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?	**Inadequate**

Summary of findings

Overall summary

This inspection was carried out on 18 April 2017 and was unannounced. At their last inspection on 25 October 2016, they were found to not be meeting the standards we inspected. At this inspection we found that they had continued to not meet all the standards.

The Orchard Nursing Home provides accommodation and nursing care for up to 63 older people, including people living with dementia. At the time of the inspection there were 47 people living there.

The service had a manager who had applied to be 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 application was in progress.

People's medicines were not managed safely and safe food hygiene practice was not consistently followed. People were not always protected from harm and views on staffing were mixed. However we found staff were recruited safely.

Quality assurance systems were not always effective and the management team needed to develop systems to ensure people's voice was sought and heard consistently. There had not been sufficient improvement in the systems in place to ensure breaches of regulation were resolved and the service people received was consistent.

There was a new management structure being implemented which included two deputy managers who would be available seven days a week. People were supported by staff who were trained and supported. People had their consent sought and the staff worked in accordance with the principles of the mental capacity act. There was a variety of meals and support with eating and drinking as needed and people had access to health and social care professionals.

People were treated with dignity and respect and they were positive about the staff who supported them. People and their relatives where appropriate, were involved in planning their care. Confidentiality was generally promoted, however, at times staff spoke openly about people in public areas. People did not always receive activities that took account of hobbies, interests, likes and dislikes and this was an area that required improvement.

People told us care needs were met, however, at times there were issues in relation to accessing the toilet or getting off the toilet. People's care plans were clear and up to date and complaints that the manager received were responded to.

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 safe.

People's medicines were not managed safely.

Safe food hygiene practice was not consistently followed.

People were not always protected from harm.

Views on staffing were mixed.

Staff were recruited safely.

Is the service effective?

Good

The service was effective.

People were supported by staff who were trained and supported.

People had their consent sought and the staff worked in accordance with the principles of the mental capacity act.

People received a variety of meals and support with eating and drinking as needed.

People had access to health and social care professionals.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

People and their relatives where appropriate, were involved in planning their care.

Confidentiality was generally promoted, however, at times staff spoke openly about people in public areas.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive activities that took account of hobbies, interests, likes and dislikes.

People told us care needs were met, however, at times there were issues in relation to accessing the toilet or getting off the toilet.

People's care plans were clear and up to date.

Complaints that the manager received were responded to. However, they were not always aware of people's concerns.

Is the service well-led?

Inadequate

The service was not well led.

Quality assurance systems were not effective.

The management team needed to develop systems to ensure people's voice was sought and heard consistently.

There was a new management structure being implemented.

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.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We also reviewed the provider information return (PIR) submitted to us. This is information that the provider is required to send to us, which gives us some key information about the service and tells us what the service does well and any improvements they plan to make.

After the inspection on 25 October 2016, the provider sent us an action plan setting out how they would make the required improvements.
The inspection was unannounced and carried out by two inspectors and an expert by experience. An expert by experience is someone who has used this type of service or supported a relative who has used this type of service.

During the inspection we spoke with nine people who used the service, five relatives, eight staff members, the regional manager, the operations director and the manager. We received information from service commissioners and health and social care professionals. We viewed information relating to seven people's care and support. We also reviewed records relating to the management of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us due to their complex health needs.

Requires Improvement

Is the service safe?

Our findings

People's medicines were not managed safely. We saw that there was a record of staff signatures and a record of a check of medicines charts twice daily. However, we also saw that there were at times checks on quantities and these did not always identify discrepancies in quantities. We counted a random sample of boxed medicines and in 23 cases we found the wrong quantity in stock or due to poor recording of variable dose, we were unable to count accurately. This indicated that people had not received their medicines as the prescriber instructed. People told us that they did not always get their medicines in a way that they were meant to be administered, for example, one tablet must be given when a person is in an upright position to aid the correct absorption of the medicine but one person told us staff at times gave it while they were lying down. They told us, "I take [medicine] and that is sometimes given to me when I'm lying down, they don't seem to understand." We were also told that at times, medicines were not given at the required times. We also found that quantities for some medicines were not recorded on medicine records and variable dose medicines, such as pain relief, therefore this made it impossible to audit these medicines and check if they had been administered appropriately.

Safe food hygiene practice was not adhered to in the main kitchen. We found that cleaning records had not been completed consistently and there were area in the kitchen that required cleaning. We found food not dated inside fridges and some fruit and salad items that were spoiled inside the fridge. We also found that bread with a best before date two days previous was in use during breakfast. In addition, raw meat was stored on tomatoes inside a fridge. We asked the chef whose responsibility it was to check the standards in the kitchen and if they used the local authorities 'Safer food, better business' processes and they were unable to give us a clear answer. We were not sure that they understood what we were asking. We spoke with the management team about this who told us that they were meant to use the 'Safer food better business' but they had not been using the open and closing checks or adhering to the guidelines.

People had their individual risks assessed and these were updated monthly. We saw that staff worked in accordance with these risk assessments in most cases. The manager had developed a falls strategy to enable them to identify themes and trends and to ensure all action to reduce a reoccurrence had been taken. For example, they identified that one person had increased falls after meals so put a plan in place for staff to assist the person directly to the toilet from meals and this had resulted in a reduction in the number of falls they had sustained. However, we also noted that following a fall of a person who was receiving one to one care from an agency staff, an incident form was completed but this did not identify that they had not checked the staff member's training or that there was not a clear protocol in place to give clear guidance to agency staff supporting this person.

We noted that one person was assessed as needing one to one to stop them from falling. We saw that they had been assigned an agency staff member to provide 24 hour care and a lap belt was to be in situ while in their wheelchair. However, we noted that previous to our inspection this person had sustained a fall resulting in injury as the staff member left them alone while going to get them food. In addition, during our inspection, we noted that the agency staff member again attempted to leave the person, on this instance the nurse stopped them, but they also did so twice more during our observations. We discussed this with the

management team who told us that they would develop a protocol to ensure agency staff stayed with them. The person who required one to one supported exhibited significant behaviour that challenged. We viewed the profile for the staff member who was supporting them and found that they had not received training in relation to dementias care or challenging behaviour. This put the person, the staff member and others at increased risk of harm.

We overheard the visiting professional conducting eye tests with people who used the service. We heard them say to one person, "Watch my finger." The person had clearly not heard them or had not understood what had been said. The optician then very sternly and abruptly repeated the instruction, "Watch my finger!" This presented as being uncaring and unkind. We raised this with the management team who acknowledged that they did not like the optician's manner. However they had continued to use this professional and had not prevented them from being left alone with people. We also noted that the professional was asking people, some of whom may have been living with dementia, if they wanted to see them, and then we noticed on one occasion the professional took the person in their wheelchair via the lift to another floor, without a staff member accompanying them. We discussed this with the management team who told us this was not something they expected.

Therefore due to the shortfalls in relation to management of medicines, the hygiene standards in the kitchen, not ensuring people were consistently supported appropriately when there were external professionals present and the systems in place in relation to the person requiring one to one care, this was a continued breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

When we last inspected the service we found that unexplained bruises or skin tears were not recorded or investigated to rule out any possible safeguarding issues. At this inspection, although we found a reduction in unexplained bruises, we found that there were still some issues remaining.

Staff had been trained in how to safeguard people from avoidable harm and were knowledgeable about the potential risks and signs of abuse. Information and guidance about how to report concerns, together with relevant contact numbers, was displayed in the home and was accessible to staff and visitors alike. However, during the lunch service we saw a person and staff member sat at the side of the dining room with the staff member trying to support them to eat their meal. The person continuously grabbed and pinched the staff member who grabbed the person's wrist to stop them inflicting pain. No staff in the dining room noticed this activity or if they did they did not identify the potential safeguarding concern. We also noted that one person's body map recorded that they sustained a skin tear on their wrist. This was not referenced in the person's daily notes, nor was there an accident or incident form available on relation to the injury. We asked the manager about this who told us that they had no knowledge of the injury.

Therefore this was a continued breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People told us that they felt there were not always the expected number of staff on duty which meant they at times had to wait to use the toilet or get off the toilet. One person said, "There is simply not time for any staff to help with anything but care, they are so busy." Another person told us, "Last week I was sitting on the toilet for more than 20 minutes and I pulled the cord 5 times." Relatives also felt there were not always enough staff around. One relative told us, "[Person] is often left sitting on the toilet or waiting for someone to take [them] to the toilet, it's a long wait sometimes, more than 15 minutes that's a very long time when you are waiting for the toilet."

We noted that the staffing levels seemed to be appropriate for the number of people who needed support.

Throughout the course of the day we noted that there was a calm atmosphere in the home and that people received their care and support when they needed it and wanted it. Call bells were answered in a timely manner and staff went about their duties in a calm and organised way. Staff told us that permanently recruited staff numbers had been increased reducing the need for as much agency staff cover as previously which had a positive impact on the standard of care delivered. However, people told us that staff told them they were short staffed and they felt the rota did not reflect the number of staff in the building. One person told us, "They are supposed to have four carers on but they almost never do. The carer told me there were only two people on, I told the manager and she took out all the rotas and told me 'you can see there are 4 on' "I said who am I supposed to believe but I think they move people around, from one floor to another."

We reviewed the rota and were not able to confirm that all shifts where staff were off sick were covered. The operations director told us that the biometrics system recorded staff member's fingerprint when they entered the home, confirming the number of staff on duty. We reviewed this and found that most shifts were recorded as being covered. This indicates that staffing deployment may be the issue rather than numbers. The regional manager told us that they were currently looking at updating the call bell system so that it can provide a record of response times for them to review. However, people's perception of staffing and the delay they experienced when wishing to use the toilet was an area that required improvement.

Staff told us that people were assisted to reposition at appropriate intervals to help maintain their skin integrity and we saw that records were maintained to confirm when people had been assisted to reposition. We checked a random sample of pressure mattresses for people who had been assessed as being at risk of developing pressure ulcers and we found that most were at the appropriate setting for their weight. However, we asked a staff member to explain why a person's mattress was set at a 51 kg – 75 kg weight band when their weight was recorded as being 38.9 kg. The staff member responsible for checking that the mattress was set at the right setting did not understand what they were checking and why. The forms that the staff signed to indicate that mattresses were at the right pressure had space for people's weight and the appropriate mattress setting to be recorded however the records had not been completed. We also found that one mattress pump, which should usually be attached to the end of the bed, was wedged underneath the bed mechanisms making it impossible to check the setting and also making the feet of the bed lift from the floor when it was put into the sitting position. We discussed this with the nurse in charge of the unit who undertook to check that all other mattresses on the unit were set correctly. They also told us that there had been discussions around nurses taking the responsibility back for checking this important area. This was an area that still required improvement.

People who had been assessed as requiring bedrails on their beds to prevent them falling had protective covers over the rails to reduce the risk of entrapment. Staff helped people to move safely using appropriate moving and handling techniques. For example, we observed two staff members using a mechanical hoist to assist a person to transfer from a wheelchair to an armchair. The staff members reassured and talked with the person all the way through the procedure. People's care plans included information about the type of hoist and sling that they used which meant that care staff had access to the information that they needed to transfer people safely.

Safe and effective recruitment practices were followed to make sure that all staff were of good character and suitable for the roles they performed at the service. We checked the recruitment records of three staff and found that all the required documentation was in place including two written references and criminal record checks.

Good

Is the service effective?

Our findings

Staff training levels had improved. We saw that the management team were working to reduce the number of staff due for updates to their training and were also working to support new staff through the care certificate. There were some gaps evident but we saw training had been scheduled in these areas. The management team and staff confirmed that there was a programme of staff supervision in place, all staff we spoke with said they received support as and when needed and were fully confident to approach the management team for additional support at any time. In particular staff told us that the newly employed deputy manager was very supportive and was already making improvements. One staff member said, "We now have a deputy manager and we are starting to see changes, we are seeing light at the end of the tunnel." Another staff member told us, "[Deputy Manager] is lovely, so supportive. They have worked alongside us on the floor which is so nice."

People had their consent sought and the staff worked in accordance with the principles of the mental capacity act. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met and found that they were.

Care plans included evidence of area specific mental capacity involving the person, their relatives where appropriate and health professionals. Where it was deemed that people did not have the capacity to make decisions, for example, around the use of bed rails, a best interest decision was made. One care plan stated, "I am able to answer simple questions but have difficulty in making any complex decisions. I like people to explain what is happening." Staff explained to people what was happening and obtained their consent where possible before they provided day to day care and support. We noted that 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) decisions were in place, and it was clear that people had been involved with making the decisions and, where appropriate, their family members as well. We found that the appropriate applications in relation to DoLS had been made and these were all pending a response.

People were provided with a good choice of food and told us they enjoyed the food. One person said, "It's very nice." We noted that staff knew people's likes and dislikes but still offered a choice. For example, we heard one staff member say to a person, "I know you'll choose curry but just in case, would you like chicken curry or beef stew?" The person chose the curry and was seen to be enjoying it. We observed the lunchtime meal served in a communal dining room and noted that people were provided with appropriate levels of support to help them eat and drink. This was done in a calm, relaxed and patient way that promoted people's independence as much as possible. We saw vegetable put in bowls on the tables for those who had curry in case they fancied adding them. People were supported to eat in whatever way was appropriate to

their needs and to maintain their independence as much as possible. For example, some people had their soup served in a bowl to eat with a spoon whilst others had a cup with a straw or a beaker with a spout. We heard staff interacting with people in a kind and considerate manner indicating that nothing was too much trouble.

On the dementia unit people were asked at the point of service which of the two lunch choices they would like. However, it was disappointing that they were not shown plated choices for them to make a meaningful choice based on the look and smell of the food.

Assessments had been undertaken to identify if people were at risk from poor nutrition or hydration. We noted that these assessments were kept under review and amended in response to any changes in people`s needs. Records maintained of people's weights showed that the support provided for people identified as being at risk was effective because people's weights were gradually increasing. For example, a dietician involved with a person's care and support had noted, "Weight is gradually increasing and oral intake is maintained." The advice from the dietician was to reduce a prescribed food supplement from four times a day to twice a day and to increase nutritionally fortified foods such as desserts if the main meal was refused. The person's care plan had been amended to reflect the latest professional advice received.

People had access to the appropriate health and social care professionals. We noted that appropriate referrals were made to health and social care specialists as needed and there were regular visits to the home from dieticians, opticians and chiropodists. People and their relatives told us that the staff sorted out their appointments. One person said, "They sort out all my appointments, they look after me well." A relative told us, "They sort out all her appointments, they are very good."

Good

Is the service caring?

Our findings

People were treated with dignity and respect. Staff respected people's dignity and made sure that they supported people in the way they wished whilst encouraging them to remain as independent as possible. During our inspection we noted that staff were courteous and kind towards people they supported. For example, during the breakfast service on the dementia unit staff chatted with people whilst they were supporting them asking if they slept well and one staff member was talking with a person about a dream they had.

We saw staff promoting people's dignity and privacy by knocking on people's doors and waiting before entering people's rooms. Throughout the day we noted there was good communication between staff and the people who used the service and they offered people choices.

People we spoke with were positive about the staff. One person told us, "The carers are very kind and helpful." Relatives also told us that the staff were kind and caring. One relative said, "The carers are very good, they are very kind." People also told us that visitors were welcome at any time. One person said, "They can come when they want and stay as long as they want." Relatives confirmed this. One relative said, "We are a big family. We can come when we want to and take x out when we want to as well, we like to do that."

The environment throughout the home was warm and welcoming. People's individual bedrooms were personalised with many items that had been brought in from their home such as cushions and pictures.

People, and their relatives where appropriate, were involved in planning their care. People were offered choices and these were respected which contributed towards people feeling that they had control in their lives. For example, we heard the staff members ask people if they wish to wear clothing protectors, "[Person's name] would you like an apron on?" All people were asked this and if they declined an apron their choice was respected.

Staff took appropriate action to comfort people. For example, a person became anxious because the lunch trolley was a few minutes late coming from the kitchen. A staff member put their arm around the person's shoulders to comfort them and found them an alternative place to sit in the dining room. We noted that the person remained calm and happily tucked into their lunch when it arrived.

Confidentiality was generally promoted, however, at times staff spoke openly about people in public areas. For example, we saw on occasion staff speak across people and one staff member tell their colleagues, in a full dining room, that the person they had just tended to was, "Wet, wet." We raised this with the management team who spoke with the staff member. People's care records were stored in a lockable office in order to maintain the dignity and confidentiality of people who used the service. We noted that the office was generally closed when staff were not using it. However, on one unit we found the office door stood ajar with no staff member present. When the staff member returned they demonstrated to us that they could not reach the door closing mechanism so were not able to protect people's confidentiality and privacy. We discussed this with the management team who were unaware of this matter, they had not identified it for

themselves and the staff member had not seen this as an issue that needed to be raised with the management team.

Requires Improvement

Is the service responsive?

Our findings

People told us that they did not have much in the way of activities to do. One person said, "There's nothing to do here, there is no activity plan and they don't circulate anything telling you what might be going on." Another person told us, "It's very boring here, even a tea party once a month like they used to have would be better than nothing." There were limited activities taking place in the home during the course of the inspection. For example, we observed an activity taking place on the dementia unit where a large foam ball was thrown to people for them to take aim and throw it into a basket. There was very little interaction between the person facilitating this activity and the people seated in the dining room. The radio was playing in the background.

On the middle floor we noted that a children's puppet programme was on the television and some people were being encouraged to take part in a giant game of snakes and ladders. People were encouraged to throw a large dice onto the floor and the activity facilitator made the move for them. Of the seven people in the room three people were partially interacting with this activity. One person told us they enjoyed the game. However, we discussed with the staff that the absence of meaningful activities may make any activity enjoyable. We asked the activity co-ordinator how people's likes and preferences were taken into account in terms of activities. They told us that people were asked what they would like to do but that they did not have records of people's life histories to refer to in order to inform a person centred approach. We asked why a children's programme was on the television, the staff member replied that it made people smile and they took that as a positive sign that people enjoyed it. They said, "If I see they are enjoying something then it is OK." We asked the management team why likes, dislikes, hobbies, interests and life histories were not documented. They told us relatives hadn't wanted to provide that information. They told us they needed to ask people themselves what they enjoyed. The regional manager told us that activity staff were booked onto activities training in the upcoming weeks.

One activity co-ordinator told us that a variety of activities were offered depending on the people that wanted to take part. For example, anagrams, drawing, painting and cooking. They told us that they sometimes did bible readings for 'religious' people. Another activities organiser told us that they asked people about likes and dislikes and gave us the example of 'tea or coffee' and 'which game they would like to play. Even though they were supporting people living with dementia they told us that they had never heard of 'This is Me' or any similar helpful document to understand people with dementia and their backgrounds and preferences. They told us that health issues made the internet a difficult tool for them.

They told us that they did talk with people who stayed in their rooms but could not give me any example of the activities they did with them. No one we spoke with in their rooms could remember a visit from an activities coordinator

In the afternoon we observed a game of dominoes going on for people who were able to participate. We did hear one person discussing 'his gardening' with a staff member and gestured to the pots on the balcony which indicated they were enjoying this. A relative told us, "I came the other day and it was really warm and they were in the garden, they enjoyed that." One person told us that they played bridge and a few friends

come in once or twice a week to socialise and play bridge together in the quiet lounge and that they arranged all this themselves. However, we noted that there was little in the way of meaningful activities for many people, and in particular those who spent their days in their rooms. This included a lack of external activities and community events. This was an area that required improvement.

People's care plans were reviewed regularly to help ensure they continued to meet people's needs. Staff told us that people's relatives were invited to attend monthly review meetings where appropriate. Care plans were sufficiently detailed to be able to guide staff to provide their individual care needs. They showed that people were asked to think about their wishes in relation to end of life care and it was documented if they had any specific wishes or if they had declined to talk about this matter when they moved in to the home.

Staff were knowledgeable about people's preferred routines, likes and dislikes, backgrounds and personal circumstances and used this to good effect in providing them with personalised care and support that met their individual needs. People told us that mostly their needs were met. One person said, "The staff are really hardworking, I don't know how they manage." Another person said, "I have a shower three times a week by arrangement, it was difficult to sort out but that's what I do." However, some people told us at times there was a delay in using the toilet or getting off the toilet in a timely way. One person told us, "I was left on the toilet for half an hour, not just once, several times."

Concerns and complaints raised in writing by people who used the service or their relatives were appropriately investigated and resolved. One person told us, "I did have issues with a night carer. I told the manager and she contacted the agency and the carer didn't come back. She did sort it out." However, we noted that some of the concerns people had raised directly with us during the inspection and prior to the inspection were not recorded and managed under the provider's policies and procedures for managing complaints. The management team told us that this was because they had not been made aware of the issues. We discussed various ways for the management team to interact with people and their relatives to learn of their concerns and to help to drive forward improvements in the service.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 25 October 2016 we found that management systems were not always effective. The service had positive conditions imposed on their registration in July 2016 to set out how they are to ensure that they have systems in place to promote the safety and welfare of the people they support. The provider sent us an action plan setting out how they would make the required improvements. At this inspection, although we found that there had been improvements in some areas, we also found that management systems were still not effective and there continued to be breaches of regulation. This meant that the provider had failed to achieve a good rating and had been rated requires improvement for the past five inspections over a period of 16 months.

We reviewed the action plan that the provider had submitted to us following the last inspection. We found that although there had been progress in many of the areas detailed on the plan, not all issues were fully resolved. For example, in relation to governance systems. This meant that the provider was not identifying and rectifying areas of concern which put people at risk of harm.

There were a range of checks undertaken routinely to help ensure that the service was safe. These included such areas as medicine audits, mealtime experience audits, infection control, staffing dependency and environmental audits. However, we found that the medicine audit and kitchen audit had not been effective in identifying shortfalls we found at this inspection. We found shortfalls in relation to medicines and the standards in the kitchen as part of our inspection which had not been identified by the management team.

We noted that the regional manager carried out a visit monthly and checked standards throughout the home. We found that the past three monthly visits all identified an issue with mattress settings and their inaccurate recording. However, we found this to still be an issue on the day of inspection. This demonstrated that systems in place to address these issues were not effective.

The management team were not able to provide evidence to demonstrate that people and their relatives were able to positively influence the service provided. For example, there had not been any satisfaction surveys undertaken in the home despite a change in management arrangements and previous shortfalls identified through inspection and local authority monitoring systems. There were no minutes of stakeholder meetings available to evidence that management tried to involve people.

There was no evidence around the home of meetings held for people who used the service to share their opinions about the service and facilities provided at The Orchard Nursing Home. We saw that there was a schedule of meetings for relatives to attend on the communal notice board but there were no minutes of meetings available for us to view at the inspection. This showed that people were not supported to be able to influence the service they received. Relatives reported that the minutes of previous relatives meetings had not accurately reflected the discussions that took place and as a result they had decided it was pointless to attend any further meetings. One relative told us, "They don't listen to us. We can go to meetings, say things but nothing ever happens. It's just not worth going because no actions are ever taken." A meeting was held

with relatives after the inspection and we received the notes to that meeting.

People and their relatives shared with us many concerns, complaints and grumbles throughout the day. The manager was not aware of any of these concerns and there was no record of these issues being raised with them. We asked if they spent time going round and speaking with people and they told us, "I do but not in depth." However, people told us that they did not know the manager and one person told us, "One day someone came in and just stood in the dining room looking, they were obviously official but didn't say anything. Then someone told me she was from Head Office, well she could have introduced herself." One person told us, "It would be nice if the manager popped in to see people once a week. It would show some interest." The manager told us that part of the role of the new deputy managers was to observe and guide staff.

People's feedback about staff deployment and effectiveness from the last inspection had not been resolved in relation to having to wait for staff assistance when they needed to use the bathroom. We received the same concerns at this inspection. We also found that one person required a staff member to support them on a one to one basis. This had been allocated to an agency staff member however, the appropriate checks had not been completed by the management team to ensure the agency staff member sent was appropriate to meet the needs of the person they were supporting. We found that they did not have the correct training nor was there a protocol in place to ensure the person's welfare, or that of the staff member. As a result the person had suffered harm from a fall and the staff member was not managing their behaviour that challenged and this posed as a safeguarding risk.

Record keeping was not completed effectively. Daily records were limited giving very little information about the person's demeanour or what they had done with their day. It was purely a record of physical interventions undertaken. On the day of our inspection people's records had not been completed since 3pm the previous day. Staff may therefore have not had appropriate and up to date information about people. The provider had not identified this as an area that required addressing.

Food and fluid records were not always accurately completed. We noted that daily fluid intake charts demonstrated that people had not received their assessed daily target required to maintain good health. For example, one person's records indicated that they had received 800mls of fluid against a daily target of 2630mls and another person's records indicated they had received 1150mls against a daily target of 2257mls. We asked a staff member what they would do as a result of these records. The staff member told us that the records were not always accurate but that they knew if people required further support in this area. The provider's quality monitoring had not picked up and remedied this issue.

The lack of effective quality monitoring was a continued breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The monthly checks on infection control and information in people's care plans were effective. We found that the service was clean and care plans were completed appropriately. Where shortfalls were found, these had been addressed by the audit the following month. At our last inspection we also found that staff were not receiving regular supervision and were not always supported. However, at this inspection regular supervision and appraisal was taking place and staff were positive about support arrangements.

Staff told us that they could go to the manager or new deputy manager if they needed to. Staff told us that they felt the leadership in the home had improved. One staff member told us, "The manager says do it and you need to do it."

There were ten minute key staff meetings each weekday. The manager told us that this would be happening seven days a week when the second deputy manager started. We saw that these meetings checked on people's welfare, any issues and share information as needed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had note ensured that people received care that promoted their safety and welfare.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that people were protected from the risk of harm.

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 The provider had not ensured that the quality of the service was effectively monitored and issues were therefore not identified of resolved.