HC-One Limited

The Orchards

Inspection report

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Ratings

Is the service safe?

Overall summary

We carried out an unannounced comprehensive inspection of this service on 31 July 2014. At which a breach of legal requirements was found. This was because the systems to monitor the quality of care were not always effective.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. We undertook a focused inspection on the 8 October 2014 2 April 2015 to check that they had followed their plan and to confirm that they now met legal requirements. We found that improvements had been made but some further work was needed and we asked the provider to give us a plan of what action they were taking.

The inspection took place on 6 June 2015 and was unannounced. This was a focused inspection because we had received some concerns about staffing level in the home. This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'The Orchards' on our website at www.cqc.org.uk'

The Orchards provides accommodation and support for up to 72 people with nursing and personal care needs some of whom were living with dementia.

There was a registered manager in post. 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.

There were not always enough staff on duty to ensure that people were adequately supervised so that their care needs were met in the way they wanted. Staff shortages meant that emergency buzzers were not responded to quickly, meals were cold by the time some people got them, some people did not get the support they needed at meal times and medication was not given at the times prescribed. This is a breach of Regulation18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe

The provider had not ensured that there were sufficient staff to ensure peoples care needs were met effectively as required in line with their assessed care needs.

There were not insufficient staff to safely provide care to people that met their individual needs and preferences

We will review our rating for safe at the next comprehensive inspection

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 a focused inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008,

We undertook a focused inspection of The Orchards on 6 June 2015. This inspection was completed because we received information of concern in relation to staffing levels within the home. We looked at staffing levels within the home and did not assess the whole domain under this question. The inspection was undertaken by two inspectors.

Before our inspection we received information of concern in relation to staffing levels within the home and raised four safeguarding alerts with the local authority.

As part of our inspection we looked at the information we held about the service. This included notifications received from the provider about deaths, accidents/incidents and safeguarding alerts. A notification is information about important events which the provider is required to send us by law. We considered any concerns or complaints we had received. We spoke with the local authority and commissioning team. We spoke with 11 staff, 7 relatives and 12 people who lived there. We looked at five people's daily living records to check if they had received care according to their assessed care needs.

Is the service safe?

Our findings

Before our inspection we had received concerning information about low staffing levels. People told us that at times people were not able to be washed and dressed at a time they would like and that this happened particularly at weekends. As a result we carried out a weekend visit to check on the staffing levels and to ensure that people's needs were being appropriately met.

On our arrival at the home at 12.15pm we saw that the majority of people were in their beds. All the people spoken with gave positive comments about the staff. Staff were described as; brilliant, lovely staff, so kind, a great bunch and very caring. One person told us, "The staff here are just the best, friendly, I have never heard any one of them say anything to anybody that was not kind." However, they also said that their needs were not being met in the way they wanted because there were not always enough staff available. One person told us, "I cannot complain about how the staff treat me because they are very good. It's just that they rush to do things, and most of the time it's not how I like it, but what choice do I have when they are short of staff."

One person told us, "I have been waiting to get up, but the staff are busy." Another person told us, "They [staff] don't answer the buzzer. I can wait up to an hour." A third person said, "There is not enough staff, I don't ring my buzzer because they are so busy, but this means I have to wait. I have a medical condition and I worry about this in case I have an accident. Staff are fabulous kind and very caring, there's just not enough of them." A fourth person said, "It a bit better this weekend, at least I have got up early, not as early as I would like, but there are no staff."

On the first floor of the home we saw that there were 22 out of 33 people who required two staff to assist them with personal care. Staffing rotas showed that there were four care staff and one nurse on duty. Of the four care staff one had been allocated to provide support and continual supervision to one person meaning they were not available to support other people. This showed that people would have to wait to be assisted and staff would be rushed to complete their tasks. One member of staff told us, "It's time people need and they just don't get that, you may spend five minutes with people if they are lucky. We want to do our job but we can't." Staff on the ground floor also confirmed that they were not able to provide the level of support people required.

The nurses were involved in administering medicines, responding to queries and concerns raised by care staff and dealing with nursing tasks such as dressings. We saw that the last morning medication finished late on both floors at around 12.30pm and the next medication round commenced at 2. One person told us, "I don't know when I am having my medication it comes at all times, early morning and then some times my morning medication is at lunch time." This showed that people were not being given their medicines as they had been prescribed to keep them healthy.

During the midday period we saw that people who required support to eat their meals had not received the assistance they needed. We observed that one person had had a meal placed in front on them on a table in their bedroom. When we went to see them we saw that they had not eaten their meal and had not received any assistance or encouragement to eat. Staff told us that the person had refused their food, and had continued to serve meals to other people and said they were coming back to support them, however when they said this we saw that they were collecting empty plates. The individual was not assisted and the meal subsequently was cold and taken away. One person told us, "It's cold again; over these last few weeks I don't think I have had a hot meal. By the time it's get to me it has been cold."

Following our inspection we spoke with the operations manager about staffing levels. The operation manager said there were usually enough staff to meet people's needs. However this was not what we observed during our inspection, we saw and staff told us that they were struggling with the staffing level they had. All the staff spoken with told us they could not meet people's needs as they felt rushed and was not able to give the time people needed to ensure that people were supported as per their assessed care needs.

Our observations showed and people told us that the staffing levels in the home were not sufficient to respond to unforeseen events; there were not enough staff to provide people with the support they needed at the time they needed it and there were not enough staff to check that people who were eating in their rooms were safe.

Is the service safe?

This meant there were not sufficient staff to effectively provide care to people that met their individual needs and preferences. This is a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection an action plan was sent to us, which showed that the staffing levels had been increased so people's care needs could be met.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider must ensure that there are sufficient staff available to meet peoples' care needs and keep them safe.