Lifeways Orchard Care Limited

209 Weston Road

Inspection report

209 Weston Road
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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

This inspection took place on the 23 November 2015 and was unannounced. At our previous inspection in August 2013 there were no concerns found in the areas we looked at.

The service provided accommodation and personal care to up to six people with a learning disability. At the time of the inspection four people were using the service.

We were supported throughout the inspection by the registered manager. 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's capacity to consent had not been assessed and some decisions were being made on behalf of people without the support they required. We found that people were being deprived of their liberty unlawfully as applications for a DoLS authorisation had not been made.

There were insufficient staff to safely meet the needs of people during the night.

People's medicines were administered by trained staff, however medicines were not stored safely.

People were not always involved in decisions relating to their care, treatment and support. Care was not always planned and delivered based on people's preferences and regularly reviewed with people.

People were not always treated with kindness and compassion. People's right to privacy was respected.

When areas for improvement had been identified, they were not made to ensure a safe, quality service was provided.

We found three breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of the report.

People had opportunities to be involved in the community and to participate in hobbies and interests of their choice. However people's requests to participate in these activities were not always responded to.

People were supported to have a healthy diet dependent on their assessed individual needs. People were given choices and asked what they would like to eat and drink.

People were safeguarded from abuse and the risk of abuse as staff knew what constituted abuse and who to report it to. The manager had previously made referrals for further investigation when they had suspected abuse had taken place.

People were supported to be as independent as they were able to be through the effective use of risk assessments and the staff knowledge of them.

Staff felt supported to fulfil their role effectively through regular support and supervision and training applicable to their role.

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 consistently safe. There were insufficient staff to keep people safe during the night. People's medicines were not stored safely.
People were safeguarded from abuse and the risk of abuse. Risks to people were minimised as staff knew people's risk and how to support them.

Is the service effective?

Requires Improvement

The service was not consistently effective. The provider did not work within the guidelines of the MCA to ensure that people were involved and consented to their care, treatment and support. People were supported to have a healthy diet dependent on their assessed individual needs and when necessary had access to a range of health professionals. Staff received regular support and training to fulfil their role effectively.

Is the service caring?

Requires Improvement

The service was not consistently caring. People were not always treated with kindness and compassion.
People's dignity and privacy was respected and their independence promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. People did not always receive care that reflected their choice and preferences. People were mostly able to engage in hobbies and interests of their choice. People told us they would complain to the manager if they had concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well led. Action was not always taken to improve the service and keep people safe. Systems to improve and maintain the quality of the service were not effective.
People liked and felt supported by the manager.

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Detailed findings

Background to this inspection

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

This unannounced inspection took place on 23 November 2015 and was undertaken by one inspector.

Prior to the inspection we reviewed the information we held about the service. This included notifications that we had received from the provider about events that had happened at the service that the provider is required to send us by law. For example, this includes notifications of serious injuries and safeguarding concerns.

We spoke with two people who used the service, a relative and four care staff, the registered manager and a visiting health professional. We observed care and support in communal areas and also looked around the service.

We viewed two records about people's care and records that showed how the home was managed including quality monitoring systems the provider had in place, staff rosters and recruitment processes.

Requires Improvement

Is the service safe?

Our findings

We saw that during the day time hours there were enough suitably trained staff to safety meet people's needs. However the manager and a member of staff told us that they felt they needed more staff during the night time hours. There was one member of staff on duty during the night and two people required two members of staff to support them with their personal care needs, due to their mobility needs and moving and handling plans. This would mean that people may not receive the care they needed or it may have been provided in an unsafe way. The manager was also concerned that one staff member may not be able to safely evacuate people in the event of a fire. This meant that people were at risk of not receiving care that was safe or being supported to safely evacuate the building in the event of an emergency. The manager had not addressed these concerns with the provider. The manager told us that they were going to speak to the provider, arrange a visit from the fire officer and gain agreement for extra staff at night.

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff and looked at the way in which they had been recruited to check that robust systems were in place for the recruitment, induction and training of staff. Staff confirmed that checks had taken place and they had received a meaningful induction prior to starting work at the service. The files provided evidence that pre-employment checks had been made. These checks included application forms detailing previous employment, identification and health declarations, references and satisfactory disclosure and barring checks (DBS). This meant that an effective recruitment process was in place to help keep people safe.

We looked at the way in which people's medicines were managed. People's medicines were kept in a locked filing cabinet in a communal area which could have been easily broken into and it was unable to be temperature checked. At one point we found that the cabinet had been left open whilst a member of staff had gone to administer one person's medication. The provider did not have a medicine fridge if people required any occasional temperature controlled medication. This meant that medicines may not be effective if not stored at the correct temperature and people were at risk of unsafe medicines due to ineffective storage facilities. Some people were prescribed as required medication (PRN). We saw there were protocols in place but they lacked details of the signs and symptoms people may exhibit at the times they may require it. This would have supported the staff to recognise people's needs for their medication when they were unable to verbally communicate. The staff members who administered medicines had all received training and were annually assessed as being competent.

People who used the service were protected from abuse and the risk of abuse as staff we spoke with knew what constituted abuse and what to do if they suspected someone had been abused. One person who used the service told us: "I feel safe and staff would look after me, if I've got any problems I speak to the manager". We saw a safeguarding flow chart was visible in the office giving staff clear instructions of the reporting process. One staff member told us: "I would report anything suspicious to the manager, or CQC". The manager had raised safeguarding referrals in the past when there had been incidents of alleged abuse.

Staff knew people well and knew what support people needed to maintain their safety. We saw that when accidents occurred, action was taken to minimise the risk of the accident occurring again. For example one person had recently fallen and staff told us they were now supporting the person in two's until the occupational therapist was able to assess the person's needs. When people required equipment to mobilise it was available. Staff had received training in the safe handling of people and we observed safe handling practices with one person who used the service.

Requires Improvement

Is the service effective?

Our findings

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. We saw that one person who we were told lacked capacity to consent to their care had requested to access the community on two occasions and had been refused by a member of staff. There was no reason as to why this person could not have been supported in the community as there had been sufficient staff available. We also saw that the person was asked to sit in a certain area of the home where the staff had recorded, 'they could keep an eye on them'. The manager told us they were not aware of these incidents and this person did not have any restrictions in place. This meant that the provider was not following the guidance of the MCA 2005 by making sure that people were not being unlawfully restricted of their liberty.

People can only be deprived of their liberty to 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). People's capacity to consent had not been assessed and some people were under constant supervision from staff, which we were told was in their best interest. There had been no application to the local authority for a Deprivation of Liberty Safeguard authorisation (DoLS). DoLS is part of the Mental Capacity Act 2005 and the legislation sets out requirements to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom.

This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person who used the service told us:" I like the staff, they help me tidy my room and take me shopping". Staff told us that they felt supported and received training to be able to fulfil their role effectively. Staff spent time with the manager in individual meetings and were able to discuss their own personal development. The provider had an on-going schedule of training which was applicable to the roles the staff were asked to undertake.

People had their nutritional needs met. One person told us: "I help make my own food; I can make a cup of tea and a sandwich". One person required a soft diet due to swallowing difficulties and required their drinks thickened following an assessment from the speech and language therapist. A member of staff told us:" We need to make sure [person's name] has their drinks thickened so they don't choke". Another person had recently gained weight and they had been supported to attend a GP appointment and a referral to a dietician had been made for advice and support.

People were supported to attend health care appointments such as their GP, optician, chiropodist and community nurses. Two people were living with dementia and had access to the memory clinic. We saw that people had access to a wide range of health care facilities. On the day of the inspection we saw a visiting district nurse supporting one person with a health intervention, staff supported the nurse throughout the

process and knew the persons' needs.

Requires Improvement

Is the service caring?

Our findings

We observed that on one occasion a person was talking to a member of staff asking them for something. The member of staff did not turn to face the person when they responded but kept their back to them. On another occasion we heard the staff member tell a person to 'Stop it' when they were anxious. We discussed these issues with the manager who recognised that these interventions could appear disrespectful and that they would refresh this staff member's training in treating people with dignity and respect.

We could not see how people were involved in the running of the home and in how their care was being delivered. The manager told us that resident meetings had not been successful in the past so they no longer held them. Care plans had not been recently reviewed with the person or their representatives and some information was out of date. We were told that no one had an advocate at present although they had been involved in the past with one person.

One person who used the service told us they liked the staff and were treated kindly. A relative told us: "The staff have been wonderful". Staff we spoke with demonstrated a passion for the people they were supporting. One staff member said: "I love it here, it doesn't feel like work, I like helping people to be independent". We saw where possible people were encouraged to be as independent as they were able to be. One person was asked to go and get their own belongings ready for a shower and another person enjoyed making cups of tea for staff and visitors.

People's care records and other confidential information were stored securely. Everyone had their own bedrooms and we saw that staff knocked on people's doors before entering. Staff shut doors to bedrooms and bathrooms when supporting people with their personal care needs.

Requires Improvement

Is the service responsive?

Our findings

We saw some people were offered choices. We observed one person being offered a choice of breakfast and accompanying drinks. However on another occasion we heard a member of staff ask another member of staff if one person would like 'weetabix' for breakfast. The staff member responded 'yes that will do' without offering the person a choice. This showed that assumptions were being made about this person's preferences.

People who used the service were supported to be involved in hobbies and interests of their choice. A plan for the week ahead was drawn up to plan activities and outings. Some people enjoyed attending a local club and getting involved in bingo, another person met their friend there. One person enjoyed going shopping, eating out and the cinema. Staff facilitated people's chosen activities on most occasions, however we did see where one person had been refused an outing in the community they had requested.

One person was being regularly encouraged to sit in a quieter aware of the service away from other people. The room they were being asked to sit in was not a comfortable living space, it consisted of a dining table and hard backed chairs. The manager told us they had recognised that it was not a comfortable room and had thought about making it a more comfortable space, but was yet to action this.

Changes were made to people's care when people's needs changed. We were told that one person's needs were changing daily and staff told us that every day was different. One staff told us: "We wait and see how they are and what they want to do, we give them time to respond". Handovers were conducted at every change of staff, to ensure the staff coming on duty were fully aware of the daily needs of each person. Staff told us they knew people well and were kept up to date with any changes through the handover process.

The manager told us that the provider was in the process of sending out the complaints procedure to relatives of people who used the service as a reminder. One person told us if they had any complaints they would speak to the manager. A relative told us that if they had any concerns the manager would respond. They told us: "I have no worries". The manager told us there had been no recent complaints.

Requires Improvement

Is the service well-led?

Our findings

We saw there had been an internal audit conducted by the provider in August 2015 and an immediate action to make DoLS referrals had been set by the auditor. This had not been completed and the manager recognised this still needed doing. They were unable to offer an explanation as why it had not been completed. This meant that the manager was not taking action ensure that people's safety was maintained and that people were not being unlawfully restricted of their liberty.

The manager told us that there was not enough staff to meet people's needs during the night. However they had not spoken to the provider or increased the staffing to ensure that the staffing levels were safe.

The manager was not always aware of incidents within the service. For example, they were not aware that one person had been refused a community activity and was regularly being asked to stay in a place where staff could keep an eye on them. These incidents were clearly recorded in the person's daily records but had not been picked up and addressed. This showed that the systems in place to monitor the quality of the service were not effective.

Medicines were not stored safely. The manager told us that they used to be stored in people's bedrooms but they had thought that this was not safe. The storage facilities for medicines was still not safe and people were put at risk.

These issues constitute a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service were comfortable in the company of the registered manager. They approached them happily and chatted with them, and the manager responded in a kind and professional manner. The manager demonstrated an understanding of the people they cared for through their discussions and interactions.

Staff we spoke with told us the manager was supportive and approachable. All staff knew that the provider had a whistle blowing policy and they told us they felt confident that they would be protected if they reported any concerns and that concerns would be acted upon. One staff member told us: "The manager is wonderful, she really values the staff", another staff member told us: "The manager is fantastic, very approachable, brilliant". Staff told us there was always someone available if they required support, as the provider had a designated on call system.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not consenting to their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Action was not taken to improve when areas of improvement were identified.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff during the night to keep people safe.