SHC Clemsfold Group Limited

Orchard Lodge

Inspection report

Tylden House Dorking Road
Warnham
Horsham
West Sussex
RH12 3RZ

Tel: 01403242278
Website: www.sussexhealthcare.co.uk

Date of inspection visit:
02 November 2017
03 November 2017
06 November 2017

Date of publication:
04 April 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 2, 3 and 6 November 2017.

This inspection was a comprehensive inspection brought forward due to concerns shared with the Commission from the local authority safeguarding team. The concerns were regarding how a person was supported when they became acutely unwell prior to their admission to hospital. Our inspection did not examine the specifics of this incident and the allegation. However, we used the information of concern raised by partner agencies to plan areas we would inspect and to judge the safety and quality of the service at the time of the inspection.

The service had been subject to a period of increased monitoring and support by commissioners. The service has been the subject of multiple safeguarding investigations by the local authority and partner agencies. As a result of concerns raised, the provider is currently subject to a police investigation. West Sussex Safeguarding Adults Board have also published information on their website regarding safeguarding concerns about Orchard Lodge. Between May and November 2017 we have inspected a number of Sussex Health Care locations in relation to concerns about variations in quality and safety across their services and will report on what we find.

At this inspection we also focused on the areas of care we identified as 'Inadequate' or 'Requiring Improvement' at the last inspection in July 2017. The service received an overall rating of Inadequate, therefore the service was placed into 'special measures'. At this inspection we could not improve the rating for Safe and Well-led from Inadequate because to do so requires consistent good practice over time and we found new areas of potential risk for people. We will check this during our next planned comprehensive inspection.

This service will remain in special measures therefore continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement, so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration, or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

At this inspection there was a manager in post who had commenced their application to become a 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.

Orchard Lodge provides accommodation in three units called Boldings, Orchard East and Orchard West, which are all on one site. Orchard Lodge provides nursing and personal care for up to 33 people who may have a learning disability, physical disabilities and complex health needs. Most people had complex mobility and communication needs. At the time of our inspection there were 27 people living at Orchard Lodge and one person receiving short term care.

People living at the service had their own bedrooms and en-suite bathrooms. In each unit, there was a communal lounge and separate dining room where people could socialise and eat their meals if they wished. The units shared transport for access to the community and offered 24-hour nurse support and a social and recreational activities programme. The home environment was spacious throughout and adapted to meet the needs of people who use wheelchairs. The home was decorated with pictures and photographs of people living at the home. Orchard Lodge also offers a spa and hydrotherapy facilities.

Orchard Lodge has not been operated and developed in line with the values that underpin the Registering the Right Support and other best practice guidance. Orchard Lodge was designed, built and registered before this guidance was published. However the provider has not developed or adapted Orchard Lodge in response to changes in best practice guidance. Had the provider applied to register Orchard Lodge today, the application would be unlikely to be granted. The model and scale of care provided is not in keeping with the cultural and professional changes to how services for people with a learning disability and/or Autism should be operated to meet their needs.

These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service should be able to live as ordinary a life as any citizen, but this was not always the case for people. Orchard Lodge is a large clinical setting rather than a small-scale homely environment. Orchard Lodge is geographically isolated on a campus in rural Horsham with many people having moved to Orchard Lodge from other local authority areas and therefore not as able to retain ties with their local communities. For some people, there were limited opportunities to have meaningful engagement with the local community amenities. Some people had limited contact with specialist health and social care support in the community due to specialist staff (physiotherapy, speech and language) that were employed by the provider. Most people's social engagement and activities took place either at Orchard Lodge or at another service operated by the provider, such as the provider's day centre.

At the last inspection we found people may have been exposed to risk, as incidents and safeguarding concerns had not been raised to the management team or external agencies such as the West Sussex Safeguarding team. At this inspection improvements had been made and care staff had a better understanding of their role and responsibilities when protecting people. However, one incident had not been referred to external agencies by the management team. We made a recommendation regarding further improvements the provider needed to make to ensure people were consistently protected from risk of harm.

Some people living at the home required enteral feeding and had a percutaneous endoscopic gastrostomy (PEG) feeding tubes fitted. A PEG allows nutrition, fluids and medicines to be put directly into the stomach, bypassing the mouth and oesophagus. At the last inspection we identified a lack of specific guidance available for staff surrounding PEG management. At this inspection we found specific guidance was in place to guide staff accordingly. However, we found a lack of accessible specific guidance in relation to other aspects of people's healthcare such as supporting people with their conditions such as asthma and bowel management. This had an associated increased level of risk due to the number of agency nurses working at the home and the lack of monitoring of their skills, abilities and training attended by the management team.

We identified gaps in knowledge amongst staff regarding which people had Do Not Attempt

Cardiopulmonary Resuscitation (DNACPR) status. The provider told us the action they would take to minimise further risks to people. Policies and procedures were in place and medicines were managed, stored, given to people as prescribed and disposed of safely. However, we found gaps in guidance available for staff when applying prescribed topical creams to people with various skin conditions.

At this inspection we observed occasions where staff did not give due consideration to people's dignity and their right to privacy was not always respected.

At the last inspection we found systems to assess and monitor the service were in place, but they were not effective. Shortly after the inspection the provider wrote to us to inform us of the action they were taking. At this inspection we continued to find they were not sufficiently robust as they had not ensured a delivery of consistent high care across the service or pro-actively identified all the issues we found during the inspection.

At the last inspection we found concerns regarding how staff were deployed particularly in Orchard West. Since the last inspection the provider took action and had increased staffing levels and there were now enough staff deployed to meet people's needs, therefore the legal requirement had now been met.

People and their relatives were involved in their own care as much as they were able to be. Environmental risks such as hoist equipment, wheelchairs and legionella checks were managed effectively through prompt and regular servicing. Staff employed by the home underwent a thorough safe recruitment process. People were offered activities and complaints were managed in line with the providers policy.

At the last inspection in July 2017 we identified three breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and rated the service as Inadequate. The provider wrote to us to inform us of the action they were taking. At this inspection we identified four breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and remains rated as overall Inadequate.

Since the inspection we have received an updated action plan from the provider which we have referred to in the Well-led section of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Further improvement was required in reporting incidents which may have placed people at risk from harm. Not all systems were in place, so that lessons were learned and improvements made when things went wrong. These needed to be embedded further to promote safe care.

There were gaps in guidance available, so that care staff knew how to care for people safely and mitigate any risks and there were inconsistencies in guidance available for the application of prescribed topical creams.

There were sufficient staff deployed to meet people's needs safely and staff underwent a safe recruitment process.

People were protected from infection due to safe control measures.

Is the service effective?

Requires Improvement

The service was not always effective.

There were significant gaps in agency nurse training regarding subjects specific to their role and responsibilities.

People received 24 hour nursing care. Some people had not received an Annual Health Check in line with current best practice.

Consent to care and treatment was sought in line with legislation under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were supported to have sufficient to eat and drink and people's individual needs were met by the adaptation of the premises.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Due consideration and respect was not always given to people's dignity and privacy.

People and their representatives were supported to express their views and be involved in making decisions about their care, support and treatment as far as possible.

People's communication needs were assessed and assistive technology employed to enable people to communicate effectively. People were encouraged to maintain their independence as much as they were able.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive.

There were inconsistencies within the guidance available within care plans and a lack of routine analysis and reflection of how staff responded to people's health needs.

People said that their concerns and complaints were listened and responded to and activities and stimulation were offered to people living at the home.

Procedures were in place to ensure people were supported at the end of their life to have a comfortable, dignified and pain-free death.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of effective and robust auditing systems in place to identify and measure the quality of the service delivered to people.

The provider has been working with other agencies with the aim of improving service delivery.

Improvements had been made to the management structure of the home which had a positive impact on the staff team and people.

People and their relatives were routinely asked their views on the care and support they received informally and formally.

Orchard Lodge

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 checked 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. We carried out this inspection to check what improvements the provider had made following our last inspection in July 2017 where we identified breaches of legal requirements and potential risk to people living at Orchard Lodge.

Orchard Lodge is a residential care home that also provides nursing care. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This inspection took place on 2, 3 and November 2017. The first day was unannounced. The inspection team on the first and second day consisted of one inspector and a specialist nurse advisor. Their area of expertise included learning disabilities and complex heath needs. The inspection team on the third day consisted of three inspectors and the same specialist advisor.

Prior to the inspection we reviewed the information we held about the service. This included information from other agencies and statutory notifications sent to us by the manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection. On this occasion we did not ask the provider to complete a Provider Information Return (PIR) as the inspection took place within six months of the publication of the previous inspection report. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Due to the nature of people's complex needs, we were not always able to ask direct questions. However, we did chat with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with two nurses who were employed by the provider, two agency nurses and four care assistants and a physiotherapist who was directly employed by the provider. We also spoke with the manager and recently appointed deputy manager throughout the inspection. The nominated individual who represents the

provider introduced themselves to the inspection team during the first day of our inspection. We also spoke with three relatives face to face to gain their views of the care provided to their family members. We spent time observing the care and support that people received in the lounges and communal areas of the home during the morning, at lunchtime and during the afternoon. We also observed medicines being administered to people.

We reviewed a range of records about people's care which included nine people's care plans. We also looked at three care staff records which included information about their training, support and recruitment record. We also reviewed 24 agency nurse experience and training profiles. We read audits, minutes of meetings with people and staff, menus, policies and procedures and accident and incident reports and other documents relating the management of the home.

Inadequate

Is the service safe?

Our findings

At the last inspection in July 2017 we identified the service was in breach of three Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was rated as Inadequate in the Safe section of our report as some aspects of care and safety posed potential risks for people. At this inspection whilst we found one area of care had improved, another area required further development. We also identified some new significant potential risks to people which meant the standard of care offered to people had not improved sufficiently enough.

At the last inspection we found gaps in staff knowledge regarding their role and responsibilities in protecting people living at the home. Some staff had failed to raise concerns about incidents involving people to their line managers or to external agencies such as West Sussex local authority safeguarding team. The procedures and processes in place aimed at protecting people were not robust and had failed to embed a culture where staff felt confident to take the proper action to ensure further risks were minimised and people were kept safe. Shortly after the inspection the manager told us the action they were taking regarding the support provided for the staff team, and they raised the concerns retrospectively with the local authority and the Commission.

During this inspection it was evident the manager had provided training and support for staff to ensure further risks to people were minimised. We read a memo which was accessible to all staff which started, 'It is the responsibility of ALL staff to report any concerns they have or observe'. It also read, 'The manager must be informed of all incidents immediately'. One staff member told us if they were concerned about a person or observed an incident and said, "I would go to the team leader, I would go to the nurse in charge, I would go to the manager or the deputy".

We read the accident and incident file. Accidents and incidents had been recorded and reported by staff to the manager who then shared the information with external agencies such as the local authority. Whilst nearly all accidents and incidents had been recorded by staff and reported to their line managers, one incident in August 2017 had not been escalated by the management team to the necessary external agencies for their review. The incident involved a person falling out of their bed after the sides on their specialised bed had not been locked by the staff supporting the person into their bed. We were told and the records confirmed that the person who fell did not suffer any significant injuries due to the bed being set on a lower level and a safety mat positioned next to the bed. The manager was also able to share the actions they had taken to ensure staff were reminded of the importance of locking the mechanism. However, the incident should have been referred to the local authority safeguarding team, the person's allocated social worker and the Commission at the time in line with safeguarding procedures. The incident had also been reviewed as part of the provider's auditing process in September 2017 by the provider's senior management team yet this had still not triggered an action the need for the manager to raise the incident with the local authority and the Commission as a potential safeguarding concern. Shortly after the inspection, the manager raised the concern retrospectively with all the appropriate external agencies. We have discussed this further in the Well-led section of this report.

Whilst we noted improvements had been made by the manager in this area, we were concerned the provider had not recognised this incident as a safeguarding concern considering the guidance already provided by the local authority and the Commission at the last inspection. Therefore we recommend the provider continues to improve and embed robust safeguarding procedures and reporting mechanisms to ensure all people are consistently protected from risk of harm.

A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. During our inspection we found inconsistencies regarding how risks to people were managed by staff to keep people safe. For example, one person living at the home had asthma yet there was no associated asthma care plan or assessment in place to describe the risks to the person. There was no care plan in place to describe the level of monitoring nursing staff and care staff had to provide to the person with this need. Another person was identified as at high risk of constipation, however the records we read did not provide a preventative plan to minimise future risks to the person. Staff used an associated daily recording chart to monitor their bowel movements. Staff had completed daily entries with a code yet the monitoring chart did not indicate what each code meant. We spoke with the nurse deployed to that area of the home who told us they did not know what each code meant. This meant the person was at an increased risk of staff being unable to identify when the person was becoming constipated and taking the necessary course of action. The same person had a diagnosis of epilepsy. Constipation is a known trigger for epilepsy, which was not reflected within the person's care records. Whilst staff we spoke with demonstrated that they knew people and their care needs well, the lack of clear guidance and care records placed people at increased risk of not having their health needs met consistently. This was particularly relevant as Orchard Lodge regularly deployed agency staff who may not have been as familiar with people's needs and associated risks.

Some people living at the home had 'Do Not Attempt Cardiopulmonary Resuscitation' (DNCPR) status. A DNACPR is a decision document which provides immediate guidance to those present on the best action to take (or not take) should the person suffer cardiac arrest. We were given a reference list of names of people from the manager who had an active DNACPR. This list was kept in the central office in the Orchard home. On the third day of the inspection we spoke with a nurse working in the Boldings area of the home and checked people's DNACPR records. The nurse told us one person not on the list had an active DNCPR and the two people on the list did not have an active DNACPR. We checked named people's care records and established the original central list provided by the manager was correct and the nurse supporting people was misinformed. This meant there was an increased risk if a person was to suffer cardiac arrest the decision of what course of action staff should, or should not take, would be incorrect. There was also an increased risk there would be a delay in staff taking action, as the correct reference list was kept in the central office which is in a separate building to the Boldings area of the home. The level of risk was increased further considering the regular use of agency care workers and nurses supporting people who may not be able to access this information quickly in an emergency.

Nurses told us prescribed topical creams were given to care staff to apply whilst supporting people with their personal care. Topical creams can be prescribed to people for a number of skin related issues. However, we found inconsistencies regarding the guidance in place for care staff to enable them to do this consistently and safely. Some people had body maps in place for their prescribed creams, which provided guidance for staff so they knew where it should be applied, whilst others did not. Whilst people, their relatives or staff did not raise any concerns regarding this aspect of care, due to the lack of guidance in place there was an increased risk prescribed topical creams would be applied incorrectly for people with skin conditions.

The above evidence demonstrates that not all was reasonably done to mitigate risks to service users. This is

a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our findings with the manager and deputy manager. They told us during the inspection and afterwards the actions they were taking to minimise further risks of harm to people. This included sending to us a completed asthma care plan which described how staff should support the person with this need. They also told us they would be including a DNACPR status list into each handover file, so it could be reviewed each staff handover session by the nursing and care staff. The quality assurance manager also emailed the Commission and other external agencies after the inspection to advise of improvements made to documenting clearly those people who had a DNACPR in place. The email had been sent to home managers to ensure they had commenced the red and green dot system. The red dot signified people that had an active DNACPR in place and green for people who were to be resuscitated. The email read, 'The dots are on the spine of every daily folder and care plan folder and in the right upper corner of every room'. The email also stated, 'All safeguarding concerns are raised promptly with WSCC and the CQC notification completed and submitted'.

Some aspects of medicines administration were managed safely. We spoke with nurses who confidently discussed how they administered medicines to people. Nurses were knowledgeable as to the reasons why people had medicines prescribed to them, any known side effects and what to do in the event of any concerns. The recording system included a photograph of the person and information that was pertinent to them, this included any known allergies. Tablets were dispensed from blister packs and medicines administered from bottles or boxes were stored and labelled correctly. We observed that the Medication Administration Record (MAR) was completed on behalf of each person by the registered nurse on duty each time someone was supported to take their oral medicines. Oral medicines were administered by nurses only.

We sampled other risk assessments during the inspection which had been carried out about people's needs and care records included the necessary detail to enable staff to support them safely. For example, one person required a tracheostomy and their care plan stated how often equipment should be changed, by whom and what the indications are for this to happen. There were instructions for how to raise concerns and seek support in an emergency and step by step guidance for care of the site. Tracheostomy is an opening created at the front of the neck, so a tube can be inserted into the windpipe (trachea) to help the person breathe. They also required enteral feeding and had a percutaneous endoscopic gastrostomy (PEG) feeding tubes. A PEG allows nutrition, fluids and medicines to be put directly into the stomach, bypassing the mouth and oesophagus. Nurses we spoke with were knowledgeable about the management of supporting the person using their PEG and the person's care records reflected the level of support they required from the staff team.

Orchard Lodge was split into three sections, Orchard East, Orchard West and the Boldings. At our last inspection we identified staff were not always effectively deployed to ensure the safety of all people living in Orchard West. People we met had limited verbal communication, lacked capacity to make specific decisions about their care and were completely reliant on staff to meet all their needs. All people were wheelchair users and required two staff members to support them to move safely. During the July 2017 inspection the area manager increased staffing levels in response to our concerns about staff deployment. Following our inspection, the area manager confirmed in writing the increase of care staff would continue to ensure people living in that part of the home had sufficient support and supervision to keep them safe. At this inspection we found that the same seven people remained living in this section of the home with an additional person who was receiving short term care. We were told and records confirmed the provider had increased staffing levels to minimise any further risk to people. There was now an additional nurse allocated to the section of the home to meet the needs of the people living there. We observed three care staff and

one nurse present in Orchard West throughout the inspection. One of the care staff was supporting the person receiving short term care on a one to one basis. At this inspection we observed this had a positive impact on people as there was always staff interacting with people to meet their needs in a timely manner. The provider had also increased night staffing levels in the Orchard East section of the home from one care staff and one nurse to two care staff and one nurse.

Staff told us about the positive impact this had on meeting people's needs and how they were able to carry out their role and responsibilities more effectively and safely. One staff member told us, "It's easier for us". Another member of staff told us how much, "Fairer" they felt everything was and, "They (provider) have increased staffing which has really helped". They also told us, "I am feeling more safe. Our residents are more safe". A relative told us there, "Always seems to be enough staff around. Other people don't seem to be distressed. I think there are enough people (staff) to meet people's needs".

Staff recruitment practices remained robust and thorough. Staff were only able to commence employment upon the provider obtaining suitable recruitment checks which included; two satisfactory reference checks with previous employers and a current Disclosure and Barring Service (DBS) check. Staff record checks showed validation pin number for all qualified nursing staff. The pin number is a requirement which verifies a nurse's registration with the Nursing and Midwifery Council (NMC). Recruitment checks helped to ensure that suitable staff were employed.

Environmental risks such as hoist equipment and wheelchairs were managed effectively through prompt and regular servicing. Infection control promoted a safe and clean environment. The home was well maintained, decorated and furnished in a style appropriate for the people who used the service. Separate domestic staff were employed and regular cleaning took place. Equipment was seen to be readily available that promoted effective infection control such as antibacterial hand wash, disposable gloves and clinical waste bins.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we identified care staff had not always received appropriate support and training to enable them to carry out the duties they were employed to perform and the provider was in breach of Regulation 18. This included a lack of epilepsy training and learning disability training. At this inspection we spoke with the manager, care staff and checked staff records. We found improvements had been made and care staff were now routinely receiving the training and support they required to carry out their role and responsibilities. One care staff member told us they had attended 17 courses which included epilepsy and learning disability training. They said the epilepsy training gave them, "More confidence in my job, a broader range of knowledge about signs to look for in epilepsy". Another member of care staff told us they had attended all the training they needed and said, "I have now completed all my mandatory training".

People living in Orchard Lodge had complex physical and learning needs. This included people who required support with percutaneous endoscopic gastrostomy (PEG) for food, hydration and medicines, had a learning disability, some people had a diagnosis of epilepsy and one person had a tracheostomy. Permanent nursing staff had access to relevant clinical courses associated with the nursing care they provided, such as palliative care and PEG management. At the time of our inspection a manager was in post who was also a registered learning disability nurse. Since the last inspection a new deputy manager had joined the management team who was also a registered nurse. At the time of our inspection agency nurses were being used to provide nursing care to people living at the home daily and the provider was undertaking a recruitment drive to employ further permanent nurses. We were told the home routinely used two different nursing agencies to supply agency nurses. The manager told us they aimed to have consistency and used the same nurses and records supported this. At the previous inspection in July 2017 we identified there were no routine checks carried out to assess whether each agency nurse attending the home had current training in key subjects such as epilepsy, learning disabilities and PEG management in order for the provider t be assured that these staff deployed had sufficient knowledge and skills to effectively care for people's complex needs.

At this inspection we asked the manager what improvements to checks had been made to assess the skills, competency and training the agency nurses had achieved. They told us they had held discussions with all agencies they used to ensure nurses with the appropriate training were sent to the home to support people. During the inspection they provided us with training and experience profiles for all the agency nurses who were used by the home. However, the training profiles we read did not confirm the agency nurses the home regularly used had attended all the training in those specific areas required. For example, we sampled 24 of those sent to us and eight agency nurse profiles stated they had PEG training, seven profiles stated the nurses had epilepsy training and five profiles stated agency nurses had received learning disability training, with a further two due to attend after the inspection. This meant there were still significant training gaps within the records the home held. There remained a lack of effective monitoring carried out by the provider to check all agency nurses had achieved essential training specific to the needs of the people they were regularly supporting. We spoke with three agency nurses during the inspection and whilst they presented as competent in their role, the training records we were given did not provide the assurances all agency nurses had been provided learning opportunities to enable them to support people effectively. Therefore there was

an increased risk people may not always have received correct levels of care in accordance with their specific needs because the provider was not effectively monitoring and confirming agency staff skills before they were deployed.

The above evidence showed that staff had not always received appropriate training to enable them to carry out their duties they are employed to perform. This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Consent to care and treatment was sought in line with legislation and guidance. 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 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).

We checked that the provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Care records showed how consent from people had been captured and capacity assessed and where deemed necessary a DoLS application completed. During the inspection the manager told us any DoLS which were due to expire were reviewed accordingly, and if needed, an extension applied for. Shortly after the inspection, the manager informed us one person's authorised DoLS had lapsed and should have been renewed in September 2017. This had been established after a reminder had been sent by the person's funding authority. The manager informed us this had now been completed and the application form had been sent to the relevant body. Training records confirmed staff had attended training in both MCA and DoLS. Staff were able to share some knowledge on the topic and provided assurances they were aware of its importance and what it meant in their roles.

Due to the level of people's complex needs nursing and care staff had to anticipate people's needs proactively. Therefore, we checked people's care records including GP appointment logs held on behalf of people by the staff teams supporting them to see if all people living at the home were offered and attended an Annual Health Check. The Annual Health Check scheme is for adults and young people aged 14 or above with learning disabilities, who need more health support and who may otherwise have health conditions that go undetected. Whilst records we sampled showed how staff had accessed GP's and other health professionals such as neurology consultants for conditions such as epilepsy, there was a lack of evidence to suggest all people living at the home had attended a routine Annual Health Check. For example, one person had complex physical needs, was a wheelchair user and had a diagnosis of epilepsy. Whilst we found medical records which stated they had attended appointments with a neurology consultant for their epilepsy management, there was no record available to say they had seen their GP for a routine health check for the past two years. This meant they had not been provided with an Annual Health Check. We spoke with nurses, the deputy manager and the manager about this and other people's opportunities to attend Annual Health Checks. Shortly after the inspection, the manager confirmed they were ensuring all people living at the home had either attended, or would be attending, an Annual Health Check to ensure early detection of any health conditions and had liaised with the GP's who visited the home accordingly. The quality assurance manager also included this in an email sent to all home managers working for the same provider after the inspection. One of the actions to be adhered to read, 'Discussions with the GP practice to take place regarding obtaining assurance of annual health checks and screening for all service users'. The provider had not proactively identified the need to ensure DoLS authorisations and Annual Health Checks were regularly reviewed for accuracy and completeness. We have expanded on this issue in the Well-Led

section of this report.

The provider employed various health professionals to support people with specific complex needs. This included a dietician and physiotherapists. A physiotherapist was employed by the provider to facilitate sessions to people assessed as needing support with this at Orchard Lodge. At the last inspection they told us they were not able to achieve all planned sessions, due to there being insufficient care staff to support them with this activity. At this inspection the physiotherapist told us this had significantly improved due to increased staffing levels and they were now able to facilitate all planned sessions. We have discussed staff deployment and increased staffing levels further in the Safe section of this report. The staff team confirmed GPs continued to visit the home weekly and would discuss and review medicines on behalf of people and any other health concerns people had. Nurses also confirmed GPs were contacted in between these visits if a person's health deteriorated. A relative told us, "GP visits on a weekly basis and [named person] has regular check-ups for bloods and thyroids". We have discussed the support provided by staff to people when they become acutely unwell in the Responsive section of this report.

The provider carried out assessments regarding people's physical, mental health and social needs holistically prior to them moving into Orchard Lodge in line with current legislation and best practice guidance. This incorporated information regarding people's complex physical and communication needs. The assessment process enabled the staff team to involve the person and/or their representative and plan the person's care they needed and wanted. This included a Disability Distress Assessment Tool (DisDAT) which had been completed for people which helped staff identify if the person might be in pain or discomfort and require medical attention. This is a nationally recognised tool designed to help identify distress in people who have severely limited communication. People also had communication passports. These were person centred booklets complete with essential information about a person. They were attached to people's wheelchairs to ensure they were accessible for the staff team to use. For example, for one person it included information about specialist adapted cutlery the person required to maintain their independence whilst eating their meals.

The assessment processes in place at the service considered certain protected characteristics as defined under the Equality Act. For example, religious status and disability. The management team told us that the service was not supporting anyone who was lesbian, gay, bisexual or transgender at the time of this inspection.

People were supported to have sufficient to eat, drink and maintain a balanced diet taking into account individual needs, likes and dislikes. There were allocated kitchen and domestic staff employed to prepare meals on behalf of people. Meal times were a busy period in the home and we observed staff support people to eat using a sensitive and discrete approach. All staff were aware of any specialist diets including any allergies people had and adjusted the menu accordingly. There were people living at the home who could not manage to eat and drink orally and had feeding tubes either (PEG) (percutaneous endoscopic gastrostomy) or a balloon gastrostomy tube, or low profile devices. We observed nurses support people who received food and fluid this way with confidence. Staff including the registered nurses completed food and fluid charts on behalf of people to monitor what people were eating and drinking. Weights were recorded and monitored on a monthly basis. Nurses were able to explain what action they would take if they were concerned about a person's weight which included informing the GP and increasing their observations of the person and what they were eating. This ensured people's nutritional needs were regularly monitored for any changes.

We were able to speak with relative's whose family member had previously had concerns surrounding their weight prior to moving to Orchard Lodge they said, "Staff understand and know [named person's] needs.

Staff will comment on how [named person] is eating when we visit". They told us they were pleased that there were no longer concerns about their family member's weight they said, "[Named person] had fluctuating weight before they lived at the home, but now their weight was consistent".

Efforts had been made to ensure the environment, adaptations and decoration of the premises met people's diverse needs. Orchard Lodge provides specialist care for adults living with a learning disability or other complex needs and physical disabilities. Corridors and doorways were wide enough for people who used wheelchairs to move around the shared areas. Where required bedrooms were equipped with an overhead tracking hoist to assist with safe moving and handling. Pathways around the grounds enabled people to move easily between different parts of the service and gardens. Some signage was in use, for example, pictorial signs denoted toilets and communal facilities to assist people with their orientation in the building.

Requires Improvement

Is the service caring?

Our findings

At the last inspection we identified the provider had not consistently used a caring approach when supporting people. This included a culture whereby people were not always protected from the risk of harm and staff were not always deployed appropriately to enable them to meet people's needs. At this inspection we found the provider had taken some steps to improve both these areas, yet further work was required and we have elaborated on this in the other sections of this report.

At this inspection we observed occasions where staff failed to demonstrate a caring approach and did not give due consideration and respect for people's dignity. Most people had complex mobility and communication needs and were completely reliant on the staff providing their support. On one occasion we observed a group activity where three staff were supporting five people to make soup to eat in the Boldings area of the home. During this activity we observed staff holding personal conversations not relating to their role or the people they were supporting. They appeared unaware of the potential impact on the people they were supporting as they continued to hold different conversations relating to their lives outside of their work place throughout the hour. Whilst people were unable to tell us how this made them feel the approach displayed a lack of care and attention from staff for the people they were supporting and a disregard for their well-being. On another occasion we sat in Orchard East communal dining and activity room and observed for a 45 minute period. In this time there was very little interaction between the staff on duty and the nine people who were in the room. The staff present in the room were involved in an administrative role creating new care record files for people they were supporting. People in the room were completely reliant on staff to support them with their communication needs and to initiate social interaction. Whilst people were unable to express how this impacted upon them, the lack of interaction we observed posed a potential risk of people not having their communication and social needs met in order to enhance their well-being. There was also a lack of interaction and respect shown from staff who walked through the room from other areas of the home at that time. One person was positioned to watch the TV in the communal room. Staff were observed walking in front of them, blocking their view from the TV. Staff did not acknowledge they were in the person's way and may have disrupted their viewing. This practice failed to demonstrate a caring approach and the person's wish to watch the TV without being disturbed.

Later in the inspection we observed a nurse administer a person their medicines through a percutaneous endoscopic gastrostomy (PEG) tube. A PEG allows nutrition, fluids and medicines to be put directly into the stomach, bypassing the mouth and oesophagus. The nurse administered their medicines confidently however whilst doing so exposed the person's bare stomach area to other people and staff in the room. The nurse also failed to speak with the person whilst they were carrying out the procedure which meant the person may not have known what was happening to them. The person was reliant on staff support for all aspects of their care therefore this practice was not dignified and did not respect the person's right to privacy.

The above evidence demonstrates staff did not treat people with dignity and respect at all times. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also observed positive interactions between staff and people over the three days of the inspection whereby staff showed compassion and respect for the people they supported. For example, the staff we spoke with were able to describe the support individual people needed, what they liked and disliked. We also observed staff knocking on people's bedroom doors before entering and gaining consent from people prior to supporting them with a particular aspect of care such as supporting them at mealtimes with food and drink. People looked at ease in the company of staff and were comfortable when anyone in the staff team approached them. Staff told us they encouraged people to be as independent as possible when supporting them with their personal care. This included choices offered to people about what they wore each day, what they ate and drank and how they spent their day. One staff member said, "We try our best".

At the time of this inspection Orchard Lodge were undergoing a period of extensive review by external agencies such as commissioning teams and the West Sussex local authority safeguarding team, due to concerns raised about specific incidents. Each person's care had been, or was in the process of, being reviewed. People were encouraged to express their views and actively encouraged people to be involved in making decisions about their care as much as they were able. Resident meetings and care plan reviews gave people and their relatives opportunities to discuss what was important to them. Care plan reviews included the person, their family representative and the relevant health and social care professionals to attend. A relative who represented their family member told us they were very much involved in the person's care and said, "[Named person] has an annual review with the home. We attend and get feedback in a report. We will also get a physio report. We will discuss this and go through this with the home together in detail".

People wore clothing appropriate for the time of year and were dressed in a way that maintained their dignity. Good attention had been given to people's appearance and their personal hygiene needs had been supported. Efforts had been made to provide information in accessible formats. For example, each unit had a large noticeboard that included photographs of staff on duty along with large print information and pictures of events planned for that day and meal options. Activity programmes and timetables had been produced in colour and included pictures and symbols that aided understanding.

The management team informed us people's equality, diversity and human rights would always be protected and staff attended equality and diversity training in their induction period.

Requires Improvement

Is the service responsive?

Our findings

Each person had a care record which included a care plan, risk assessments and other information relevant to the person they had been written about. We were told care plans and daily records were reviewed monthly and included information provided at the point of assessment to present day needs. This included guidance on areas such as communication needs, continence needs, mobility needs and specific health information such as if the person had a diagnosis of epilepsy. Pictorial images were used throughout care plans to enable them to be more accessible for the individual they concerned. Moving and handling assessments used photographs of the person and their equipment to guide staff on how the person needed and liked to be moved and transferred from one place to another, such as from a chair to their bed. Care plans also wrote about significant people in their lives, places they liked to visit and whether the person may have a religious belief or another passion or hobby. They also included a 'how I like to look document' about how the person wanted to be seen by others such as how they liked their hair styled and what they liked to wear.

However, at this inspection we found some inconsistencies in how staff implemented the guidance available surrounding people's communication needs as we observed occasions where staff failed to interact with people. We have referred to this further in the Caring section of this report. We also identified inconsistencies within the care plans we read. For example, one person breathed through a tracheostomy. A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea). This person had a comprehensive care plan with clear details of how to staff needed to support them with their respiratory needs and other aspects of their life. However, another person was diagnosed with a condition that required them to have 'regular blood tests'. The care plan did not specify how regularly the blood tests should take place. We asked the nurse on duty who told us they didn't know whether it was every six months or once every year. This demonstrated there was a lack of clarity and knowledge about the person and their health needs which might prevent staff providing the correct care and treatment.

We discussed the inconsistencies we found with the manager and deputy. They told us they had recognised the need to revisit and review some care records in place. They informed us they were introducing a new care planning process and named this the 'Resident of the day'. This included a focus on a different person and all their care needs and associated care records each day of the week. The deputy explained they would be able to review and respond to any gaps they found to ensure the correct person centred guidance for staff was available. The deputy also said all staff would be involved with the review of this person and their care plan which would encourage and promote staffs understanding of a person. The provider also reinforced the introduction of the 'Resident of the day' within the action plan they sent to us shortly after the inspection.

Prior to this inspection the local authority safeguarding team shared with the Commission concerns regarding how a person was supported when they became acutely unwell. Whilst we were not investigating the specifics of this incident, we wanted to check what the management team had in place to assure themselves the correct action was taken by staff each time other people were unexpectedly admitted to hospital. From the records we sampled it showed nurses had responded effectively to historical incidents

and situations whereby people had become unwell. However, there was a lack of records, for us to refer to, relating to routine analysis of unexpected hospitalisations, or other incidents that had taken place to enable the management team to proactively learn from unexpected events to ensure staff have acted consistently, appropriately and in line with best practice at the time. The deputy manager told us they were introducing routine reflective practices which would be carried out at the time of any incident including when a person became acutely unwell and required emergency treatment to assure themselves the staff team had effectively responded to situations impacting people. This was an area that required further improvements.

People were provided with stimulation and were offered various group activities to be involved in at the home. Activity co-ordinators were employed by the provider to support people with their interests. People had weekly activity schedules which incorporated arts and crafts, various games, music session, sensory sessions and various outings. Outings away from the building included trips out for lunch and shopping. One person enjoyed trampolining and went once every few weeks. People also had access to the providers day centre and were supported by staff to attend throughout the week. People were provided with opportunities to discuss their views on the activities offered at monthly resident meetings and we have referred to this further in the Caring section of this report.

As at our previous inspection complaints were looked into and responded to in a timely manner. There was an accessible complaints policy in place available for both people living at the home and their relatives. There was a clear log of all complaints and the actions taken by the management team. There were no formal complaints open at the time of our inspection.

There was no one who was being supported at the end of their life at the time of our inspection. However, procedures were in place with the GP so that people would receive a comfortable, dignified and pain free death. This included access to pressure relieving equipment and pain relief medicines.

Inadequate

Is the service well-led?

Our findings

Since the last inspection there had been a change in the management structure at Orchard Lodge. The area manager was now the manager and had commenced their application to become the registered manager. The provider had also recruited a deputy manager who was a qualified registered nurse and had been working at the home for two weeks.

At the last inspection in July 2017 we identified there were inadequate systems in place to assess, monitor and improve the quality and safety of the services provided to people. The providers systems had failed to identify the areas of poor care we found at the last inspection. This included a lack of specific written guidance available for nurses surrounding people's PEG management. At this inspection we found guidance provided in this area had improved, yet we identified other gaps in people's care plans and associated risk assessments which we have elaborated upon in the Safe section of this report.

At the last inspection we also identified a lack of effective monitoring around the skills, training and competencies of agency nurses the home used. At this inspection this remained a concern as we found gaps in specific training they had received and insufficient action taken by the provider to address this. The service had also failed to report an incident to the local authority safeguarding team in August 2017 and we have written about this in the Safe section of this report. On 15 September 2017 an internal audit was carried out at Orchard Lodge by the provider's quality assurance manager and an area manager. This is a routine audit the provider carries out in all the homes to check the quality of care provided to people. The audit check failed to establish procedures to safeguard and protect people had not been followed, even though the audit made a note of the same incident as we had found. This was an area discussed at the previous inspection as requiring improvement yet this had not triggered senior managers to query the omission.

At this inspection the provider's quality monitoring systems had also failed to establish the gaps in people's care records we found relating to a person's asthma care and another person's bowel management and the potential impact of risk from harm. Checks also failed to highlight one person's DoLS application for renewal had lapsed as the provider was reminded by a representative from an external agency. There was a lack of monitoring of nurses' knowledge regarding which people living at the home had DNACPR status which could have had serious implications for a person as to whether critical emergency aid would have been given or not if they had suffered cardiac arrest. At the time of this inspection the management team were carrying out continuous changes within people's care records, which included care plans and associated risk assessments. However the reviews they had undertaken had failed to identify some people had not had an Annual Health Check to detect early signs of a health conditions. Checks on the people's medicine records and systems had also failed to highlight the lack of written specific guidance regarding the application of people's prescribed topical creams. Audits failed to highlight the inconsistencies which increased the potential risk of people not receiving their preventative creams as prescribed.

The above evidence shows that there continued to be inadequate systems or processes in place that operated effectively to ensure compliance with requirements. There was a failure to assess and monitor and to improve the quality and safety of the services provided. There was a failure to assess, monitor and

mitigate the risks relating to health, safety and welfare of service users. There was a failure to maintain securely an accurate and cotemporaneous record in respect of each service user. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Shortly after the inspection we wrote to the provider. We informed them despite some improvements the Commission remained significantly concerned about some areas of care which had yet to improve and highlighted some new potential risks for people living at the home. The provider had failed to highlight the new concerns prior to this inspection. The provider responded to us and informed us of the action they were taking and the progress they had already made to improve the quality of care they provided. Whilst we recognised the action the provider was taking, we would need to be assured the new systems would be embedded and sustained consistently over a period of time to ensure safe care and treatment was being delivered and having a positive impact on people living in the home.

On the 1 November 2017 amendments to the Key Lines of Enquiry (KLOE) came into effect with five new KLOE and amendments to others that all regulated services are inspected against. We were unable to explore these fully with the manager due to priority care reviews taking place at the time of the inspection and the challenges they faced. The Commission will review this further at the next inspection. However, we were able to note some of the work they were introducing to embed systems and practices with the aim to improve on the quality of care provided to people living at the home. This included implementing the National Early Warning Score (NEWS). This is a standardised system for recording and assessing baseline observations of people to promote effective clinical care. For example, it will include a baseline for what a person's temperature, pulse rate and oxygen saturations should be and what actions nurses should take if physiological checks they take are outside of the baseline and a person's health deteriorates further. The deputy manager described the system to the inspectors. They expressed their commitment and involvement with the process and how it would improve the quality of records provided at the time nurses take action and make decisions when supporting people when they become unwell. Nurses we spoke with were aware this was going to be implemented and agreed it would be support them to carry out their clinical role and responsibilities.

We were also told in the future a member of the management team would be based in each area of the home to support the staff teams more effectively. Relatives and other representatives of people were routinely asked their views on the care people received. Opportunities were provided informally when they visited their family members or formally within care plan reviews and questionnaires. These were routinely sent out from the providers head office on a monthly basis. The ones we read were all positive. We also took note of an email written by the quality assurance manager which was sent to home managers and presented action points of items they had to implement to drive the quality of care provided.

Due to the level of the concerns raised and scrutiny the home were under the management team were involved in continuous review meetings throughout the inspection. Reviews were relating to people's care involving health and social care professionals and relevant family members throughout the three day inspection. Despite this they made themselves available when possible and supported the inspection team with their requests in accessing the necessary care records and responding to our queries. We also received positive feedback from all the staff we spoke with about the changes to the management structure and what that meant for the staff and the people they supported. One staff member said, "I can talk to the [named manager] about everything. She is really good". Another staff member said, "The new change in management has been really good". They added, "Management are very supportive". They also told us, "Staff morale has risen, they are more proactive in their approach". A third staff member said, "[Named manager] and [named deputy manager] really care about the place". They also said, "The culture of the home has changed for the better".