Orton Manor Ltd

Orton Manor Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Orton Manor Nursing Home provides accommodation, personal and nursing care for up to 40 older people living with physical health conditions or dementia. The home has two floors, each with a communal lounge and dining area. At the time of the inspection 28 people lived at the home.

People's experience of using this service
People's individual risks were not always identified, assessed and well-managed. Records related to people's care did not demonstrate all planned care had been provided safely and records to monitor people's health were not consistently completed.

Medicines were not always managed safely. For example, staff did not always follow nationally recognised guidance and records did not always evidence people had received their medicines as prescribed.

At the time of our inspection visit there were enough staff on duty to meet people's needs, but there was a heavy reliance on agency staff to ensure safe staffing levels were maintained. The provider was focused on trying to address this to improve staffing stability and had recruited new staff who were going through recruitment processes.

Overall, the provider was acting in accordance with up to date guidance to minimise the risks of infections spreading. However, we found some areas for improvement to ensure the environment and clinical equipment was clean and ready for use.

The provider had processes in place to assess and monitor the quality of care, but these had not been completed which meant shortfalls in safety and quality had not been identified. The provider had failed to maintain sufficient and accurate oversight of the service and to identify risk management was ineffective and that regulations were not being met.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 31 October 2017).

Why we inspected
The inspection was prompted in part due to information received about the management of individual and environmental risks within the service. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those

key questions were used in calculating the overall rating at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service is now inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Orton Manor Nursing Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches of regulations in relation to safe care and treatment and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

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.

Details are in our safe finding below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Orton Manor Nursing Home

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by three inspectors and a nurse specialist advisor. Two inspectors visited the service and one inspector contacted relatives and staff by telephone to gather feedback on their experiences of the home.

Service and service type
Orton Manor Nursing Home is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. Registered managers and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The deputy manager had taken over the day to day management of Orton Manor Nursing Home on a temporary basis and is referred to as the interim manager in this report.

Notice of inspection
Our inspection was unannounced.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection and any recurrent

themes of concerns. We sought feedback from the local authority and commissioners who work with the service. We also contacted Healthwatch and an advocacy service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We used all of this information to plan our inspection.

During the inspection
We carried out observations to assess people's experiences of the care provided. We spoke with the interim manager, the clinical lead, a senior member of care staff, an agency nurse, a housekeeper and the administrator. We spoke with two people and fifteen relatives to gather their experiences of the care provided.

We reviewed three people's care records and a selection of daily records for people. We looked at 28 people's medicines records. We looked at a sample of records relating to the management of the service including health and safety checks, accident and incident records and safeguarding records.

After the inspection
We continued to seek clarification from the provider to validate evidence found and to ensure immediate action was taken to address our concerns. We also attempted to contact eight more staff by telephone and email to seek their views on the service. Only two members of staff chose to engage with our inspection process.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management;

- Risk was not always identified, assessed and well-managed.
- One person had a catheter due to their health condition. The catheter was connected to a urine collection bag which must be kept at a lower height than a person's bladder. This is done to prevent urine flowing back into the bladder from the tubing and urine bag. We found this person's urine bag laying on their bed which posed an increased risk of infection. We immediately alerted a nurse who rectified this.
- The maximum period between changing internal catheter tube devices should be 12 weeks. Records did not evidence one person's catheter had been changed in accordance with good practice.
- Monitoring fluid output of people with a catheter supports early recognition of the signs of an infection. Staff were not consistently recording the fluid output of people with a catheter as required by their care plan.
- Records to support the management of wounds and skin damage were incomplete. One person had wounds on their legs, but there was no care plan to inform staff how these should be managed.
- Another person had leg ulcers, but there were no records of the wounds being assessed, photographed, monitored or dressed for 17 days.
- One person was at risk of falls and had fallen five times over 13 days. There was no formal assessment of the risk of this person falling. The person's mobility care plan had been reviewed on 12 November 2021, but just read 'reviewed'. There was no evidence of what had been included in the review and it did not reference the falls the person had sustained in the previous 13 days.
- The provider's falls protocol stated, "nurses must complete hourly neurological observations for 24 hours for people who have an unwitnessed fall or head injury using the Glasgow coma scale". Observations were not being completed as required by the protocol which put people who may have sustained a head injury at risk.
- Risks to people's oral health had been identified but action had not always been taken to mitigate the risks associated with poor oral hygiene. For example, one person required assistance from staff to brush their teeth twice a day. Records showed this person had only been supported to brush their teeth on one occasion in 11 days and their teeth were notably dirty. Another person did not have a toothbrush or toothpaste in their room. Poor oral care can affect people's ability to eat, speak and socialise.
- One person had bruising and a skin tear to their hand. These injuries had not been recorded in the person's records or on a body map and no action had been taken to identify the potential cause.
- There was a lack of oversight to ensure risk management plans were consistently followed. Some people were on fluid charts because they were at risk of not drinking enough. Charts were not being used effectively to identify those people who needed to be encouraged to drink more. One person was on a bowel chart. The

chart had only been completed on two occasions between 1 November 2021 and 18 November 2021.
● Some environmental risks had not been identified. Window restrictors on the first floor did not meet current health and safety standards.
● There had been a recent inspection by the fire service who carried out an inspection of the premises. Failures to comply with The Regulatory Reform (Fire Safety) Order 2005 had been identified but little action had been taken to mitigate these failures. For example, the fire risk assessment had not been reviewed by a trained professional, new furnishings in the premises could not be confirmed as being fire resistant and there were some excessive gaps at the bottom of bedroom doors which could allow for uncontrolled smoke spread. Following the inspection, the provider gave assurance the identified actions were being addressed.
● There were some gaps on Medicines Administration Records (MARs) where staff had not signed to confirm people had received their medicines. We were not able to check whether this was only a recording issue because of the number of inaccuracies in recording stock balances. This meant we could not be assured people always received their medicines as prescribed.
● Medicines which had shortened expiry dates when opened, did not always have the date of opening recorded on them. This meant we could not be assured of the continued effectiveness of some medicines.
● Some people were prescribed medicines 'as required'. Guidance was not always available to inform staff when they should give these medicines in line with national guidance for 'as required' medicines. Guidance is important to ensure these medicines are administered as prescribed.
● Some people were given their medicines covertly, that is hidden in food or drinks without their knowledge. Records had not been fully completed to evidence there had been a full mental capacity assessment, or a formal best interests meeting had taken place to ensure it was in the person's best interests. There was no guidance from a pharmacist on safe administration methods.
● The morning medicines round on one floor did not conclude until 12.20pm. This can result in risk to people as potentially a safe period between doses may not be observed.

Systems and processes were not sufficient to demonstrate risk associated with people's care was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were somewhat assured the provider was promoting safety through the layout and hygiene practices of the premises. However, we found some environmental concerns. For example, one grab rail in an assisted bathroom had rust damage and the water drainage system was not working efficiently. Staff had removed the drainage plug which was extremely dirty and left it on the shower floor. Some bedrail covers required deep cleaning and a toilet seat was missing. We discussed this with the interim manager who told us they would take action to resolve these issues immediately following our inspection.
● The suction machine to clear secretions was out of reach on a high shelf in the clinic room. The unit was dirty and full of condensation which meant it had not been cleaned properly.
● Containers for the disposal of needles or sharps were not always disposed of in accordance with NICE guidelines.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely. During our inspection we found one area of the home where PPE was not easily accessible and one area with no aprons. The interim manager assured us they would address this immediately.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were somewhat assured that the provider was making sure infection outbreaks can be effectively

prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong
● The provider's processes were for accidents and incidents to be recorded on an electronic system, but at the time of our inspection no staff had received training on how to use that system.
● The interim manager had recently introduced paper accident and incident forms but there was a gap of four months where no records of accidents and incidents were available. This meant we could not be sure action had been taken to mitigate individual risks or identify any trends or patterns at service level.

Systems and processes to safeguard people from the risk of abuse
● The provider had a safeguarding policy which was available for staff to refer to. The policy guided staff on how to report and escalate any concerns. One staff member told us, "Say if I heard a member of staff not being professional, I would ask that staff member to leave to make sure my resident was safe. I would then talk to my line manager."
● The interim manager understood their obligation to report concerns to the relevant authorities. However gaps in records meant there was a risk some issues of a safeguarding nature may not be identified.

Staffing and recruitment
● Records showed enough staff to meet the needs of the people living at the home, however there was a heavy reliance on agency staff. For example, there were no permanent night nurses employed at the service.
● The interim manager acknowledged that staff vacancies were an issue and they were focused on trying to address this to improve staffing stability and continuity of care for people. They had recently recruited nursing staff who were due to start their employment soon.
● Feedback from relatives about staffing levels was mixed. One relative told us, "I only see [Name] in his bedroom but there are plenty of staff walking about. I hear the call bells going off, but they seem to respond to them." Another commented, "Staff seem very busy, they do their best, but they need more staff."
● The interim manager ensured agency staff had the skills and experience required to work at Orton Manor Nursing Home and had requested evidence of their vaccination status as per new government guidelines of vaccination as a condition of deployment in care homes.
● The recruitment process ensured staff were suitable for their roles by conducting relevant pre-employment checks which included an enhanced Disclosure and Barring Service [DBS] check.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- The provider had a range of audits in operation to monitor the health, safety and welfare of people and the environment in which they were supported. However, these were not being carried out in accordance with the provider's schedule of checks which meant shortfalls in service provision had not been identified. For example, health and safety audits had not been carried out and we found some risks in the environment.
- Medicines audits had not identified and addressed shortfalls in medicines practices as they had not been completed since June 2021.
- The provider's processes to monitor care records and ensure that an accurate, complete and contemporaneous record in respect of each person had been maintained were ineffective.
- Monitoring of care plans had failed to identify risks associated with people's care had not always been identified or managed well.
- Records related to people's care were not detailed or complete. This meant the provider could not demonstrate all planned care had been provided safely, in line with people's individual risk management plans. For example, records to evidence monitoring of food and fluids, bowels and personal care.
- The interim manager told us some issues around record keeping were due to the high level of agency staff in the home. The provider had not implemented extra checks or support to ensure agency staff had the appropriate knowledge or understanding of people's needs.
- The provider had failed to ensure senior staff had the skills and knowledge to carry out their role and responsibilities. For example, at the time of our inspection visit the interim manager had no training on, or access to, the provider's electronic system for recording accidents and incidents. This meant there were gaps in the records maintained.
- The provider had failed to maintain sufficient and accurate oversight of the service and to identify risk management was ineffective and that regulations were not being met. Therefore, people were not in always in receipt of safe care.

The above issues demonstrate a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- At the time of our inspection visit, there was no registered manager in place. An interim manager had been managing the home for three months.
- The interim manager was open about the challenges during that time and told us her focus had been on

recruiting staff because of the very high level of staff vacancies.
● Following our inspection visit, the provider confirmed the interim manager had been offered the permanent position of manager and was going to submit their application to become registered with us, CQC. The provider was confident this would bring an extra level of stability to the management of the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider understood their responsibility to be open and honest when things had gone wrong. Following our feedback, the provider implemented an action plan to improve standards and practice at the home.
● The provider had met the legal requirements to display the services latest CQC ratings in the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working with others
● We received mixed feedback from relatives about the quality of care their family members received. Many relatives were happy with the standards of care provided. Comments included: "I can't fault anything there really. I think the care is amazing" and, "I am happy with [Name's] care, the staff are kind and pleasant."
● However, two relatives raised concerns about the number of falls and injuries their relative had sustained and the responsiveness of staff to requests for assistance.
● Both relatives and staff spoke about the impact of recent changes in management. One relative told us, "The management changes have been a bit unsettling. A lot of staff left, but we are in a better place now." A staff member said, "I have had four managers in the last two years, and they all have different ways of doing things. I think sometimes a new manager comes in and wants to do it their way which is fine if it works for the home."
● At the time of this inspection visit, the provider and the management team were working with the local authority to a service improvement plan (SIP).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had failed to assess the risks to the health and safety of service users and do all that was reasonably practicable to mitigate any such risks.

The enforcement action we took:

We issued a Warning Notice against this provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider's systems and processes to manage and monitor the quality of safety of the service were not effective.

The enforcement action we took:

We issued a Warning Notice against this provider.