Flightcare Limited

Orchard Nursing

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
Orchard Nursing is a care home registered to provide nursing care to up to 31 people, including people living with dementia. At the time of the inspection there were 28 people living in the home.

People's experience of using this service and what we found
The systems in place to monitor the quality and safety of the service were not effective. They did not identify the risks to people we highlighted during the inspection. When audits identified actions, it was not always clear if they had been addressed. There was no oversight of the completion of records regarding care provided to people to enable the provider to be assured that people's care needs were met. The Commission had not been informed of all reportable incidents and events providers are required to inform us about.

Risks to people had not all been assessed to ensure measures could be put in place to minimise risks. When risks had been identified, steps were not always taken to reduce the risk and maximise people's safety and wellbeing. Checks were made by external companies to help maintain the safety of the building and equipment. However, required internal checks were not completed robustly. Medicines were not all stored and managed safely and not all staff had completed assessments to ensure they were competent to administer medicines safely. Appropriate infection prevention and control measures were not all in place to prevent the spread of infection. Not all parts of the home were clean, and we could not be assured that all staff had completed COVID-19 testing in line with government guidance.

People were supported by staff who had been safely recruited, however the high use of agency staff had an impact on the quality of the care people received. Not all staff had completed necessary training to ensure they had the knowledge and skills to undertake their role safely.

People's relatives told us they felt their family members were safe in Orchard Nursing. Staff were aware of safeguarding procedures and knew how to raise any concerns they had, although only half of the staff had completed safeguarding training recently.

There was no registered manager in post at the time of the inspection. A new manager had been appointed and was due to start the following week. There had been several changes in the management of the service and not everybody knew who was managing the home. Staff did not feel supported and did not all know who to turn to when they needed support.

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 22 December 2020).

Why we inspected
We received concerns in relation to staffing levels, infection prevention and control procedures and the management of the service. 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 has changed from good to 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 see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Orchard Nursing 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 in relation to the management of risk, infection prevention and control, staffing levels and the governance of the service.

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
We will meet with the provider and request an action plan to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
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 findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Orchard Nursing

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided 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 team included two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Orchard Nursing is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. 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. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection and received feedback from the local authority. 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 spoke with ten relatives about their experience of the care provided. We also spoke with the interim manager, area manager and seven members of the staff team.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at four staff files in relation to recruitment, as well as a variety of records relating to the day to day running and management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found and review evidence sent virtually after the on-site inspection. We requested feedback from two professionals who regularly engaged with the service.

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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks to people had not all been assessed, monitored regularly or mitigated to maximise people's safety.
- Measures put in place to reduce risk were not adhered to. For example, there were gaps in the recording of people's support to reposition and their diet and fluid intake charts, despite high levels of risk being identified.
- Accidents and incidents were recorded and investigated. However, learning from these investigations were not transferred into people's care plans to help prevent recurrence.
- Advice provided by other health professionals was not incorporated within people's plans of care to ensure all staff knew how best to support people.
- Although regular checks were made by external organisations to maintain the safety of the building, internal checks were not always completed robustly. For example, fire alarm tests were not completed weekly and water temperatures were not always within recommended limits. We observed fire doors that were wedged open during the inspection, a bathroom window that was broken and a door did not close properly in its frame.
- Personal emergency evacuation plans were in place but had not been updated to reflect changes in people's needs. This increased the risk that people would not be evacuated safely in the event of an emergency.

Failing to adequately assess and mitigate risk to people is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines were not all managed safely. The temperature of medicines in the clinic room were monitored and within range, but medicines stored in the basement were not temperature checked to ensure they were stored appropriately and within recommended ranges.
- Although staff had completed training, records showed that not all staff had had their competency assessed to ensure they could administer medicines safely.
- The stock balance checks we completed showed that records regarding administration were not accurate, as not all of the balances were correct. Therefore, we could not be assured that people had always received their medicines as prescribed.
- The guidance for staff to follow when administering 'when required' medicines was not sufficiently detailed to ensure these were administered consistently or when people needed them. A relative told us, "Recently [relative] did not get their medication on time because of staff shortages; that is a problem because the medicines need to be evenly spread time wise."

● Although most processes had been followed to ensure medicines administered covertly, were done so safely, there was one medicine that did not have any guidance as to how it should be administered.

Failing to manage medicines safely is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Appropriate infection prevention and control measures were not all in place to prevent the spread of infection.
● COVID-19 testing procedures were in place, however records showed that not all staff had completed tests in line with government guidance. There was no evidence that agency staff completed any COVID-19 testing.
● Not all areas of the home appeared to be clean. Although cleaning schedules were in place, there were gaps in the completion of them and they did not include regular cleaning of frequently touched areas.

Failure to ensure effective infection prevention and control systems were in place is a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had access to sufficient supplies of PPE and were seen to wear this effectively.

Staffing and recruitment
● There was not always enough staff on duty with the knowledge and skills to meet people's needs.
● Although feedback regarding staffing levels was mixed, staff told us the high use of agency staff impacted on the quality of care provided to people. One staff member told us, "It takes more time showing [agency staff] what people need. It impacts on the residents as they are not getting the right care, not as much food and drink as we would like to give them." Several staff members explained that they were unable to provide repositioning support to people as often as they should.
● Some relatives felt that there were enough staff available, but others did not. One relative said, "On one occasion recently, they refused a visit request because staff said that they were too busy. Call bells do work, but last week they had not responded for 20 minutes so I had to find the staff myself."
● Not all staff had completed training to ensure they had the required knowledge to undertake their roles effectively. For example, only 57% of staff had completed fire safety training and more than 40% had not completed recent moving and handling training.

Failing to ensure adequate numbers of staff sufficient knowledge and skills to support people safely is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Records showed that most safe recruitment practices had been followed to ensure staff were suitable to work with vulnerable people.

Systems and processes to safeguard people from the risk of abuse
● A safeguarding policy was in place to guide staff in their practice.
● Only 54% of staff had completed safeguarding training recently, however staff understood their responsibilities with regards to safeguarding and how to raise concerns.
● When safeguarding concerns were raised, records showed that investigations were completed, and relevant people informed.

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 now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care

- Systems in place were not effective in monitoring the quality and safety of the service. Although some audits were undertaken, they did not cover all aspects of the service, were not all accurate, completed regularly or followed up to help drive improvements.
- The provider failed to ensure systems were in place to manage risks to people's safety and wellbeing; to ensure medicines were managed appropriately and to ensure staff with adequate knowledge and skills were always available to support people in a timely way.
- There was no oversight of the completion of records regarding care provided. For instance, there were gaps evident in people's temperature monitoring, repositioning records and diet and fluid intake charts.
- Management of infection control practices required improvement to ensure risks were minimised and to ensure staff completed COVID-19 testing in line with government guidance.

Failing to ensure effective systems are in place to monitor the quality and safety of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There had been several changes to the management of the service and staff told us they did not all feel supported. One staff member said that the constant changes were stressful, that they did not know who was most senior, or who to turn to.
- Most staff we spoke with told us they would not be happy for their family members to live in Orchard Nursing.
- Although relatives did not raise concerns regarding the management of the service, they told us they did not know who managed the service as there had been several changes.
- There was no evidence to show that actions had been taken to address negative feedback received from staff, such as feedback regarding the poor quality of meals provided to people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Systems were not in place to gather regular feedback from people or their relatives, regarding the service provided, to enable changes and improvements to be made as necessary.

● People were referred to other health professionals for their expert advice when needed. However, the advice provided was not always clearly reflected in people's care records to ensure it was known and followed.
● Relatives told us they had not been involved in any reviews of their family members planned care.

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
● Relatives told us staff informed them of any accidents or incidents involving their family members.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● There was no registered manager in post at the time of the inspection. A new manager had been appointed and was due to start the following week.
● The Commission had not been informed of all notifiable incidents providers are required to inform us about.
● The provider had failed to meet regulatory requirements and several breaches of regulation were identified due to risks to people's health, safety and welfare.
● There were a range of policies in place to guide staff in their roles.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The high use of agency staff had an impact on the quality of care people received. Not all staff had completed necessary training to ensure they had the knowledge and skills required to support people safely.

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	Risk to people was not adequately assessed, monitored or mitigated in order to keep them safe from potential harm. Medicines were not all managed safely. Effective infection prevention and control measures were not in place.

The enforcement action we took:

A warning notice was issued.

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	Systems in place to monitor the quality and safety of the service were not effective and provider oversight of the service was not adequate.

The enforcement action we took:

A warning notice was issued.