

R Sons (Homes) Limited

Orchard House Residential Care Home

Inspection report

155 Barton Road
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Tel: 01536514604

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21 September 2022

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Orchard House is a residential care home without nursing, providing personal care for up to 33 older people including those living with dementia. At the time of the inspection 22 people were being supported.

Orchard House has accommodation across two floors, in one adapted building.

People's experience of using this service and what we found

Systems in place to ensure the proper and safe management of medicines were not robust and did not ensure people received their medicines as prescribed.

Provider level quality assurance audits of the service to ensure oversight and safe care had not been effective in identifying areas for improvement and ensuring required improvements.

People felt safe living at Orchard House. Staff were trained in safeguarding and understood their responsibilities to protect people from harm.

Staff followed all necessary infection prevention measures. Staff wore appropriate personal protective equipment (PPE) and received training in infection prevention and control.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff continued to work in partnership with health professionals involved in monitoring and providing care and treatment for people using the service.

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 Requires Improvement (published 11 March 2022)

The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected

We received concerns in relation to the management of medicines. As a result, we undertook a focused inspection to review the key questions of safe and well-led.

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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has remained Requires Improvement.

We have found evidence that the provider needs to make improvements. 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 House Residential Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations

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 monitor the service and will take further action if needed.

We have identified breaches in relation to medicines and the management and the governance systems 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

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.
Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.
Details are in our well-led findings below.

Requires Improvement ●

Orchard House Residential Care 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. 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 Health and Social Care Act 2008.

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 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 House is a care home. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. [Care home name] is a care home [with/without] nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

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. We sought feedback from the local authority safeguarding and quality monitoring teams. The provider had not been asked to submit a PIR since the last inspection. This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with six people who used the service for feedback on their experience of care.

We spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We had discussions with six staff including housekeeping, activities and care and support staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We had a meeting with the registered manager on 21 September 2022 as she was not available at the time of our site visit.

We looked at three care plans for all aspects of people's care and three staff files. We examined 13 medicine administration records (MAR) charts and six medicine care plans. We looked at a range of other records including quality assurance checks and information about training and staff supervision.

Is the service safe?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating for this key question has remained Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- Systems in place to ensure the proper and safe management of medicines were not robust. When medicines were prescribed as and when required (PRN), guidance was either not available or did not help staff make decisions about when it was appropriate to administer. For example, one person was unable to communicate verbally, but there was no information available to staff on the visual signs they would need to look for to determine whether this person was in pain and administer pain relief if needed.
- We observed that staff did not accurately measure liquid medicines using the oral syringe. We raised this at the time of inspection with the staff responsible for administering medicines and were told they had not received training about this procedure. This demonstrated that staff did not have the necessary skills and knowledge to administer people's medicines safely.
- When staff applied transdermal patches, they did not record where the patch was situated on the person's body and this was not rotated as per the manufacturer instructions. Care plans lacked key information about people's medicines. For example, the care plan for one person did not detail the risks and side effects to their complex medicine regime.
- Liquid medicines, eye drops, and creams did not have a date of when they were first opened. We saw that staff had been administering eye drops which had surpassed their expiry date. We highlighted this immediately to senior carers and the eye drops were discarded and replaced. We also found that some people had not received their medicines because they had not been ordered in a timely manner.
- People who were prescribed topical medicines did not always have records of where to apply the cream, so we could not be assured that care staff were applying these correctly. We were told that staff applied barrier creams when getting people up in the morning, but this was not documented. Senior care staff told us they signed the medicine administration record (MAR) chart after obtaining a verbal handover by care staff, however we did not see this on inspection.
- Risks to people had not been identified and improvements had not been made to the timings of people's medicines. We observed the morning medicines round, which took approximately four hours to complete. This meant that there was too little time between medicines rounds, which placed people at risk of being given their medicines too close together. Staff did not record the time they administered medicines, which meant that for some medicines they could not tell whether it was safe to give the next dose.

People did not receive their medicines safely or as prescribed because the provider had failed to ensure proper and safe management of medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the registered manager informed us they had an emergency meeting with the senior staff to discuss and highlight areas of concern and to delegate to staff areas of responsibility and monitoring. The registered manager also informed us that she would continue to audit and check medicines.

Assessing risk, safety monitoring and management

- People had risk assessments in place which guided staff on how to keep people safe in relation moving and handling, pressure area care, falls and nutrition. For example, if people were at risk of poor nutrition and dehydration a nutritional risk management plan was put in place to reduce the risk to the person.
- Risk assessments in place were reviewed and updated if there were any changes or incidents.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Systems and processes to safeguard people from the risk of abuse

- Systems and processes to safeguard people from the risk of abuse were in place. People felt safe when staff provided them with care and support. One person said, "Yes I do feel safe. Staff treat me with kindness and respect. They treat me as I treat them."
- Discussions with staff demonstrated they knew how to recognise when people were at risk of harm or felt unsafe, and they felt comfortable to report unsafe practice. One staff member said, "I would report anything I wasn't happy about to the manager, without any hesitation."
- All staff we spoke with confirmed they had completed training and understood the provider's whistleblowing and safeguarding policies and procedures. Records showed the provider reported safeguarding concerns, as required, to the relevant agencies.

Staffing and recruitment

- There were sufficient staff to keep people safe. One person said, "Yes, there are enough staff. There are quite a few. They are quite good people, a mixture of nationalities."
- We received positive feedback from staff about staffing levels. One staff member said, "Staffing isn't an issue. We have enough staff to support people safely. "
- Our observations confirmed there were sufficient staff to meet people's needs in a timely manner. We saw the deployment of staff throughout the day was organised and people who required support with their personal care needs received this in a timely and sensitive way. We found staff had time to spend with people on an individual basis.
- The provider followed robust recruitment procedures to ensure people were protected from staff that may not be fit to support them. Disclosure and barring service (DBS) security checks and references were obtained before new staff started the probationary period. These checks help employers to make safer

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
 - We were assured that the provider was supporting people living at the service to minimise the spread of infection.
 - 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.
 - We were assured that the provider was responding effectively to risks and signs of infection.
 - We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
 - We were 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.
- Visits to people living in the service were facilitated and arranged in line with national guidance. This included essential carers continuing to visit during an outbreak of COVID-19 when the service was closed to routine visits.

Learning lessons when things go wrong

- The provider had systems in place to monitor incidents and accidents so action could be taken to promote people's safety. There was thorough recording of all accidents and incidents. This ensured all areas of accident and incident reporting were looked at and recorded.

Is the service well-led?

Our findings

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The service has been rated, 'requires improvement' following the last two inspections. The action plan developed following the comprehensive inspection completed on 20 May 2021 had not been effective in driving and delivering the required improvements to achieve a 'good' rating in all areas.
- The systems in place to ensure people received their medicines as prescribed were not safe or effective. For example, medication audits and stock checks had failed to identify and make improvements to out of date medicines. Eye drops were out of date but were still being administered.
- Care plan and medication audits had failed to identify and make improvements to information for staff about when to administer people's PRN 'as needed' medicines. This meant staff did not have the information and guidance they required to safely administer people's PRN medicines.
- We found that staff expected to administer medication did not have the necessary skills and knowledge to do so safely. For example, we saw a medicine for one person that had been signed for as given even though there was no stock available.
- Senior staff responsible for administering medicines were not working in line with the providers policies and procedures, despite training, supervision and performance management. Staff had failed to escalate concerns to the registered manager putting people at risk of receiving inappropriate and unsafe care, despite training and performance management.

We found no evidence that people had been harmed however, oversight of the service was not effectively managed by the provider to ensure people received safe and person-centred care at all times. This was a breach of Regulation 17 (Good Governance) 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

- Some staff spoke to us of low morale amongst the staff team, some spoke of not feeling valued or appreciated. A staff member told us, "Staff morale is low at the moment. I think it's because of a mixture of things, such as new staff and new roles." A second staff member told us, "I feel undervalued by the owner, not the manager."
- We found there was insufficient support for the registered manager to effectively manage the service. Although there were senior staff in post, continuous medication errors were being made and the registered manager told us she was having to audit records daily.
- On the day of our inspection the registered manager was absent from the service. The provider came to the service to assist with the inspection. However, the registered manager told us they had been contacted when we arrived. The provider or senior staff were not able to locate some records we asked for during the inspection. We had to wait until the registered manager returned to send them to us via email. This meant that unless the registered manager was in the service some records were not accessible.
- Feedback from people using the service was positive and we were told how valuable the service was to people. One person said, "I would be lonely at home because there is no one to look after me. I'm not lonely

here. It's my home now."

- We received positive feedback from people and staff about the registered manager. One person told us, "I would go to [name of registered manager] if I was worried about anything." A staff member commented, "[Name of manager] is really supportive and tries her absolute best to be there for the staff. I do think she has too much on her plate. She does everything."

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; Working in partnership with others

- The registered manager understood their responsibility regarding the duty of candour. They had been working transparently with a family member following an incident and had been open and honest.
- The provider had a policy that covered what actions they would take to ensure the duty of candour would be met in instances of this nature.
- Staff continued to work in partnership with the local authority and health professionals involved in monitoring and providing care and treatment for people using the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Resident meetings were held every two months and in the minutes of the last meeting we saw the topics of food and menus were discussed. Changes had been made to the menu following feedback from people.
- The activities coordinators supported people to complete satisfaction surveys, and these were also sent to relatives to complete so they could give their views about the service.
- Effective communication systems were in place to ensure that staff were kept up to date with any changes to people's care and support systems to staff. They confirmed they had regular staff meetings and one to one meetings with a senior staff member. There were daily handover meetings where staff discussed anything of note and made sure they always had up to date information.

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 People did not receive their medicines safely or as prescribed because the provider had failed to ensure proper and safe management of medicines.

The enforcement action we took:

We issued a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Oversight of the service was not effectively managed by the provider to ensure people received safe and person-centred care at all times.

The enforcement action we took:

We issued a Warning Notice