Orchard Homecare Services Limited

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Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Orchard Care Home Services is a domiciliary care agency. It provides personal care to people living in their own homes in the community. It provides a service to younger and older adults. At the time of the inspection 182 people were using the service.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
Further improvements were needed with medicine records. Risks to people were not always effectively assessed. Quality assurances process had identified some of the concerns we found but needed to be more robust. Missed or late calls were looked at but not fully analysed with learnings or outcomes.

People felt safe and were supported by staff who were recruited safely.

There were enough staff to cover all calls.

Staff felt supported by the management team and enjoyed working at Orchard Care Home Services.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection (and update)
The last rating for this service was requires improvement (published 5 February 2020) and there were two breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of some regulations.

Why we inspected
We undertook this targeted inspection to check whether the breaches of regulation and other concerns identified at the last inspection had been addressed. The overall rating for the service has not changed following this targeted inspection and remains requires improvement.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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 have identified continuing breaches of regulation in relation to safe care and treatment and good governance.

Follow up
We will request an action plan for the provider 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question where we had specific concerns about.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question where we had specific concerns about.

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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.

This was a targeted inspection to check whether the breaches of regulation and other concerns identified at the last inspection had been addressed.

Inspection team
An inspector, an assistant inspector and an Expert by Experience carried out this inspection.
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
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This allowed the provider time to let people know we would be contacting them for feedback and provide us with records for review as part of the inspection.

What we did before the inspection

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We reviewed information we had received about the service since the last inspection.

We sought feedback from the local authority and professionals who work with the service.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with nine people and 10 relatives about their experience of the care provided over the telephone. We reviewed a range of records. This included eight people's care records and six medication records. We spoke with 11 members of staff, including a director, the registered manager, care coordinators, senior care workers and care workers.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question where we had specific concerns about. The purpose of this inspection was to check whether the breaches of regulation identified at the last inspection had been addressed. We will assess all of the key question at the next comprehensive inspection of the service.

Using medicines safely
At our last inspection the provider had failed to manage medicines safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Medicine records did not always evidence people were receiving their medicines as prescribed.
• The medicine policy needed updating to make sure it was in line with NICE guidance.
• Staff were not following the current medicine policy.
• Staff said they always ensure people receive their time critical medicines on time. One staff member said, "I have a couple of time sensitive calls for medicines, I don't follow the rota the office supply as it is not done in a logical order and sends me all over the place, so I make sure people get their medicines, the office needs to sort this but my clients are very happy."

Assessing risk, safety monitoring and management
At our last inspection we found that risk assessments needed more guidance to support staff on how to reduce the risk. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

• Not all risks to people had been identified.
• Risks that had been identified contained little or no guidance on how to prevent the risk.

Learning lessons when things go wrong
At our last inspection we found systems needed to be improved for the monitoring of late and missed calls. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Although missed or late calls were investigated no reason why they happened was recorded. Therefore, to lessons could be learnt or trends found.
• Missed or late calls were not monitored out of hours or at the weekend. The director said they were going to implement this straight away.
• People said time keeping was still a problem. Comments included, "The two carers arrive roughly together, but sometimes they can be an hour late, some of the carers care but others just do it for the money", "I have no idea what time they are coming if they haven't turned by 11am I ring to see where they are. No regular

carers but there is a team of carers, but the office does not let me know anything. Original I asked for no one to call before 9.30am. and once a carer turned up at 8.10am" and "Usually not bad, they do vary, but sometimes too early and do not let me know."
• Staff did not have travelling time between each appointment. Most people we spoke with said the carers tried very hard to be on time for each visit. The director said they would start adding travelling time to staff rotas.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Staffing and recruitment
At the last inspection the provider failed to deploy staff effectively. At this inspection we found improvements had been made and the provider was no longer in breach of this part of the regulation.
• People were starting to see a consistent staff team, although this still needed improvement. People we spoke to said, "I do have some idea who's calling, I don't think that I have ever been missed and nothing is too much trouble" and "We get regular carers and they are spot on."
• Staff said there were always enough staff to cover calls. One staff member said, "I always stay the length of time required, I have excellent continuity and stick with the same clients."
• People were supported by staff who had been safely recruited; appropriate checks helped make sure suitable staff were employed.

Systems and processes to safeguard people from the risk of abuse
At the last inspection safeguarding systems needed to be more robust.
• The provider had effective systems in place to safeguard people from the risk of abuse.
• People told us they felt safe when staff visited their home.

Inspected but not rated

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 requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question where we had specific concerns about.

The purpose of this inspection was to check whether the breaches of regulation identified at the last inspection had been addressed. We will assess all of the key question at the next comprehensive inspection of the service.

At our last inspection the provider had failed to ensure good governance processes were in place. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. Although we could see some improvements had been made at this inspection further improvements were needed, and the provider was still in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014..

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• We found the provider still needed to make improvements. Quality audits were not effective.
• Audits that did take place, had action plans put in place. However, staff were not completing these action plans.
• People we spoke with said the day to day running of the service still needed to be improved. Comments included, "I have no problem with the carers, but the office staff do not communicate with each other and they do not listen" and "The office can be accommodating at times, but it does vary."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• Records still did not provide enough information to support staff to deliver person centred care.
• Improvements were needed to ensure people were at the centre of their care which was how they wished it to be.

Staff we spoke with said they feel very supported in their role and enjoyed working at Orchard Care Home Services. One staff member said, "I work well with people. Get a lot of positive feedback from people. Absolutely love my job. Love to keep people safe, well people aren't able to see their families. I have been named personally in the surveys sent into the office for a job well done."

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not doing all that was reasonably practicable to mitigate risks. 12(2)(b)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were not protected from the risk of inappropriate care and treatment as records and robust systems were not in all place to monitor the quality of care provided. 17(2)(a)(b)(c)