R Sons (Homes) Limited

Orchard House Residential Care Home

Inspection report

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Tel: 01536514604

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 28 September 2017 and was unannounced. Orchard House Residential Care Home provides accommodation and personal care for up to 33 people. At the time of our inspection there were 24 people living in the home.

There was a registered manager in post who was also the provider of the service. 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.

We inspected Orchard House in June 2015 and rated the service as 'Good', during this inspection we found that the service was rated as 'Requires Improvement'.

Risks to people were not always managed appropriately by staff. People had plans of care outlining their known risks however; staff did not always take appropriate action in order to reduce the known risks to people.

Staff did not always apply the learning from their training effectively when providing people's care. We observed that not all staff were confident or competent when supporting people with moving and handling.

People's dignity and privacy was not always maintained by staff. We observed staff entering people's bedrooms without knocking.

The provider needed to review people's mealtime experience. We observed that people's meal time experience was chaotic and took too long resulting in people becoming bored and not eating their main meal.

Staff did not receive supervision and appraisal to assess their competency in carrying out their duties.

The provider had not implemented or utilised a systematic approach to quality assurance. This had resulted in ongoing shortfalls in people's care and support and a risk that further shortfalls would not be identified or acted upon.

People were supported by sufficient numbers of staff to provide their care and support. People could be assured that they would be supported to receive their prescribed medicines safely.

People were supported by a staff team that knew them well.

Staff knew their responsibilities as defined by the Mental Capacity Act 2005 (MCA 2005) and Deprivation of

Liberty Safeguards (DoLS) and had applied that knowledge appropriately. Staff understood the importance of obtaining people's consent when supporting them with their daily living needs.

People had detailed plans of care in place to guide staff in providing consistently personalised care and support according to people's preferences. People's feedback about the care they received was actively sought and acted upon.

The provider was visible throughout the home and was committed to improving the quality of care and support that people received.

At this inspection we found the service to be in breach of two regulations of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. The actions we have taken are detailed at the end 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?

Requires Improvement

The service was not consistently safe.

People's plans of care and risk assessments that had been developed to maintain their safety were not always followed by staff.

People could be assured that they would receive their medicines safely.

People were supported by sufficient numbers of staff that had been subject to robust recruitment practices.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not receive on-going or periodic supervision to make sure their competence was maintained.

Staff did not always apply their training effectively.

The provider needed to review people's mealtime experience to ensure that this was positive.

Care staff knew and acted upon their responsibilities as defined by the Mental Capacity Act 2005 (MCA 2005) and in relation to the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Requires Improvement

The service was not consistently effective.

People's dignity and privacy was not always maintained.

Staff involved people in decisions about their care and support.

People were supported by staff that knew them well.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed prior to admission and reviewed regularly.

People's needs were met in line with their individual care plans and assessed needs.

Appropriate and timely action was taken to address people's complaints or dissatisfaction with the service provided.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality assurance processes had not been implemented in the service. This resulted in on-going shortfalls in people's care.

The provider, management and staff were committed improving the service and to providing person centred care to people.

Staff felt that the registered manager was approachable and supported them in their role.

Orchard House Residential Care Home

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 was planned to check 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.

This inspection took place on 28 September 2017 and was unannounced. The inspection was undertaken by one inspector and one 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. The expert by experience had experience in sourcing care homes and community services for their relative.

Before the inspection, the provider completed a Provider Information Return (PIR). This 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. The provider returned the PIR and we took this into account when we made judgements in this report. We also reviewed other information that we held about the service such as notifications, which are events at the service that the provider is required to tell us about, and information that had been sent to us by other agencies. This included the local authority who commissioned services from the provider.

During our inspection we spoke with seven people who used the service, five members of staff including the provider. We also spoke with three people's relatives. 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 looked at records relating to the care of three people using the service and three staff recruitment records. We looked at other information related to the running of and the quality of the service. This included quality assurance audits, training information for care staff, staff duty rotas, meeting minutes and arrangements for managing complaints.

Requires Improvement

Is the service safe?

Our findings

People's plans of care to guide staff in managing the known risks to people were not always followed. For example, a number of people living at Orchard House had been identified as being at risk of developing pressure sores. These people had specialist beds that had been provided for them with alternating air mattresses to reduce the risk of them developing pressure areas. These are mattresses that are inflated with air to reduce the likelihood of people developing pressure sores. These mattresses are meant to be set at a setting that corresponds to the weight of the person using the bed to reduce the risk of pressures areas developing. However, we found that three people's beds were set at the incorrect setting placing them at greater risk of developing pressure sores. At the time of inspection the provider did not have a system in place to monitor the settings of people's mattresses. Following the feedback from our inspection the provider told us that they would introduce a daily check of the setting of people's air mattresses to ensure that these were set at the correct setting.

We also observed that people who required their bed sides to be up when they were in bed did not always have bumpers covering their bed sides to protect them from the risk of entrapment. We bought this to the attention of the provider who took immediate action to ensure that people's bedsides were covered by protectors to ensure that their safety was maintained.

People told us that the support that they received from staff made them feel safe. One person told us "It's just like home here; I feel comfortable and safe." Another person told us "I just feel safe." People's relatives had confidence in the ability of the staff to maintain people's safety. One person's relative told us about an incident that had occurred within the home and said "There was an incident when [Name of person] first moved in, but that was early on. They reacted to it well and learned what to do to keep [Name of person] safe and it's never happened again. I am confident that the people here are safe." Incidents and accidents had been recorded by staff and appropriate action had been taken to learn from any incidents or accidents within the home, to reduce the likelihood of them occurring again.

People could be assured that they would receive their prescribed medicines safely. One person told us "The staff here look after my medicines and give them to me whenever I need them. I have tablets every day that they give to me." Staff had received training in how to administer people's medicines safely. One member of staff told us "I am a senior carer so am responsible for administering the medicines. Before I was able to do this I had training and then was observed by the manager to make sure I could do it safely." People received their medicines in the way that they preferred and medicines were stored and disposed of safely. We observed staff administering medicines to people and heard them explain what the medicines were for. The member of staff checked each individuals Medication Administration Record (MAR) sheet before dispensing medication and ensured that people received the right medicines at the right time.

The provider had systems in place to ensure that safeguarding concerns were reported, responded to and investigated appropriately. One member of staff told us "If anyone had been harmed or wasn't safe, I would report is straight away to the manager. I also know how to contact the Safeguarding team or the CQC." Records showed the provider had submitted safeguarding alerts to the local authority when required and

had completed investigations that had been allocated to them in a timely manner.

People were supported by sufficient numbers of staff to meet their care and support needs. One person told us "I think there are enough staff working here. We don't usually have to wait long if we need help." We observed that people's call bells were answered in a timely manner and that staff had time to engage people in conversation. One member of staff told us "There are enough of us working on each shift. It has got even better recently since the activities coordinator started working."

The provider was reliant upon agency staff to work within the home to cover staff vacancies however; they were actively recruiting to reduce their reliance upon agency staffing. The provider had block booked agency staff to ensure that the same staff worked within the home. This meant that agency staff knew people well and provided the care that people needed at the right time and according to people's preferences. The provider told us "We use the same agency staff so they know people just as well as our permanent staff. We also ask the agency staff to attend our own in house training so they are as skilled and knowledgeable as our permanent staff." The provider had also reduced the number of people that they supported in the home by refusing to accept new admissions whilst new staff were recruited and inducted into the home.

People were safeguarded against the risk of being cared for by staff that were unsuitable to work in a care home. The staff recruitment procedures explored gaps in employment histories, obtained written references and checked whether staff had any criminal convictions. Staff we spoke with confirmed that checks were carried out on them before they commenced their employment.

Requires Improvement

Is the service effective?

Our findings

Staff had not received regular supervision or appraisal of their performance. The registered manager told us that no member of staff had received formal supervision in over 12 months because they had been concentrating upon other areas of the management of the home. Staff felt well supported and had access to informal supervision and support from senior staff however had not received formal supervision or appraisal. One member of staff told us "The manager is great; she is always available if we need any help and is incredibly supportive. I don't think I have had a formal supervision. I know that I had one booked a while ago but it got cancelled."

Staff had received training in key areas however, did not always apply their knowledge confidently when providing people with care and support. We observed one person being supported to transfer by staff from their wheelchair to an arm chair in the lounge. Two members of staff attempted to support this person to transfer using a moving and handling belt. We saw that this person was unable to weight bear and that their moving and handling belt was used to lift the person and moved from their waist to under their arms placing pressure on their joints. We had to intervene and stop staff from supporting this person using the moving and handling belt to maintain their safety. A moving and handling belt should only be used to provide support to people to transfer when they are able to weight bear and should not be used to lift people as this places people at risk of injury.

Records showed that these staff had received training in moving and handling however, our observations demonstrated that staff were unable to apply this training in a consistently safe or confident manner within the home. We also observed two further instances of staff supporting people to transfer using a hoist. Staff did not appear to be confident in using the hoist. When supporting people to transfer staff were unsure which loop on people's sling should be used and looked to one and other for reassurance and guidance however, no member of staff confidently took the lead in supporting people to transfer safely. We bought this to the attention of the provider who told us that they would take action with the staff involved to ensure that they were competent to support people when moving and handling. The provider told us that they would observe staff supporting people to transfer to ensure that they were competent.

Staff had not received appropriate supervision or appraisal of their performance to make sure they were competent to carry out their roles. This was a breach of Regulation 18(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

New staff were supported through a comprehensive induction programme to work effectively within the home. One member of staff told us "When I first started I had two weeks where I was just working on shift shadowing other staff learning what I needed to do. I also spent a week with the manager so she could ensure I was ok to work independently."

The provider ensured that there was an on-going programme of training that staff accessed to update their knowledge in key areas such as safeguarding and health and safety. One member of staff told us "There is regular training that we have to do. I think the last training course I did was the management of medicines. It

was interesting and reminded me of the procedures we should follow like checking the MAR (Medication Administration Record) charts carefully for changes before we give people their medicines." The provider had also made their in house training available to the agency staff working within the home to ensure that they had the same skills and knowledge as permanent staff.

The provider needed to review people's mealtime experience. We observed how people were supported at lunchtime to eat their main meal of the day. We saw that people were taken to the dining room and asked to sit 45 minutes before the main meal was available. We also observed that there were not sufficient numbers of staff to support everyone to eat their main meal at the same time. This meant that some people had to wait and watch other people eat until staff were available to support them. The home supported a number of people living with dementia, we observed that some people had to wait a long time before their food arrived (up to 45 minutes) and then they left the table and did not eat it. We also observed that some people were provided with their meal and had to wait for staff to become available to support them to eat it by which time it had become cold. We discussed our feedback with the provider who told us that they would review people's mealtime experience and introduce a new system of two sittings for lunch. This would ensure people did not have to wait excessive amounts of time to receive their meals and that appropriate staff support was available to assist people to eat their meals.

People told us that they enjoyed the meals that were offered within the home. One person told us "I have no complaints, the food is lovely" another said "The food is good we get two choices." People at risk of not eating or drinking enough had been identified and plans of care implemented for staff to follow to mitigate the risk. Staff quickly referred people to health professionals if they were concerned that people were not eating or drinking enough.

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).

The management were knowledgeable and experienced in the requirements of the MCA and DoLS. Detailed assessments had been conducted to determine people's ability to make specific decisions and where appropriate DoLS authorisations had been obtained from the local authority. Staff had received training in the MCA and DoLS and had a good understanding of people's rights regarding choice. They carefully considered whether people had the capacity to make specific decisions in their daily lives and where they were unable; decisions were made in their best interests. Staff considered whether people's ability to consent to their care and support changed as their needs were reviewed. People were encouraged to make decisions about their care and their day to day routines and preferences. We observed staff seeking people's consent prior to providing care.

People were supported to access healthcare services. One person told us "If I feel unwell I only have to say and the staff will sort me an appointment to see a doctor if I need one." Staff worked closely with people's allocated health professionals and followed the plans of care that they implemented.

Requires Improvement

Is the service caring?

Our findings

People's privacy and dignity was not always respected. Throughout the inspection we observed occasions when staff entered peoples' bedrooms without knocking. One person told us "The staff sometimes knock on my bedroom door." On one occasion we observed a member of staff open someone's bedroom, to discover they were using their ensuite toilet, the member of staff quickly closed the bedroom door. On another occasion whilst we were talking to someone in their bedroom staff entered without knocking, saw that we were present and apologised to the person before leaving the room again. We bought this to the attention of the provider who told us that they would take immediate action to remind all staff that they should not enter people's bedrooms without first knocking and gaining people's permission.

However, in other aspects of their care people's dignity was upheld. One person told us "The staff always makes sure my door is shut when they help me get dressed." A member of staff told us "I always make sure that people are covered up when I am providing their personal care. For example, if I am helping someone to wash I cover their bottom half while I help them to wash their top half."

People told us that they were treated with kindness and respect. One person told us "The staff take their time to stop and have a chat with me. I think that they are kind really." Another person told us "The staff are always very polite and nice to me." Staff were observed speaking to people in a respectful manner and offering people choices in their daily lives, for example if they wanted to participate in activities. Staff provided support to people discreetly; for example when asking if people needed the toilet or would like their medicines; staff approached the person and asked them privately if they required support so attention was not drawn to people's care and support needs. One person told us "If the staff need to ask me questions about my care they always do it in private with me in my room."

People's preferences in relation to their care and support was sought and acted upon by staff. One person's relative told us "The staff encourage [Name of person] to stay independent. [Name of Person] is still able to dress herself and will make her own choices; she had a pair of trousers on today, but didn't like them and went back to her room to change them." One member of staff told us, "People choose when they would like to have a bath or a shower and we support them when they want. For example [Name of person] likes to have a bath in the evening so we wouldn't suggest that they had one in the morning." People looked well cared for and were also supported to make decisions about their personal appearance, such as their choice of clothing.

People's faith, personal beliefs and culture were considered by staff providing their care. For example, people who required support to worship according to their faith received the support they needed to do so. Religious services were also held in the home and people were able to attend these should they wish to.

Good

Is the service responsive?

Our findings

People's needs were assessed prior to moving into the home to ensure that the service could meet their care and support needs. People had detailed individual plans of care that they had been involved in developing for staff to follow. When people were unable to participate in the development of their plans of care staff consulted with their relatives that knew them well. One person's relative told us "I know that [Name of person] has a care plan. Before they moved into the home the staff spent time with me finding out about them and what help they needed."

People received care according to their plans of care and in line with their individual preferences. One member of staff told us "People's care plans are often updated and that means that they always match what we need to do to help people. When I first started I spent time reading all of the care plans and when I met the person it matched. It meant that I felt confident when I started providing their care on my own."

The provider had recently employed an activities coordinator and we saw that the provision of activities had recently improved within the home. One person told us "There is usually something going on in the home so we don't get bored." One member of staff told us "Last week we went to Wicksteed Park. The people we took had a terrific reaction when they saw the show and music that was on." The activities coordinator told us "I focus on one to one activities rather than in a group. My focus is on rich interaction with people so I play games like dominos with them. I also arrange things like cinema afternoons where we choose a film together."

People knew how to make a complaint and had confidence that if they did complain this would be managed appropriately. One person's relative told us "I have never needed to make a complaint but know who to approach if I need to." We reviewed records relating to complaints maintained by the home and saw that no complaints had been received. However, systems were in place to ensure that if a complaint was received that it would be investigated thoroughly.

The provider sought people's feedback and took action to address the issues raised. The provider was in the process of arranging a relatives meeting to gather feedback from people's relatives. The provider also used annual questionnaires to gather feedback from people, their relatives and other professionals. Any issues raised from the feedback questionnaires were dealt with and people and relatives informed of the issue raised and action taken. For example, in response to feedback from people and the providers own observations action was being taken to renovate the home and to improve the décor. The provider had also employed an activities coordinator in response to feedback received from the surveys sent out in 2016.

Requires Improvement

Is the service well-led?

Our findings

There was not a systematic approach in place for quality assurance however; the provider had plans to improve their processes for quality assurance. The provider had not completed any audits of people's plans of care, staff training or staff supervision records. The provider did not have a system in place to have oversight of accidents or incidents that had taken place in the home or to analyse these for any trends. Although we found that people received their medicines safely, the provider did not have a system in place to regularly audit the administration of people's medicines. This presented a risk that shortfalls in people's care would not be identified or acted upon.

We found that the records of one person's weight identified that they had lost 9% of their weight in one month and that no action had been taken in response to this. The provider was unaware of this person's significant weight loss. During the inspection the provider supported this person to be weighed again and found that the record of this person's weight was a mistake and that they had not lost weight. However, this incident illustrated that systems were not in place to provide oversight of people's care and to ensure that appropriate and timely action was taken in response to changes in people's care needs, health or wellbeing. This was because the provider did not have systems in place to monitor people's care and support consistently.

Audits were not in place to consider people's experience of living at Orchard House. A number of people living at Orchard House were living with dementia and were unable to articulate their experience of living in the home. The provider had not utilised a system to monitor the quality of interaction between staff and people or to consider the quality of people's meal time experience. This inspection highlighted shortfalls in the way that people's dignity was maintained. Staff were observed entering people's bedrooms without knocking, which had compromised people's dignity. The meal time experience for people was also observed to be chaotic resulting in people leaving the table before finishing their meal. Although the provider told us that they would take action in response to our feedback, no system had been implemented by the provider to observe or consider people's experience of living in the home with dementia.

The failure to implement and utilise effective systems to monitor and improve the quality of care and support that people received constituted a breach of regulation. This was a breach of Regulation 17 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had recognised this shortfall and purchased an electronic system for recording people's care plans and daily records, and accidents and incidents. The provider told us the system would enable them to have oversight of people's care and to take timely action in response to any concerns. The provider had purchased tablets for staff to input their observations and records throughout their shift in real time to provide a contemporaneous record of people's care. The provider told us that this system would be implemented during October and November 2017 however; we could not yet see this had been effective at monitoring and improving the quality of people's care and support.

There was a visible and supportive management team in place within the home. People and staff told us

that they felt valued in their role and that the management team were accessible and they felt the home was well managed. One member of staff told us "This is the best place I have ever worked. The manager is so supportive and is committed to providing good care. The manager is always on the floor supporting people and is involved in their care."

The provider was committed to gathering and acting upon people's feedback. For example, in response to people's feedback an activities coordinator had been employed and extensive works were taking place within the home to improve the general environment. The provider had also recognised that the home required more permanent staff to be employed. As a result of this the provider had stopped accepting new admissions so that they could maintain the quality of care and support provided to people already living in the home. The provider had also taken steps to review how and where staff were recruited from and had implemented targeted recruitment campaigns to try and recruit more permanent staff. Whilst this recruitment was on-going the provider had also taken steps to ensure they used the same agency staff to provide continuity of care for people. The provider told us that this was to ensure that staff had time to build therapeutic relationships with people and provide consistent personalised care and support.

Policies and procedures to guide staff were in place and had been updated when required. We spoke with staff that demonstrated a good understanding of policies which underpinned their job role such as safeguarding people, health and safety and confidentiality.

The service was being managed by a registered manager who was also the provider. The providers' previous rating from our inspection in June 2015 was displayed prominently within the home. They were aware of their legal responsibilities to notify the Care Quality Commission (CQC) about reportable events that occurred at the service and had submitted the appropriate statutory notifications to CQC, for example, deaths, serious injuries, and other events at the service.

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	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to implement and utilise effective systems to monitor and improve the quality of care and support that people received constituted a breach of regulation. This was a breach of Regulation 17 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate supervision and appraisal to support them in carrying out the duties they were employed to perform. Staff did not receive on-going or periodic supervision to make sure their competence was maintained. Staff did not receive regular appraisal of their performance to identify and plan their learning and development needs. This constituted a breach Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.