R Sons (Homes) Limited

Orchard House Residential Care Home

Inspection report

155 Barton Road
Barton Seagrave
Kettering
Northamptonshire
NN15 6RT

Tel: 01536514604

Date of inspection visit:
20 May 2021

Date of publication:
28 June 2021

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 providing care for up to older 33 people with a diagnosis of dementia, mental health or physical disabilities. At the time of inspection 21 were being supported at the service.

People's experience of using this service and what we found
Risks to people were not always mitigated. Some care plans and risk assessments held conflicting information within them. Some care plans did not contain enough information to ensure staff could support them safely.

Records of care tasks had not been completed, so we could not be assured that these needs had been met. For example, repositioning a person who was at risk of skin pressure damage or additional snacks or food being offered to a person at risk of malnutrition.

Medicines were not always managed safely or in line with best practice. We found missing information in people's medicine administration records (MAR).

Systems to ensure oversight and governance of the service required improvement. Audits had been completed but had not identified the concerns found on inspection. The registered manager implemented changes after the inspection to rectify some concerns.

Staff were recruited safely, and people told us that staff knew them well. We received mixed views on the staffing levels at the home.

The home appeared clean and tidy during the inspection. The outside space available to people had been designed to include a working tuck shop, bar and hairdressers. There was also a bus shelter, shop fronts and sensory lights.

People told us that staff were "nice and kind." People and relatives knew how to complain and felt they would be listened to. The registered manager understood the duty of candour.

The registered manager and staff worked with external professionals and referred people to healthcare professionals as required.

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 16 December 2020)

Why we inspected
We received concerns in relation to staff training, staffing levels and use of personal protective equipment (PPE). 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 requires improvement. This is based on the findings at this inspection.

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
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.

We have identified breaches in relation to risk assessments, medicine management and governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our well led findings below.

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 Care Act 2014.

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

Inspection team
The inspection was carried out by two inspectors. One inspector visited the service and another inspector completed telephone calls to people's relatives and staff.

Service and service type
Orchard House Residential Care Home 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 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
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 and professionals who work with the service.

During the inspection
We spoke with three people who used the service and three relatives about their experience of the care provided. We spoke with eight members of staff including the registered manager and care workers.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

Requires Improvement

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 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.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management; Using medicines safely

- People were at risk of skin pressure damage. People who required support with repositioning due to skin pressure risks, did not have this support consistently documented. For example, we found records showing that people were not repositioned within the timeframes specified to reduce this risk. This put people at risk of pressure sores.
- Risk assessments for known risks did not always contain sufficient details to enable staff to support a person safely. For example, two people's behaviour risk assessments did not contain details of the types of behaviour shown.
- Care plans did not always contain the relevant information needed to support people safely. For example, we found two people's care plans did not contain the correct information regarding the food consistency they required to prevent them from choking. People's health conditions were not always recorded in their care plans.
- Unexplained injuries had not always been investigated fully or followed up to establish the cause.
- Staff did not always record whether people ate and drank sufficiently. For example, one person who required additional snacks to be offered to reduce the risk of malnutrition did not have the snacks or additional food recorded. People's records did not evidence that food or fluid had been fortified or thickened as required. This put people at risk of malnutrition.
- Staff did not consistently record the water temperature for people requiring support with bathing or showering. This put people at risk of scalding.
- Medicine management required improvement. When staff had applied transdermal patches, records did not evidence where the patch was situated on the person's body. (A transdermal patch is a medicated adhesive patch that is placed on the skin to deliver a specific dose of medication through the skin and into the bloodstream.)
- People's MAR charts did not detail where staff should apply people's prescribed creams and lotions.
- Staff did not always have protocols to follow for people's 'as required' (PRN) medicines; to understand why, how and when to give the medicine and the dosage required. When PRN medicines were administered staff had not always recorded to reason why. This meant the effectiveness of the PRN medicines could not be monitored.
- Staff did not always follow safe medicines practice in line with the provider's policy. For example, one person's MAR chart did not have their date of birth or allergies section recorded and transcribed information had not been signed by two staff. This put people at risk of receiving incorrect medicine or dosage of medicine.

The provider had failed to ensure risks were assessed and that all was done to practically mitigate these risks. The provider had failed to ensure the proper and safe management of medicines. These are a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager put new systems in place to rectify these concerns after the inspection.

Learning lessons when things go wrong

● Accidents and incidents had not been fully reviewed to identify any trends and patterns with falls or incidents. This meant lessons could not be learnt or shared with the staff team.

We recommend that incident and accident forms are reviewed and analysed regularly to identify any trends that could be mitigated.

Staffing and recruitment

● We found adequate staffing on the day of inspection. However, staff and people told us that at times staffing levels were not sufficient. One person said, "Staff will respond when I call my bell. However, they have lots of paperwork to do. I sometimes I have to wait if they are doing something more important." Three staff members told us there was not enough staff on each shift to spend any quality time with people.

● Staff were recruited safely. Safe recruitment and selection processes were followed. Staff files contained all the necessary pre-employment checks, including references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

● Staff received induction training when they first began working at the service. There was also ongoing training for staff to attend to refresh and update their knowledge. However, the training matrix did not evidence that all staff had completed updated training as required.

Preventing and controlling infection

● We were not fully assured that the provider was promoting safety through hygiene practices of the premises. We found gaps in the recording of cleaning schedules. However, the home appeared clean.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● 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.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Requires Improvement

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 requires improvement: This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Systems and processes to ensure effective oversight of the service required improvement. Audits had not identified the issues found relating to conflicting or missing information within people's care plans or risk assessments. For example, what consistency of food and fluid the person required or what signs or triggers to look for regarding an epileptic seizure and what strategies are implemented regarding known risks.
- Audits completed on medicine records had not identified the concerns found during the inspection. We identified prescribed thickener not being recorded as administered and records missing regarding where creams, lotions or patches were applied.
- Systems to ensure people receive person centred care did not identify when consent had been gained from a relative who did not have the legal powers to do so. Consent to share information was not always gained.
- Systems and processes were not in place to identify when support and care was not delivered consistently. For example, there were no audits completed on food and fluid charts, personal care records or bathing records.

We found no evidence that people had been harmed however, systems and processes were not effective or robust enough to monitor the quality and safety of the service. This placed people at risk of harm. This was a breach of regulation 17(Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager and staff all had good knowledge and understanding of the people they were supporting. People were very positive about the staff at Orchard House. One person told us, "I love them they are my second family."
- The provider had redesigned the outside space to support people to engage in activities and to support people living with dementia.

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

- Complaints made by people, relatives or staff were responded to and actioned within the providers time frames. People and relatives told us they would feel comfortable making a complaint should they need to.

One person said, "If I tell them [staff] they try and sort any problems out." A relative told us, "Yes, I know how to complain, I think [registered manager] is open and I think they deal with whatever is happening."

● The registered manager understood their responsibility under the duty of candour. The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support and truthful information. A relative told us, "There was an incident where [person] fell and banged their head, it was found to be staff's fault. The home was very open, [registered manager] contacted me and kept me up to date."

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

● Relatives were kept up to date with changes and information. The registered manager sent out regular newsletters and emails. One relative told us, "They always take on board anything I have to say about [person]."

●People told us they could talk to staff or the registered manager to feedback on changes they wanted made.

● People's communication needs were met. Information was made available in different formats to meet individual needs. For example, easy read, large print or pictorial.

Working in partnership with others

● Referrals were made to professionals as required and any recommendations had been documented and followed.

● The registered manager and staff were open, transparent and accommodating throughout our inspection. Where possible, immediate action was taken in response to our feedback.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risks were assessed and that all was done to practically mitigate these risks. The provider had failed to ensure the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure systems and processes were effective and robust enough to monitor the quality and safety of the service.