Mrs Milijana Kiss

Orchard Lodge Care Home

Inspection report

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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?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

Orchard Lodge is a privately owned care home, registered to provide accommodation and care for older people. The house can accommodate 26 people in 20 single bedrooms and three double bedrooms. The property is a large detached house which has been converted for use as a home and is situated in a residential area of Seaforth, Liverpool. There were 20 people living in the home at the time of the inspection.

This was an unannounced inspection which took place over two days on 22 and 23 April 2015.

The service did not have a registered manager in post. 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. The manager told us they intended to ensure an application for registration was submitted to CQC.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We found that necessary checks had not always been made to ensure staff were suitable. You can see what action we told the provider to take at the end of this report.

People reported that they felt safe and protected at the home. They said, "I feel safe here; they look out for you

Summary of findings

and make sure you are alright.'' When we reviewed the care of some of the people living at the home we found that risks to people's health such as, monitoring of falls and risk of pressure sores were assessed and monitored.

The staff we spoke with clearly described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. All of the staff we spoke with were clear about the need to report through any concerns they had.

We asked about staffing at the home. People reported they thought there was sufficient staff to meet their needs. We were told, "There is always someone about if you need them.''

The manager showed us the arrangements in place for checking the environment to ensure it was safe. For example, a health and safety 'walk about' was completed by the manager on a regular basis where hazards could be identified. This had not identified health and safety hazards and risks we saw on the inspection.

You can see what action we told the provider to take at the back of the full version of this report.

We looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) [MCA]. We found the manager understood the general principals of the Act but there were some key decisions regarding people's health and wellbeing that had not been effectively recorded and updated to demonstrate that people's consent had been attained.

You can see what action we told the provider to take at the back of the full version of this report.

We were told, at the time of our inspection, the home did not support anybody who was on a deprivation of liberty authorisation [DoLS]. We found the manager was aware of the process involved if a referral was needed.

People reported that they had access to medical and healthcare support when they needed it. People told us the home provided good support and staff were very caring.

We looked at the training and support in place for staff. Staff we spoke with confirmed they had up to date and on-going training; they felt the support they got with training was good.

People reported that they liked the food in the home and there was a choice of different food at each meal. One person said, ''The food here is excellent, I have no complaints whatsoever.''

People were treated with dignity, respect, kindness and compassion. Relatives commented on the qualities of the staff, one relative said, "The staff are very respectful and caring, they knock before they come in and they respect [persons] privacy." We saw staff taking time to interact and involve people throughout the day. The interactive skills displayed by the staff were positive and people's sense of wellbeing was very evident.

People living at the home and their relatives told us they felt involved with their care. When we looked at people's care files we saw that people had been asked for their consent at various stages of care and that the care plans were signed by people where possible.

We found care plans listed and covered people's care needs but they were brief and lacking the detail to make plans personalised for the person concerned. Also some important details regarding care needed to be updated on care plans. We fed this back to the manager who said they would act on this.

We saw some good examples of people experiencing active daily living pastimes. This was not wholly reflected in the general culture of the home however.

There was a complaints procedure in the home which was displayed. None of the people we spoke with had any complaints about the home.

From the interviews and feedback we received, the manager was seen as open and receptive. The manager was seen as supportive and caring.

We found there was a lack of formal process such as effective audits and systems to ensure the quality and safety of the home was monitored. This included a lack of regular input and support from the registered provider.

On this inspection we found there were breaches of regulations covering staff recruitment, infection control, health and safety monitoring and monitoring of how the home operates aspects of the Mental Capacity Act 2005. We were concerned that the home's current auditing and monitoring processes had not effectively identified any shortfalls or improvements needed.

Summary of findings

You can see what action we told the provider to take at the back of the full version of this report.

We found on inspection that issues requiring the service to notify the Care Quality Commission had not been made. The manager said they would notify us retrospectively and would seek to review the regulations and guidance available regarding notifications.

This is being followed up and we will report on any action when it is complete.

People said they got their medication on time and had access to health and medical support when they need it. Medicine administration records [MARs] we saw were completed to show that people had received their medication as prescribed. Care records we saw confirmed that some people had been reviewed recently by a visiting GP.

Summary of findings

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.

Staff had not been checked thoroughly when they were recruited to ensure they were suitable to work with vulnerable adults.

There was a lack of consistent and thorough monitoring of the homes environment to ensure all areas were safely maintained.

Medicines were administered safely. Medication administration records were clear. We made some recommendations to further improve good practice.

There was a good level of understanding regarding how safe care was managed. Care was organised so any risks were assessed and plans put in place to maximise people's independence whilst help ensure people's safety.

There were enough staff on duty at all times to help ensure people were cared for in a safe manner.

Is the service effective?

Requires improvement

The service was not always effective.

We saw that the manager and staff were following the principals of the Mental Capacity Act (2005) and knew how to apply these if needed but evidence for this was inconsistent. There were examples where consent was not clear for some important aspects of care and treatment.

We saw people's dietary needs were managed and people had a choice of food and meals.

Staff said they were supported through induction, appraisal and the home's training programme.

Is the service caring?

Good

The service was caring.

We observed people living at the home and saw they were relaxed and settled. People we spoke with and a relative told us they were happy with the care and the support in the home and described the care and quality of life for people living at the home as of a good standard.

We observed positive interactions between people living at the home and staff. Staff treated people with privacy and dignity. They had a good understanding of people's needs and preferences.

People we spoke with and a relative told us the manager and staff communicated with them effectively about changes to care. We saw that staff were able to support people who needed specific care at the end of their life.

Summary of findings

Is the service responsive?

Requires improvement 

The service was not always responsive.

People's care was not planned in a way that reflected their individual needs. There was a lack of detail to personalise care plans and some had not been updated.

A process for managing complaints was in place and people we spoke with and relatives were confident they could approach staff and make a complaint if they needed.

Is the service well-led?

Inadequate 

The service was not well led.

There is currently no registered manager for the service.

There were a lack of formal systems in place to get feedback from people so that the service could be developed with respect to their needs and wishes.

On this inspection we found there were breaches of regulations covering standards in the home. We were concerned that the home's system of auditing and monitoring the service had not effectively identified any shortfalls or improvements needed.

Issues requiring the service to notify the Care Quality Commission had not been made.

Orchard Lodge 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 checked 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 was an unannounced inspection which took place over two days on 22 and 23 April 2015. The inspection team consisted of an adult social care inspector 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.

We were not able to access and review the Provider Information Return (PIR) as the manager had not received a request for this before the inspection. The PIR 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. We did review other information we held about the service.

During the visit we were able to speak with nine of the people who lived at the home. We spoke with six visitors/ relatives who were visiting at the time.

As part of the inspection we spoke with a health care professional who was able to provide feedback concerning recent reviews of care for people as well as a contract monitoring officer from social services.

We spoke with four staff members including care/support staff and the manager for the service. We looked at the care records for two of the people living at the home, two staff recruitment files and other records relevant to the quality monitoring of the service. These included medicines, safety audits and quality audits, including any feedback from people living at the home, professional visitors and relatives. We undertook general observations and looked round the home, including some people's bedrooms, bathrooms and the dining/lounge areas.

Requires improvement

Is the service safe?

Our findings

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We were shown the homes recruitment policy which was dated from 2011. We discussed the need to review and update the policy given the recent change in regulations and the introduction of the 'fundamental standards' and changes to regulations. The policy said the provider would have 'effective recruitment and selection procedures in place' and 'carry out relevant checks when employing staff' so that the recruitment process would meet regulations. This would ensure staff employed were 'fit' to work with vulnerable people.

The manager explained that the home has a low turnover of staff. The last person recruited had been in November 2013. We inspected two staff files, including the person last recruited. We found the files well organised and easy to follow. There were application forms on file and one file contained all of the necessary checks to ensure the person was fit to work in the home. The second file had some omissions. For example there was only one reference on file. Although the homes policy did not specify the number of references the manager said that 'normally' there would be two sought. There was also a lack of photographic identification. The most notable omission however was a lack of any record of the person's Disclosure and Barring Service [DBS] check. This checks an applicant's police record and is an important to help ensure staff suitability. The manager was not able to produce any evidence that these checks had been made for this staff member and agreed this 'should have been checked'. There was a concern that recruitment procedures were not thorough enough to help ensure staff employed were fit to work with vulnerable adults.

This is a breach of Regulation 19 of the HSCA 2008 (Regulated Activities) Regulations 2014.

The manager showed us the arrangements in place for checking the environment to ensure it was safe. For example, a health and safety 'walk about' was completed by the manager on a regular basis where hazards could be identified. We saw an example of this carried out on 25 March 2015. The checklist items were very generalised and did not include some key aspects whereas some items had been ticked as satisfactory but other records contradicted this. For example 'water temperature' safety had been marked on the audit with a tick [as 'satisfactory'] but other records showed high water temperatures in bathrooms. There had been no action taken to correct the high water temperatures. The risk here was that people were being exposed to an unnecessary risk of scalding. The records showed high temperatures recorded in all bathroom outlets since October 2014. The manager said she had been aware and would now address this.

Similarly we found some issues with infection control such as a lack of adequate hand wash facilities in bath rooms / toilets and incorrect storage of mops which had not been identified by the staff or manager. Generally the home was clean with no malodour apparent. We saw, however, that some of the fabric of the building and furnishings needed attention and upgrading. For example there was chipped paintwork in a bathroom which was difficult to clean. Likewise the floor was badly stained and the grouting around bath was stained and difficult to clean. Some of the furnishings had covers that were torn exposing the foam underneath. These could not be effectively cleaned. This exposed people living at the home to a unnecessary risk of harm from cross infection.

These findings are a breach of Regulation 12(1)(2)(d)(g) of the HSCA 2008 (Regulated Activities) Regulations 2014.

We saw documented evidence that regular fire safety checks were made. We saw that personal evacuation plans [PEEP's] for the people living in the home were available in care files. These were supported by a fire risk board kept in an easily accessible place to assist in an emergency evacuation.

People said they got their medication on time and had access to health and medical support when they need it. One person told us, "I'm on tablets now and I get them with my breakfast and last thing at night; that always happens like clockwork." Another person said, "I have eye drops for my glaucoma, the staff come three times a day to give them to me, and they make sure I don't miss them." During the medication round staff were observed giving medication to people and asking some if they needed any analgesic medication.

Medicine administration records [MARs] we saw were completed to show that people had received their medication. We saw part of the morning medication round and this was carried out safely so people got their

medicines and they were recorded as per the home's policy; following each individual administration the records were completed by the staff. This helped reduce the risk of errors occurring. We saw that people's medicines were reviewed on a regular basis. Care records we saw confirmed that some people had been reviewed recently by a visiting GP.

We discussed ways the medicines could be further improved in line with good practice. We asked about two people who we were told was on PRN [give when needed] medication [for pain relief]. There was no entry in any of the care plans regarding these medicines and in what circumstances it was to be administered. The importance of a PRN care plan is that it supports consistent administration and on-going review.

There were no people self-medicating in the home. We saw records that showed people had been asked for their consent regarding the administration of medicines by staff. We spoke with the manager who explained that people were asked whether they wanted to manage their own medicines but all declined. We discussed how a more proactive approach might encourage people more in this area so people were given the opportunity to manage all, or aspects, of their medicines which would encourage their independence.

We looked at the medication 'audit' [check] which the manager completed on a regular basis. This involved a monthly stock check of four or five peoples' medicines to ensure medication records did not show any discrepancy from the number of tablets in stock. This is a way of detecting any errors in administration. There was no other specific audit tool being used to support this process however, which would look at aspects of medication safety such as [for example] storage, medicine reconciliation [medication review], supporting people to make informed decisions regarding medicines, covert administration, non-prescription and over the counter medicines and self-administration.

We would recommend that good practice around medication management be developed with reference to the current relevant guidance relating to the management of medicines in care homes.

People reported that they felt safe and protected at the home. They said, "I feel safe here; they look out for you and make sure you are alright", "They look after me properly in here and I feel safe", "The staff come and see if I'm OK if I am in my room, they check regularly, that makes me feel safe.''

Relatives said they were reassured that people were safe and in a protected environment. They said, "The staff here are very friendly and look out for the residents. I've been here when they have been to check on [person]". "The residents all seem very settled and treat the place like their own home.''

We spoke with one person who said they found the service to be safe and very good at managing any risks so that they felt as independent as possible. This meant the person was supported to use the local community. Other people, who had risks associated with their health were also supported appropriately. When we reviewed the care of some of the people living at the home we found that risks to people's health such as, monitoring of falls and risk of pressure sores were assessed and monitored.

The staff we spoke with clearly described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. All of the staff we spoke with were clear about the need to report through any concerns they had.

We asked about staffing at the home. To support the 20 people currently living at Orchard Lodge there was normally a minimum of three care staff including the manager. We saw from the duty rota that this staff ratio was consistently in place to provide necessary safe care. Care staff were supported by ancillary staff such as a cook, maintenance person and domestic staff. People reported they thought there was sufficient staff to meet their needs. We were told, "There is always someone about if you need them", ''The staff are very good; they are always there if you need anything.''

There had been two safeguarding investigations in October and December 2014 involving the care of two people at the home. These related to staff approach and attitude, appropriate recording of incidents and medication administration for one person. The home had assisted the local authority safeguarding team and agreed protocols had been followed in terms of investigating and ensuring any lessons had been learnt and effective action had been taken. We saw that the local contact numbers for the Local Authority safeguarding team were available if needed.

Requires improvement

Is the service effective?

Our findings

We looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) [MCA]. This is legislation to protect and empower people who may not be able to make their own decisions. Some people living at the home varied in their capacity to make decisions regarding their care although most were assessed as having full capacity to make decisions about their daily life, care and treatment. We found in some instances the provider did not have full regard for upholding the rights of people regarding consent.

Where people had lacked capacity to make decisions we saw that decisions had been made in their 'best interest'. For example we reviewed the care of a person who had a 'do not resuscitate' [DNR] in place. This is a decision regarding the right to refuse specific medical treatment in case of a cardiac arrest. We saw this had been carried out in the person's best interest when they were ill and lacked capacity to make this decision. The decision had been made with GP input and had included the opinion of a relative. However, we discussed the fact that the person's condition had changed since the time of the assessment and decision and the person would now be assessed as having the capacity to make their own decision regarding a DNR. The DNR had not been reviewed however and the person was not aware it was in place. There was no entry in the care file to say this had been reviewed with the person. The manager said this would be reviewed immediately.

We were shown an assessment tool used to assess people's mental capacity if needed. This had been used to assist in the DNR decision discussed above. We discussed some key decisions such as covert or self-administration of medicines and the initial decision to be admitted to the home as some areas where assessment may be needed if there was doubt about the person's capacity to make these decisions. When we looked at the assessment tool we found it was not made clear which decision was being made [no place to record this] and the manager said they would review the assessment tool to include this so any specific decisions assessed could be more clearly evidenced.

One person we reviewed had a relative who told us they had 'Power of Attorney' [POA]. When we spoke with the manager they were not clear whether this was for the person's finances, health or both. There was no record of this in the person's care plan so it was unclear as to the legal basis for making specific decisions about the person's health and welfare. We discussed how this information could be better evidenced and supported by a care plan that was open to regular review. The manager said they would address this.

These findings were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told, at the time of our inspection, the home did not support anybody who was on a deprivation of liberty authorisation [DoLS]. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. We found the manager was aware of the process involved if a referral was needed.

People reported that they had access to medical and healthcare support when they needed it. They said, "I have appointments at five of the local hospitals for various things and if I need to see the doctor they call him for me", "I like to spend most of my time in bed now, but the District Nurse comes and sees to me", "If I need to see the dentist or have a problem with my glasses they will arrange things for me" and "I need a new mould for my hearing aid and they have arranged for me to get one next week." During the inspection one person presented with a minor medical complaint. The person was reassured quickly and an appointment made for a GP assessment.

We reviewed two people in more depth who had varying levels of medical and care needs. We saw that there had been regular input from various health care professionals and the home had made appropriate referrals when needed.

We looked at the training and support in place for staff. Staff we spoke with confirmed they had up to date and on-going training; they felt the support they got with training was good. We saw training recorded in staff records but the records we saw had not been updated since 2013. Following the inspection the manager sent us an updated record of more recent staff training which evidenced on-going training for staff including 'statutory' subjects such as, health and safety, medication, safeguarding, infection control and fire awareness. Staff reported they

Requires improvement

Is the service effective?

were due to attend updates in health and safety awareness which had been organised. Following the inspection we also received a date for moving and handling training as it was identified that staff needed an update for this.

Staff told us that they had had an appraisal by the manager and there were support systems in place as the manager was very approachable and would offer support for any on-going issues they raised. The home was small with an informal approach to staff support. We discussed the need to offer and develop on-going support for staff including regular supervision and staff meetings. These were not currently being held but had been held in the past. The manager said they would look at reinstating these.

The manager told us that many staff had a qualification in care such as, NVQ [National Vocational Qualification] or Diploma. This was confirmed by records we saw where all care staff [100%] had a care qualification. This provided a good knowledge base for staff to support them in carrying out their work.

People reported that they liked the food in the home and there was a choice of different food at each meal. They said, "I go to the dining room for my meals as I like the company, but I could eat in my room if I wanted. The food here is excellent, I have no complaints whatsoever", "There is usually a choice of two options, there is plenty to eat. You have breakfast, a light lunch then a big meal at tea time. There are sandwiches or something like that at supper, but I don't usually bother with that" and "I like yoghurts and they get them for me. The food is very good.''

We observed the dinner time meal and saw that meals were served appropriately and the portion size was also appropriate. We saw that people were offered choice and staff were attentive and staff took time to talk to and socialise with people. Nobody was rushed. The meal times were clearly seen as a social occasion.

Good

Is the service caring?

Our findings

We observed the interactions between staff and people living at the home. We saw there was a rapport and understanding. We asked people if they were treated with dignity, respect, kindness and compassion. We received positive comments: “The staff here are very good; I get on well with all of them”, “I have no complaints about the staff, they do very well to care for you so well”, “We are well looked-after here by the staff, they are very good and always on the go”, “She [staff] is one of my favourites, she is very helpful, but they are all very good here.’’

Relatives also commented on the qualities of the staff, they said “The staff are really friendly here, they are really good”, “The staff are very respectful and caring, they knock before they come in and they respect [person] privacy” and “I think [people] are well looked-after here by the staff.’’ One relative we spoke with told us how they felt staff go ‘the extra mile’, ‘’They are always keen to support us [relatives] as well – they listen to our problems and are always positive and cheer us up.’’

People living at Orchard Lodge and relatives confirmed that visitors could visit without restriction. One person said, “My granddaughter comes to see me every fortnight and my sister comes every week, they can come any time, there are no restrictions.”

Throughout the inspection we observed staff supporting people who lived at the home in a, dignified and respectful way. We saw staff respond in a timely and flexible way, so people did not have to wait if they needed support. Staff told us that they spent time talking with people living at the home as a normal part of the day. We made some observations of both day areas over the two days of the inspection. We saw staff taking time to interact and involve people throughout the day. The interactive skills displayed by the staff were positive and people’s sense of wellbeing was very evident.

The manager told us about training staff had undertaken around end of life care. This supported staff to deliver care and support people during the final stages of their life. We discussed and reviewed a person who had been assessed and was being supported. This included the home liaising with health care professionals such as the GP and the district nursing team. We spoke with a visiting member of the district nursing team who gave us positive feedback regarding the way staff supported the person and carried out care. When we visited the person they were comfortable and were being well supported. There was an obvious rapport with staff who were attending and supporting them.

We asked people who lived at the home how staff involved them in planning their care. We were told that staff kept them up to date with any important changes and they felt reassured by this. Relatives we spoke with also confirmed that staff spoke with them about the care provided to their family member. When we looked at people’s care files we saw that people had been asked for their consent at various stages of care and that the care plans were signed by people where possible.

We asked about any examples of people making use of local advocacy services. The manager told us there were no examples of people using these services currently. Most people could advocate for themselves or had relatives/ supporters who could assist. We saw advocacy services were advertised in the hallway of the home.

Requires improvement

Is the service responsive?

Our findings

We found care plans listed and covered people's care needs but they were brief and lacking the detail to make plans personalised. For example, one care plan for a person's personal care said, 'to be supervised/assisted with all personal care' but no further detail for staff to follow regarding this person's preferences and individual choice of routine. When we discussed the care of this person we found that not all personal care needed to be carried out as the person was independent to some degree.

We looked in detail at two care records. We found the care plans had been reviewed on a monthly basis and some of the detail in the evaluations showed some of the ongoing changes to the care. We found, however, that they had not been updated to reflect some important information. For example, information around Power of Attorney for one person and in the other example, information about a person's social contacts and supporting care plan around a 'do not resuscitate' decision.

There was a lack of detail around people's social histories and personal preferences. The manager and staff clearly knew the people who lived at the home well but we discussed how care could be developed to reflect people's personal preferences if these were assessed and discussed and then accommodated.

There was some evidence that this was considered. For example one resident reported that they could play a role in the operation of the home and continue with an independent approach to their stay in the home. They helped prepare breakfast, did some of the washing-up after meals and drink breaks and continued to launder some of their own clothes and kept their room tidy. Another person had a pet dog and this had been accommodated in the home. This approach allowed for the person to still engage with normal activities of daily living that they had carried out before their admission.

This was not wholly reflected in the general culture of the home however. We observed the main activities carried out in the lounge area and these were group activities such as music and sing-along. When we asked staff about the kinds of activity on offer these were likewise very group based and lacked any reference to people's personal choice. The impression given was that everyone was expected to take part in the activity as there was no alternative on offer. Some people enjoyed the activity but not all and there was space for other activities to take place in the dining area and in the smoking room (conservatory) of a more individual nature. Given the numbers of staff on duty the needs of people who wanted to continue with reading or knitting or some other activity could have been catered for.

These observations were reflected by some of the comments by people who said, "They have some things that they do, but they are not for me", "Activities do take place in the lounge, but I don't get involved", "We used to have an exercise woman every Tuesday, but not for a while now, otherwise it's watching TV or games. I'd rather watch TV in my room and I'm not interested in games.'' We fed these observations back to the manager to consider.

We observed a complaints procedure was in place and most people, including a relatives, we spoke with were aware of this procedure. We found reference to the procedure in the 'Statement of Purpose' available to people on admission. The complaints procedure was also displayed in the home. None of the people we spoke with had any complaints about the home. The manager told us that there had been no complaints recorded over the past few years.

Inadequate

Is the service well-led?

Our findings

The service did not have a registered manager in post. The home is required to have a manager registered with the Care Quality Commission because the provider lives in another part of the country and is not in day to day control of the home.

The manager of the home has been in post for a number of years. We had discussed the need for the manager to register with CQC in June 2014 and were told this was being actioned. We have received no application. We advised the manager to apply as a matter of priority.

We asked the manager about plans for further developments in the home. We were told about some plans to develop and upgrade the environment of the building and decorate some areas of the home. We asked for a written development plan for the home but the manager said there was no written development plan; these were improvements the manager had identified. We asked about the providers input and support for these. We were told the provider allocated a budget for the running of the home but did not visit the home very often. We were told the provider had visited about twice in the last year. During the visits the provider did not carry out any formal checks or audits on the home and provided no documented feedback for the manager with respect to developing the home.

We enquired about quality assurance systems in place to monitor performance and to drive continuous improvement. We asked about how people living at the home were able to feedback their opinions regarding the running of the home. The manager reported that they no longer have regular meetings with people living in the home, or relatives, to discuss the operation of the home or how the residents can influence what goes on in the home. These used to take place and were formally minuted until about a year ago, since then the manager told us they had dealt with issues as they arose, on an informal basis. We asked whether there was a record of any feedback to date and were told there was none. The manager told us the home had an externally commissioned quality audit carried out in the past where people's opinions about the home were routinely asked and fed back. This had not occurred since 2013 however, when this quality audit had been discontinued and not replaced. People we spoke with said they did not know how the home received feedback about their views. One person said "I don't know how to give feedback to the manager."

The lack of formal systems to gain feedback meant that people living at the home, and their relatives, were not being canvased for their opinions and the manager could not collate people's views to develop the way the service was being run.

We spoke with a member of the contracts monitoring team at social services who had visited the home in December 2014 to follow up some care concerns reported through safeguarding at social services. There had been some recommendations made from the visit and the contracts monitoring officer had asked for some feedback about these. One of the recommendations made was for the home to devise a system for recording incidents, near misses and occurrences along with the accident recording system. The contracts monitoring officer recommended the monitoring and auditing of these would assist in identifying trends and help the home to reduce and manage such incidents more effectively. With this in mind, we were shown how accidents were recorded. The manager advised us these were not audited however. Currently the information regarding accidents were filed, but no assessment and analysis of these had been carried out to identify any overall patterns or lessons that may need to learnt for the home.

The manager showed us a monthly quality audit for the home dated 25 March 2015. This audit covered 'health and safety', 'residents care', 'staffing' and 'administration'. We were concerned on this inspection that the audit had not identified some of the basic health and safety and quality issues we had identified. On this inspection we found there were breaches of regulations covering staff recruitment, infection control, health and safety monitoring and monitoring how the home operates aspects of the Mental Capacity Act 2005. We were concerned that the home's current auditing and monitoring processes had not effectively identified any shortfalls or improvements needed.

These findings were a breach of Regulation 17(1)(2)(a)(b)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

We found on inspection that issues requiring the home to notify the Care Quality Commission had not been made. These included notifications about serious injuries to people living in the home [person with a pressure ulcer, people who had accidents involving tissue damage] and a safeguarding investigation at the home. The manager said they would notify us retrospectively and would seek to review the regulations and guidance available regarding notifications.

These findings were a breach of Regulation 18 of the Health and Social Care Act 2008, Care Quality Commission (Registration) Regulations 2009.

This is being followed up and we will report on any action when it is complete.

We also found The Care Quality Commission had not been notified about deaths that had occurred in the home.

These findings were a breach of Regulation 16 of the Health and Social Care Act 2008, Care Quality Commission (Registration) Regulations 2009.

This is being followed up and we will report on any action when it is complete.

From the interviews and feedback we received, the manager was seen as open and receptive. Staff told us they received on-going support; for example, staff we spoke with told us the manager had had supervision or appraisal sessions and we were told there was training organised on a regular basis. People living at Orchard Lodge also spoke well of the manager and considered that the manager was approachable. People said, “If I had any worries I would talk to [the manager]; She is easy to talk to”, “She is very good; you can talk to her and she listens.’’ Relatives agreed and told us, ‘’ The manager is very good, she knows all the residents very well and encourages them to treat it like their own home” and, “[The manager] is a very caring person.’’

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **How the regulation was not being met** Key decisions regarding people's health and welfare had not been effectively updated and recorded. Regulation 11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met** There had been no action taken following identified health and safety issues which exposed people to unnecessary risk. There was a lack of adequate monitoring, assessing and preventing the risk of spread of infection in the home Regulation 12(1)(2)(d)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met** There was a lack of effective recruitment and selection processes in place. Regulation 19(3)a

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not met:** The provider did not have an effective system to regularly assess and monitor the quality of service that people received. The provider did not have a wholly effective system in place to assess and manage risks to the health, safety and welfare of people using the service. Regulation 17(1)(2)(a)(b)(e)(f)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services The provider has failed to submit notifications to the Care Quality Commission of people who have died in the home.

The enforcement action we took:
We served a warning notice to the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Events requiring the home to notify the Care Quality Commission had not been made. These included notifications about serious injuries to people living in the home and a safeguarding investigation at the home.

The enforcement action we took:
We served a warning notice to the provider.