C & V Residential Limited

C & V Orchard Residential Limited

Inspection report

1-2 Station Street
Darlaston
Wednesbury
West Midlands
WS10 8BG

Tel: 01215264895

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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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 18 May 2017 and was unannounced. At the last inspection on 20 June 2016, we rated the service as 'requires improvement'. When we carried out this inspection we found the provider was not now meeting the requirements of the law.

C & V Orchard Residential Ltd is a residential home providing accommodation and personal care for up to 32 older people. At the time of the inspection there were 27 people living at the home.
Some people living at the home have dementia or additional health needs such as mental health, physical disability, sensory impairment, learning disabilities or autistic spectrum disorder.

It is a requirement that the home has a registered manager in post. There was 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.

People told us they felt safe living at the home. Staff we spoke with understood their responsibility in keeping people safe from the risk of abuse or harm and said they would report any concerns to the registered manager. People did not always receive support from sufficient numbers of staff, which meant their needs were not met in a timely manner.

Risks to people's health and welfare were assessed and action taken to minimise these risks. Improvements had been made in medicine management however people's medicines were not always clearly recorded.

People were asked for their consent before support was provided. Assessments had been carried out around people's capacity to make certain decisions. Staff and the managers knew how to obtain consent from people if they lacked capacity to make decisions around their own care.
Mealtimes were not always a positive experience for all. People had adequate to eat and drink and had access to healthcare professionals when required.

People said their choices were not always respected because staff did not always have enough time to spend with people. People's dignity was not always promoted and maintained. People told us staff were kind and caring. Care was planned to meet people's individual needs and preferences. People told us there were not enough leisure activities and people were not always encouraged to follow their interests or hobbies. People and their relatives knew how to complain and there were processes in place to manage concerns and complaints.

People told us staff were approachable. Quality assurance systems were not effective and failed to ensure that issues identified at the last inspection had been addressed or that improvements made had been sustained. The systems in place had not identified the areas of concern we found during the inspection.

During this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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.

There were not always enough staff to meet people's needs that led to delays in when people received support and assistance. People told us they felt safe with the staff that supported them. Staff knew how to identify and report potential harm to people. Risks to people were assessed and managed to protect people from avoidable harm. People's medicines were not always clearly recorded.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Mealtimes were not a pleasurable experience for everyone living at the home because of the lack of support available from staff. People were happy with the food choices available. People were supported by staff who had the skills and knowledge to meet their needs. People were asked for their consent before receiving care or support. People had access to healthcare professionals as required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People described staff as kind and caring. Staff knew people well and demonstrated an understanding of people's needs although at times staff were rushed and focussed on tasks. People's dignity was not always respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not have access to sufficient leisure activities. People received care that met some of their needs but failed to ensure that individual wishes and preferences were known and met. People and their relatives knew how to raise a complaint.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had failed to ensure improvements identified as needed at previous inspections had been implemented .Quality assurance systems failed to identify and ensure that areas of improvement and risk were addressed and resolved. People were cared for by staff who understood their roles and responsibilities.

C & V Orchard Residential Limited

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.

The inspection took place on 18 May 2017 and was unannounced. The inspection team consisted of one inspector and one expert by experience. The expert by experience had experience of care services. During our inspection we carried out observations of the support and care people received. In addition, we undertook 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.

As part of the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some information about the home, what the home does well and improvements they plan to make. We reviewed the information we held about the home and looked at the notifications they had sent us. These are events that the provider is required to tell us about, by law, in respect of certain types of incidents that may occur like serious injuries to people who live at the home. We contacted the local authority to gain their views about the quality of the service provided. We used this information to help us plan our inspection of the home.

We spoke with eight people who lived at the home and four relatives. We spoke with six staff members and the registered manager. We also spoke with one healthcare professional. We looked at the care records for four people to see how their care and treatment was planned and delivered. We looked at six medicine records and other records related to the running of the home such as a selection of policies. We also looked at two staff records and records to monitor the quality and management of the home.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in June 2016 we rated the provider as "requires improvement" under the key question of "Is the service safe?" We saw people did not always receive support when they needed it and we were informed by the registered manager staffing levels would be reviewed. During this inspection we again found there was not always adequate numbers of staff available to meet people's needs in a timely manner. The provider was not now meeting the requirements of the law.

People told us they had to wait for their care needs to be met. One person said, "[Staff] do get to you but you have to wait while they look after other people. I think they could do with more staff as sometimes you wait a long time and it gets uncomfortable if you need help with [personal care]." Another person said, "I do have to wait it's not the staffs fault they are just very busy." We saw one person who became distressed; staff were supporting other people and were not able to respond to this person's needs in a timely manner. This resulted in the person becoming more anxious. We spoke to staff who said they would attend to the person's needs as soon as they had finished supporting other people. The person waited for a period of fifteen minutes before staff were able to respond to their needs. We saw another person trying to attract the attention of staff for ten minutes. They required the support of staff to mobilise; we saw the person trying to stand up unaided. This meant they were at an increased risk of falls. We spoke with staff who responded to the person and supported them to mobilise safely.

Staff we spoke with told us they were very busy and this had resulted in some people experiencing delays with their personal care needs being met. One member of staff said, "There are not enough staff; people's needs have increased but staffing levels have not." Another member of staff told us, "We are very short staffed particularly lately there are not enough staff to meet people's needs, we are very rushed and people have to wait for [personal care] or for their meals and sometimes they have to wait to get up in the morning." Staff told us the number of staff available and waiting times we observed people had to wait for their care needs to be met was usual for the home. They said if they raised concerns about staffing levels with the registered manager or provider they had been told there were adequate numbers of staff to meet people's needs. At the last inspection we observed mealtimes and saw some people were kept waiting for their meals to be served for periods exceeding fifty minutes. At this inspection we saw people continued to experience delays in receiving their meals. We saw people were again sat for periods up to 50 minutes before they received their meals. One person told us, "[The] food was stone cold." Another person said, "There are delays in serving food." We saw there were not enough staff available to meet people's needs in a timely manner.

We discussed with the registered manager how they determined there were adequate numbers of staff to meet people's needs. We were told staffing levels were based on people's individual dependency needs. However they told us they did not have a system in place to accurately determine this and were looking to implement a process to determine the number of staff required. We discussed with the management team the number of staff available to provide support to people. We found again although the registered manager said staff numbers were determined by people's dependency level a system was not in place to determine the number of staff required to meet people's care needs. They advised us they would review people's

dependency and said they were in the process of recruiting new staff to ensure sufficient numbers of staff were available to meet people's needs. There were not a sufficient number of staff to meet people's needs and the provider did not have adequate processes in place to determine the number of staff required to meet people's needs.

This was breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection the process for managing medicines needed to be improved. At this inspection we found improvements had been made to the management of people's medicines.

People told us they received their medicines when needed. One person said, "I get my medicine from the staff I don't have any problems I always get my [medicine]." A member of staff said, "I feel confident administering people's medicines." We looked at six people's Medicine Administration Records (MAR) and found for three people's medicines the total amount of medicines available did not match the person's MAR. This meant we could not be assured people received their medicine as prescribed. We discussed this with the registered manager who said they would investigate the issues we found straight away. The registered manager reviewed the records and found errors were in relation to the recording of the medicines. Staff told us they were aware how medicines should be administered and we found guidance was in place for medicines that had been prescribed for 'as required' (PRN). We looked at the systems used to manage medicines and found medicines received into the home were stored securely and when no longer needed they were disposed of safely.

We looked at how the provider ensured staff were recruited safely and were suitable to work in their role. We saw the provider completed interviews and pre-employment checks before staff started in their role. We looked at two staff records and found one staff member did not have a reference from their most recent employer and only had a personal reference on file. We discussed this with the registered manager who assured us they would seek a reference from the staff member's previous employer. We looked at other recruitment checks such as Disclosure and Barring Service (DBS) checks and saw these had been completed prior to staff starting work. DBS checks help providers reduce the risk of employing staff who are potentially unsafe to work with vulnerable people.

People told us they felt safe with the staff that supported them. One person said, "I feel safe here the staff look after me." One relative commented, "I don't have any concerns about [person name] safety." There were a number of people who lived at the home who were not able to tell us about their experience and whether they felt safe living at the home. One member of staff said, "I would be able to tell by people's [body language] or how they were in them self how they felt." Staff were able to explain the different types of potential abuse and how they would respond to protect people from the risk of harm. One member of staff explained, I would tell the [registered manager]." Staff told us they were confident the registered manager would take action if any concerns were raised. They explained if they felt appropriate action was not being taken they would report concerns to the local safeguarding authority or CQC. This showed that a process was in place to ensure any allegations of potential abuse or harm would be appropriately escalated.

People told us staff understood potential risks to their safety. One person said, "Staff use [moving and handling] equipment to move me. They know what they are doing and I feel safe as there is always two staff supporting me to move." We spent time with people and saw how staff supported people to keep them safe. For example, when a person was using equipment to help them mobilise we saw staff encouraged the person to grip the frame and pull them-self up. Staff we spoke with were aware of potential risks to people and explained to us how they supported people in a way that minimised risk. One member of staff said,

"[Person's name has [soft diet] to reduce the risk of them choking." We found risk assessments were in place in people's care plan's that reflected the risks we observed. We saw where actions had been identified to reduce any risk these measures were implemented by the staff.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in June 2016 we rated the provider as "requires improvement" under the key question of "Is the service effective?" We found people were kept waiting for long periods of time for their meals and did not have a positive mealtime experience. At this inspection we found improvements had not been made in terms of people's meal time experience.

At our last inspection we found meal times were not a positive experience for some people. People were not offered a choice of where they would like to sit to eat their meal and we saw people waiting for their meals for long periods of time. At this inspection people told us they enjoyed the food. One person said, "Food is good and it is what I like to eat." People also told us they were offered a choice of meal and we saw people's individual dietary requirements such as softened meals and personal preferences were adhered to. However we found little effort had been made to make the meal time experience pleasant, there were no condiments available to people and some people remained in the same chairs as they had been in all the morning. We found for those people who were brought into the dining room for their meal they had to wait in excess of 50 minutes for their meals to be brought to them. One person we spoke with told us, "We do have to wait for our meals." Those people who required support with eating their meals had to wait until staff had finished serving other people's food before they were provided with support. This meant for some people their meals had become cold. Staff we spoke with had an understanding of people's dietary needs and their preferences. We saw for those people who required special diets such as a soft food, these needs were met. During meal time people were given squash to drink with no alternative offered. Throughout the day although we saw people were offered drinks there was little choice available for people to choose from. We spoke with the registered and deputy manager about this who said they would look to address the concerns we had found.

People told us staff asked for permission before carrying out any care. One person said, "[Staff] ask me first before they do anything and check I am happy with what they are doing." One member of staff said, "I always ask people [before providing any care]." Throughout the day we saw staff asking for consent before providing any care. At the last inspection we found that staff were not aware of the restrictions in place in respect of people who were subject to a Deprivation of Liberty Safeguards (DoLS). This placed people at risk of not having their rights upheld and protected. At this inspection staff had an understanding of DoLS and of those people who were safeguarded by an authorised DoLS

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.

Staff told us they had received training in the Mental Capacity Act and were able to explain to us the principles of the Act. One member of staff said, "People make their own decisions about their care". Another member of staff said, "People who may not have capacity to make decisions may need to be taken in their

best interest to keep them safe." We looked at information about people's capacity in their care records and found they contained assessments and decisions made in people's best interest in accordance with the MCA.

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 procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked to see if the service was working within the principles of the MCA and whether there were any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager told us they had submitted applications to the supervisory body and one had been authorised. We looked at records for people who had authorised DoLS to see if the conditions of the authorisation were being met and found that they were. Staff we spoke with were aware of any restrictions placed on people's rights and freedoms and the registered manager had sought advice and support from the relevant local authorities in accordance with the MCA. People subject to an authorised DoLS were protected by those conditions in place because staff were aware of the people whose liberty were being restricted.

People were complimentary about the staff and said they thought they had the skills to meet their care needs. One person said, "[Staff] seem to know what they are doing." One member of staff told us, "I have attended different training courses they do help you understand people's needs." Staff told us when they needed advice and support from management, this was available to them. We were told staff had team and supervision meetings which enabled them to discuss their roles and responsibilities.

People told us they were happy with the access they had to healthcare professionals. We saw from people's care records that intervention was sought from professionals such as district nurses, doctors and opticians when needed. One healthcare professional we spoke with told us staff contacted them as required and followed the guidance they provided. Staff we spoke with were aware of people's health needs and the support they needed to maintain their health. This showed people's health care needs were appropriately met.

Requires Improvement

Is the service caring?

Our findings

We saw staff were busy and often focused on tasks and did not always have the time to spend with people. We saw instances throughout the inspection of people asking for assistance or gesturing to staff for support and staff telling people they would need to wait as they were busy supporting other people.

Although people told us staff treated them with dignity and respect. We saw on occasions people's dignity was not consistently respected. When some people required hoisting to move from one chair to another staff failed to take action to preserve the person's dignity. For example, we saw one person's dignity was not maintained when being transferred using equipment. The person told the staff their clothing was not covering them appropriately when being transferred and whilst staff tried to pull the person's clothing around them but this did not protect the person's dignity. We saw some people requested support with their personal care and because staff were not available their personal care needs were not met. By contrast some staff we spoke with were able to provide us with examples of how they had protected people's dignity. For example, closing doors when providing care and speaking to people respectfully using words that they understood.

People we spoke with told us staff were kind and caring. One person said, "[Staff] are so very kind to you." Another person commented, "[Staff] are very good." Relatives we spoke with expressed similar views. One relative told us, "The staff are very good they are kind to [person's name]." Staff we spoke with said they tried to support people in a caring way but commented they were often busy and people might have to wait before they could respond to their needs. We saw staff interacted with people in a kind manner and saw they had developed positive relationships with people. For example, we saw that when one person had become upset a member of staff responded to this person by talking in a kind manner. Some people were able to talk to the staff and explain what they wanted or how they were feeling. Staff spoke to people at eye level, speaking slowly, using short sentences or single words. Other people required staff to interpret and understand their communication style. We saw staff observed people's body language and gestures to understand what support or care they required.

People gave us mixed views about the choices they were able to make about their care. One person said, "As much as I can I make my own choices. I choose when I get up and go to bed things like that." Another person told us, "I make some choices about what I eat but I am not sure I been involved in what support I need." Staff we spoke with were able to tell us about people's likes and dislikes and knew people well. One member of staff said, "I encourage [people] as much as I can to make choices such as what they would like to wear or eat." We saw staff did not always have the time to offer people choices about their day to day care as they were often completing tasks and were not always able to respond to people's requests. For example, one person wanted to go to their room and staff were not available to assist the person with this request and the person remained in the lounge.

People were supported to maintain relationships that were important to them. People and their relatives told us they were able to visit at any time. We saw visitors throughout the day and staff were friendly and welcomed them.

Requires Improvement

Is the service responsive?

Our findings

People were not supported to take part in activities that interested them. One person told us, "There is nothing to do here." Another person said, "There is not much to do here. The television is on I am not sure if anyone watches it." The majority of people living at the home were reliant on staff being available to support them to engage in activities. Staff we spoke with told us activities were part of their role. As staff were often very busy focusing on tasks they did not have time to engage with people to do activities or things that interested them. We saw one activity took place in the morning of our inspection, one person requested a game of bingo. We saw people were given bingo sheets however the member of staff called out bingo numbers whilst they completed other tasks such as noting people's lunch time meal choice and supporting people with their care needs. We saw that whilst the bingo game had started the member of staff was unable to encourage or support people with the activity for over 20 minutes. People became dis-engaged and one person left the communal area. People who were able to occupy themselves did so, by reading, talking to other people or spending time with relatives. One person said, "I love doing puzzles and I have a newspaper every day." We saw most people spent the day sitting in the communal lounge other than when they were supported with their personal care. Staff told us they did try to undertake different activities but did not always have time to do so. We discussed this with registered manager and provider who advised us they were in the process of recruiting new staff which would mean staff would have more time to support people with their interests.

People told us they received care that was responsive to their needs. One person said, "They provide me with the care that meets my needs." The majority of staff had worked at the home for some time and had got to know people's needs well. We saw staff had a good knowledge of people's individual needs and how to best support them. For example, we saw staff explain things to people in a way they understood. We looked at four people's care records and saw although they contained information about people's care and health needs they were not personalised and did not contain information about people's individual likes, dislikes and preferences. Staff told us they shared and received updates on people's needs during shift handover meetings which were held at the start of each shift. This ensured staff were able to provide people with the care and support they required. Staff said any changes in people's needs were reported to a senior member of staff and this then would lead to the care plan being updated to reflect any change.

People and their relatives told us they knew how to complain if this was necessary. One person said, "I would speak to the staff if I was unhappy." A copy of the complaints procedure and a comments box was available in the reception areas where people could place feedback or comments for the attention of the provider or registered manager. Staff we spoke with were able to tell us what they would do if anyone raised any concerns or issues. One member of staff said, "I would inform the senior or [registered manager]." The provider had a system in place for receiving and handling complaints. Records we looked at identified one complaint had been received and we saw this had been dealt with promptly and in line with the provider's complaint procedure. We also saw a system was in place to record and review issues raised to identify any improvements needed to the service. This showed people's complaints would be listened to and addressed appropriately by the provider.

Inadequate

Is the service well-led?

Our findings

At our previous inspections we have rated the provider as requires improvement overall. We found the provider had failed to ensure the required improvements had been made and in some areas the provider was not meeting the regulations.

We looked at the quality assurance systems in place to identify areas for improvement. We found issues highlighted from our last inspection regarding staffing had not been addressed. At our last inspection we discussed staffing levels and the deployment of staff with the registered manager; they told us they would review people's individual dependency levels and the deployment of staff. At this inspection we found these concerns had not been addressed. The quality assurance system in place had failed to identify the issues that were still in need of attention. People were kept waiting for pro-longed periods of time when they required support with personal care, eating their meals or to mobilise. We also found at this inspection concerns about the lack of stimulation or activities available to people. At the last inspection the registered manager told us they would review the deployment of staff whilst considering people's dependency levels. We found there was no process in place to determine the number of staff required to support people's needs. Although some people's care needs had increased, this knowledge had not been considered by the provider when determining staffing levels which had resulted in people waiting for their needs to be met and outcomes for people using the service were poor.

At our last inspection we saw there were processes in place for people to express their views and experiences of life living at the home. For example, residents meetings and questionnaires. We found there was evidence that people's views had been sought to improve the quality of service people received. At this inspection whilst people told us they recalled being asked for their opinions about the home they could not recall if they had been provided with any feedback. We looked at the records and saw evidence of conversations with people but there was no evidence that information obtained had been analysed to identify how many people were satisfied with the service provided or used to improve the quality of care people received.

We looked at other quality assurance systems within the home we saw checks had been completed on care plans and medicines including stock counts. We also found processes in place to record allegations of abuse, incidents, accidents and falls. Information was analysed to identify patterns and trends and improve the quality of service provided. However, we found some checks were ineffective and did not identify risks within the home. For example, one fire door was propped open by mobilising equipment. We found the magnetic catch to hold the door open was not working correctly. We spoke with the provider about this who said this would be fixed.
Systems for monitoring the quality of care and service had not been consistently robust and the provider had not been effective in identifying and acting upon areas which needed improvement.
The issues related to the lack of ineffective systems in place are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they knew who the registered manager of the home was. People said they would ask to speak

with the registered manager if they had any concerns. We had mixed views from people on whether they felt the home was well-managed. One person told us, "The staff are good they keep you informed of things going on." Another person said, "I am not sure it is well –managed as you do have to wait for support." People and relatives told us care was provided by a consistent staff group which meant that people were familiar with them and staff knew people well.

Staff demonstrated a clear understanding of their responsibilities. They said that they worked as part of a team and said they felt they could speak with the registered manager if they needed to. They told us they were committed to their role and they wanted to provide good care for people. Staff said they were aware of the provider's procedures and of whistle–blowing. They said if they felt issues or concerns were not appropriately addressed by the management team they would contact the local authority or CQC. Whistleblowing means raising a concern about a wrongdoing within an organisation.

Organisations registered with CQC have a legal responsibility to notify us about certain events. The provider had a system in place to notify us of events they are required to do so by law. We also saw the provider had ensured information about the home's inspection rating was displayed as required by the law.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were not protected by effective quality assurance processes that identified required areas of improvement within the home.

The enforcement action we took:

We issued the provider with a Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not taken sufficient steps to ensure there were adequate numbers of staff available to meet people's needs.

The enforcement action we took:

We issued the provider with a Warning Notice