C&V Orchard Residential Limited

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Inspection report

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08 November 2017

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 20 and 21 September 2017. Breaches of legal requirements were found. We undertook this unannounced focused inspection of C&V Residential Limited on 08 November 2017. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection of 20 and 21 September 2017 had been made. The team inspected the service against two of the five questions we ask about services: Is the service well led and is the service safe. This is because the service was not meeting some legal requirements. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

At our September 2017 inspection we gave the location a rating of 'inadequate' and entered it into special measures. We identified a number of breaches of regulations and the Commission made a decision to exercise its urgent enforcement powers by way of Section 31 of the Health and Social Care Act 2008, in the form of issuing a Notice of Decision to restrict any further admissions to the home including service users who may require to use the service for respite care. We also required people's risk assessments to be updated and reflective of people's needs along with assuring adequate numbers of qualified trained staff were deployed effectively across the home. On the basis that service users may be exposed to the risk of harm.

C & V Residential Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates people in one adapted building. C & V Residential Limited accommodates 32 people, some were living with dementia. At the time of the inspection there were 25 people living at the home.

The home currently has a registered manager in place. 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 did not always have their needs met in a timely manner. Staff did not always have the skills and knowledge to meet people's needs effectively nor were they well deployed. People were not protected from the risk of harm or potential abuse as the management team and provider were not managing safeguarding concerns appropriately. Staff did not understand how to manage people's individual risks to keep people safe. People received their medicines as prescribed.
People were not protected by a quality assurance system that identified areas of improvement needed to ensure people received safe care. The provider failed to recognise and improve the quality of care being provided to people. Staff did not have effective leadership which meant people were not protected from risks to their health, safety and well-being.

During the September 2017 inspection we identified seven breaches of the Health and Social Care Act 2008 and one breach of the Care Quality Commission (Registration) 2009. At this inspection we found the provider continued to be in breach of the regulations. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months. If there is not enough improvement so there is still a rating of inadequate for any key questions or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

People who were at risk did not have their risks assessed and managed effectively. Staff were not effectively deployed or skilled to meet people's needs. People were not always protected from potential harm or abuse. Systems in place did not always identify and investigate potential abuse. People received their medicines as prescribed.

Is the service well-led?

Inadequate

The service was not well-led

People were not protected by effective quality assurance systems that identified areas for improvement. People continued to be at risk of harm or abuse because incidents had not been identified, reported or investigated. The provider had failed to notify us of incidents as required by law.

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 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.

The inspection was partly prompted because another service owned by the provider had been de-registered by us using our urgent enforcement powers. Due to potential concerns about the management of risk and staffing levels we decided to complete a focused inspection. This inspection examined those risks.

This inspection took place on 08 November 2017 and was unannounced. The inspection team consisted of two inspectors and an inspection manager.

As part of the inspection, we reviewed the information we held about the service, including statutory notifications. A statutory notification is information about events that by law the registered persons should tell us about. We also asked for feedback from the commissioners of people's care to find out their views about the quality of the service. We also contacted the local authority safeguarding team for information they held about the service. We used this information to help us plan our inspection.

During the inspection, we spoke with four people who lived at the home and one visitor or family member. We spoke with two deputy managers and the provider. We also spoke to eight members of staff. We carried out observations throughout the home to help us better understand the experiences of people living at the home to review the quality of care people received. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at six care records for people. We also looked at other records relating to the management of the service including staff files, accident reports, audit records and four medicine administration records.

Inadequate

Is the service safe?

Our findings

At our last inspection in September 2017 we found the service was not safe and we rated the provider as 'Inadequate' in this key question. We found risks to people had not been assessed and managed to reduce the risk of harm. We also saw unsafe moving and handling techniques were used to mobilise and transfer people. We found there were insufficient staff to keep people safe and meet their needs and people were not always protected from the risk of harm or abuse. We issued a Notice of Decision on the provider's registration to restrict admissions into the home. We imposed conditions to ensure staff knew people's individual risks and care records were reflective of people's current needs. We also required sufficient numbers of suitably skilled and experienced staff be deployed at all times. We inspected the home again in November 2017 and found the provider continued to not meet the requirements of the law.

At this inspection we found although improvements had been made to the staffing levels; people continued to tell us they had to wait for staff to respond to their care needs. One person said, "There are more staff now but I still have to wait and I can't go out as there are not enough staff." Another person said, "It is better now but you still wait because some people need two staff to help them."

At our inspection in September 2017 we saw one member of staff remained in the lounge in order to respond to people's requests; we saw this was not sufficient because people waited for periods up to twenty minutes for their needs to be responded to. At this inspection we continued to see one member of staff remained in the lounge to ensure people's safety. We saw although staff were present in the lounge for the majority of the time people still waited for their needs to be met. One person told us they required support from staff to meet their personal care needs. We saw they had waited for a period exceeding 20 minutes for their needs to be met and this had caused them to feel discomfort. A member of the inspection team intervened and requested a member of staff support them with their personal care. At our inspection in September 2017 we saw staff prevented people from moving freely around the home. At this inspection we continued to see people's movements being restricted. We saw one person who was at high risk of falls attempting to mobilise independently. One member of staff saw this and told the person to 'sit down' on three separate occasions. The person continued to attempt to mobilise independently for a period exceeding 15 minutes because there was only one member of staff in the lounge area. We spoke to a member of staff about this; they told us some people regularly asked to leave the lounge and go to their bedroom but said they could not always accommodate their wishes as there was not enough staff available to meet these requests.

At our previous three inspections in June 2016, May 2017 and September 2017 we asked the provider how they determined the number of staff required to meet people's needs. We were informed by the registered manager and provider that people's dependency levels would be reviewed and a process developed to determine the number of staff required to meet people's needs implemented. At this inspection we found a system had been developed to determine people's dependency needs. However, we found although a process had been developed it did not take account of people's current care and support needs nor did it determine how many staff would be required to meet people's needs. This meant people's needs continued not to be met effectively and they were exposed to the risk of harm due to the inadequate deployment of

staff.

This is a continued breach of Regulation 18 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. Staffing.

At our inspection in September 2017 risks to people's safety were not managed in order to protect people from avoidable harm. At this inspection, we found the provider was not complying with the condition imposed on their registration to ensure people's individual risks were known and care records were reflective of people's current needs. For example, where people had risks to their health and safety we found the provider had not ensured up to date information was in place in order for staff to manage their risks safely; this included those people whose needs had recently changed or had sustained an injury. One person was at high risk of falls, staff we spoke with explained how they supported this person's needs. We looked at this person's care record and found they did not correspond to the way staff had told us they provided care; we found there were not clear instructions on how staff should support this person's mobility safely. Another person's mobility needs had changed and they required equipment to mobilise safely. However we found the person's risk assessment which provides guidance for staff about how to safely support the person had not been reviewed following a change in the person's needs. We found at our inspection in September 2017 the provider had not ensured staff had the skills or training to move people safely. At this inspection although staff had received training in relation to moving and handling this had not been embedded into practice. We saw people were at risk of moving and handling and transfers in wheelchairs. We observed staff incorrectly positioning a sling to transfer a person. This increased the risk of them slipping from the sling and sustaining an injury. We also saw the person's wheelchair was not secure during the transfer which increased the risk of the person falling.

We identified concerns about the environment at the home. The provider had procedures in place in the event of an evacuation of the building. We saw a fire policy and procedure was in place and saw signs in the communal area of the home in the event of an evacuation. We looked at people's care records and found the information recorded in their Personal Emergency Evacuation Plans (PEEPS) was not up to date nor did it contain relevant information about a person's mobility. This meant people were at risk of delayed escape from the building in the event of an emergency because information was not up to date. We also noted that flooring in some communal areas of the home were uneven and carpet was frayed in the lounge which posed a trip hazard for those people living in the home.

People continued to be at risk of harm as staff did not understand risks and how to effectively manage them. We found staff continued to have inconsistent knowledge of people's risks and what action to take to mitigate them. For example, staff were not always aware of how to keep people safe when they displayed behaviours that could challenge. We found several occasions where people had injured themselves or others. We found although incidents were recorded staff and managers were not monitoring incidents that arose due to these behaviours. As a result potential 'triggers' had not been identified or ways in which staff might decrease the risk of reoccurrence in order to reduce the risk of harm to themselves or others. We also found there were a number of incidents recorded where people had fallen, had unexplained bruising or had a skin tear. There was no evidence to demonstrate that these incidents had been investigated, that lessons had been learnt or that preventive measures put in place to reduce the risk of reoccurrence or harm. We could not be assured risks to people were effectively managed because the provider had not ensured risk assessments relating to the health, safety and welfare of people had been assessed, reviewed or managed.

This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

At our inspection in September 2017 people told us they felt safe. We found incidents of potential harm or abuse had not been recognised by staff which had resulted in incidents not being referred to the local authority or investigated. At this inspection people told us they felt safe with the care they received. One person said, "I feel safe with the staff when they are supporting me." Another person told us, "I would tell staff if I was not happy I do feel safe living here." Staff we spoke with were able to describe signs of potential abuse and how they would report these concerns. However we found although staff informed the management team of potential harm or abuse both the provider and management team did not have sufficient knowledge of how to recognise or report safeguarding concerns to ensure people would be sufficiently protected from potential abuse. For example, the management team were asked by us about specific incidents that had resulted in injuries to people. They did not recognise these incidents as possible safeguarding and had not taken any action to mitigate the risk of reoccurrence; as a result had not protected people from potential abuse or improper treatment. We identified a person who had unexplained bruising. The management team were made aware of the bruising by staff however they did not follow their own safeguarding policy and procedures for reporting potential abuse and protecting a person from the risk of further harm. We identified a further situation that had caused harm to others that had not been reported to the local safeguarding authority. This shows people were not always protected from the risk of abuse or harm.

This is a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding people from abuse and improper treatment.

People told us they received their medicines when they needed them. One person told us, "I get my medicines from staff. I do not have any problems with getting my medicines when I need them." We saw a member of staff supporting people to take their prescribed medicines. We saw people received their medicines in a safe way. For example, we saw a member of staff stay with a person whilst they took their medicine and prompted them to have a drink to ensure they swallowed it. We reviewed the management of medicines including the Medicine Administration Records (MAR) for four people and found these indicated what medicine people had received and were completed accurately. Some people's medicines were only given as and when they needed them. Staff were aware of when these medicines should be offered. Staff told us they referred to the guidance in place about when these medicines should be administered. Staff told us one person was given their medicine covertly. This is a term used when medicines are administered in a disguised format, such as in food or drink without the knowledge or consent of the person receiving them. As a result, the person is unknowingly taking a medicine. We looked at this person's records and found although the person's doctor had been consulted about this there was no evidence that the person or their family members had been involved in the decision or that the decision had been made in the person's best interests. We also found an assessment of the person's capacity to determine whether they had capacity to consent to this method of receiving their medicines had not been completed. This meant the person might be prevented from making their own decision and staff may not have received accurate guidance about the person's capacity to make certain decisions. At our last inspection in September 2017 we were told competency checks would be completed for those staff who administered medicines. At this inspection we found competency checks still needed to be completed. We looked at how medicines were stored and unwanted medicines disposed of; we found medicines were stored securely and unwanted medicines returned to the pharmacy for disposal and staff kept records of all medicines that were disposed of.

We looked at how the provider ensured members of staff were recruited safely. We saw a range of pre-employment checks were completed including reference and Disclosure and Barring Service (DBS) checks. A DBS identifies those people who are barred from working with children or vulnerable adults and informs the service provider of a criminal conviction noted against the applicant. This meant people were supported by

members of staff who are suitable to work with vulnerable people.

We looked at the cleanliness and hygiene of the home. Domestic staff worked at the home whose responsibilities were to ensure people's rooms, communal areas and bathrooms were cleaned. Although we found the home was clean in some communal corridors and bedrooms odours were present. We spoke to a member of staff who told us daily hygiene checks were completed of all the rooms. We looked at the bathrooms and found they contained soap, hand towels and clinical waste bins along with hand washing instructions for staff to follow. Around the home aprons and gloves were available for staff to use when providing care. We looked at the laundry and found it was organised and had a system in place to prevent cross infection from dirty to clean laundered clothes. We also looked at food hygiene and found the fridge and freezer were checked daily and temperatures checked to ensure food was stored appropriately. We also observed the kitchen area was regularly cleaned to ensure the area was suitable to prepare food. Adequate measures were in place to protect people from the risk of infection.

Inadequate

Is the service well-led?

Our findings

At our last inspection in September 2017 we found the service was not well led and we rated the provider as 'Inadequate' in this key question. This was because the provider's quality assurance systems were ineffective and risks to people were not managed. We issued a Notice of Decision on the provider's registration to restrict admissions into the home. We inspected the home again in November 2017 and found the provider had failed to make improvements identified from the previous inspection so that safe and effective care was provided to people. This meant the provider continues to be in breach of the regulations.

At this inspection we looked at the systems the provider used to ensure the service was safe. We found the monitoring systems used to assess the safety of people who lived at the home as well as the quality of the service delivered were not effective. At our inspection in September 2017 we found people's health and well-being were not sufficiently protected as the provider had failed to implement systems and processes to make sure people received the care and support they needed. At this inspection we found the provider had not made sufficient improvements to ensure people's health and well-being were protected. We found systems had not been sufficiently developed to monitor people's needs. We found incidents had not been acted upon and action had not been taken by the provider to ensure people were protected from harm and reoccurrence was reduced. We found systems and processes in place did not identify learning from incidents to mitigate future risks to people. The manager confirmed there was no overarching system in place to review patterns, identify trends or factors in incidents to show if any changes needed to be made to people's care. We found the providers monitoring system had failed to identify that incidents had not been reported to the relevant authorities as legally required, or that care records were not updated, which meant the opportunity to use information to ensure people's safety was missed.

At our last inspection in September 2017 we found people's care records were not reflective of their needs. At this inspection we found people's care records and risk assessments had not been reviewed since our last inspection. Care records we looked at showed the provider was not maintaining accurate, complete and contemporaneous records in respect of each person living at the home. We found there were no effective audits in place to monitor the quality of people's care records and checks completed by the management team had not identified the gaps we found in relation to people's risks. At our last inspection we found risk assessments were not up to date and staff's knowledge of people's risks were inconsistent. At this inspection we found this had not been resolved; the provider had not established an effective system to assess, monitor, manage and review risks to people, which meant staff continued to have inconsistent knowledge of people's risks.

During this inspection we found that recurring concerns identified as far back as June 2016 in relation to staffing levels and the deployment of staff had still not been rectified. We found at this inspection although staffing levels had increased by one member of staff on each shift, people still waited for prolonged periods of time for their care needs to be met. Since our last inspection in September 2017 the provider had developed a dependency tool detailing people's individual dependency levels. However this was not reflective of people's current needs nor did it identify the number and skill mix of staff required on each shift to meet people's varying needs. At our inspection in September 2017 we looked at the systems to ensure

staff had the skills, knowledge and training to meet people's needs. At this inspection we looked at the checks completed to assess the skills of the staff and to ensure training was embedded into practice. This was because the provider had failed to implement effective systems to evaluate staff practice. Staff we spoke with understood the responsibilities of their roles but the provider was not able to demonstrate staff had the skills, training and support needed to provide care to people safely. We found the provider had failed to maintain an oversight of the service in relation to staff skills and competencies and did not effectively monitor how they staffing compliment impacted on the quality of care and service people received.

At our last inspection in September 2017 people had mixed views on whether the service was well-led. At this inspection people continued to have mixed views about the management of the service. People told us they were aware of who the management team were but said they were not always visible around the home. At our last inspection in September 2017 people told us their views were sought about the quality of service they received but they could not recall having any feedback. At this inspection people told us they could not recollect any meetings since our last inspection. We spoke to the management team about this and were informed a meeting had been arranged for families. The management team acknowledged that opportunities had not occurred recently for people to feedback about the quality of the service and they were looking to address this. We found there were systems in place for visitors and staff to raise concerns or make compliments by the use of a comment box along with questionnaires. The systems in place did not ensure that any feedback received was analysed to identify issues or areas for improvement. This showed us although views were sought; they were not used to improve the quality of the service.

At the last two inspections we identified shortfalls in the leadership and management of the home. At this inspection staff told us if they had any concerns they would report them and said they thought the management team or provider would take appropriate action. Staff told us they were aware of the whistle-blowing policy and said they felt confident to approach the registered manager. Whistle blowing means raising a concern about a possible wrong doing within an organisation. Although staff we spoke with were aware of the management structure and said they felt supported in their role; we found staff were not adequately supported by the management team and the opportunity to guide staff was not available. We found the leadership of the service continued to be weak. We observed management continued to communicate with the staff team via telephone even though they were in another part of the building. This meant the management team and provider continued not to have an effective oversight of the home, or of how staff delivered care to people in a way that would meet their individual needs. They did not ensure improvements which were required were implemented and embedded in order to ensure people received a good standard of care.

We found the management team and provider continued to fail to take responsibility for the failings of the service and the continued regulatory breaches. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

Prior to the inspection we reviewed the information we held about serious incidents and safeguarding's within the home. Providers have to notify CQC about significant events as required by law. We looked at the providers systems in relation to incidents and safeguarding and the reporting procedures to the local authority and CQC. We identified a number of notifications which had not been made in line with reporting procedures. We found no clear rationale as to which incidents were referred to the local authority for investigation or to CQC. We had not received notifications about safeguarding incidents nor did we receive notifications about other incidents as required. We spoke with the manager about this who confirmed checks had not been completed to ensure safeguarding and incidents had been notified as required. The provider could not be assured incidents and safeguarding's that required reporting to CQC or the local

authority would be actioned; because the manager sought our advice and guidance on recognising incidents of abuse. The provider lacked knowledge in relation to their obligations to report serious incident as required by law.

This is a continued breach of Regulation 18 Care Quality Commission (Registration) 2009.

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 18 Registration Regulations 2009 Notifications of other incidents We found the provider had not always completed appropriate notifications about incidents that had taken place.

The enforcement action we took:

We have issued a Notice of Proposal to Cancel the providers registration.

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 not enured risks to the health and safety of people were assessed and managed.

The enforcement action we took:

We have issued a Notice of Proposal to Cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured there were effective systems and processes to protect people from abuse or improper treatment.

The enforcement action we took:

We have issued a Notice of Proposal to Cancel the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and improve the quality and safety of services provided.

The enforcement action we took:

We have issued a Notice of Proposal to Cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs.

The enforcement action we took:

We have issued a Notice of Proposal to Cancel the providers registration.