Review of compliance

Health & Care Services (NW) Limited Orchid Lawns	
Region:	East
Location address:	Steppingley Hospital Grounds Ampthill Road Steppingley Bedfordshire MK45 1AB
Type of service:	Care home service with nursing
Date of Publication:	October 2011
Overview of the service:	Orchid Lawns accommodates up to 24 people who are elderly, have dementia and require nursing care.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Orchid Lawns was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 7 October 2011, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

During our visit on 6 October 2011, we were unable to speak with people who use the service about the care and support they receive as many of the people living in the home were unable to communicate verbally. We spent time observing and listening to the care people received.

What we found about the standards we reviewed and how well Orchid Lawns was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People were treated with respect and they, or their families, were involved in decisions about their daily care and support needs.
The provider is compliant with this outcome.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People cannot be assured that their health and personal care needs are met in a consistent and safe manner.
The provider is not compliant with this outcome.

Outcome 07: People should be protected from abuse and staff should respect their human rights

The provider is non compliant with this outcome. Not all staff were able to demonstrate they could recognise potential abuse which could put people at risk of not receiving the appropriate care at all times.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

People do not live in a safe, well decorated home; it compromises their privacy and dignity and does not promote their wellbeing. The provider is non compliant with this outcome.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

Whilst there is sufficient staff available to meet people's basic personal care needs, there is a lack of staff to provide social activities on a regular basis. The provider is non compliant with this outcome.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The provider does not have a sufficiently robust quality assurance system in place to ensure that the service provided is safe and of the highest possible quality. The provider is non compliant with this outcome.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
During our visit on 6 October 2011, we were unable to speak with people who use the service about respecting and involving them as many of the people living in the home were unable to communicate verbally. We spent time observing and listening to the care people received.

Other evidence
During our visit on 6 October 2011, we looked at the personal files of three people who live at the home. These were large and cumbersome documents, which made them difficult to use and find information. However, we did find evidence that people's relatives had seen the care plans. Relatives we spoke with confirmed this, and said they were happy with them. Family members told us they were satisfied with the care that is provided at Orchid Lawns. Comments included, "Staff are friendly" and, "they are always willing to help and support". They told us they felt they were kept up to date and are informed straight away of any incidents that occur to their relative.

Our judgement
People were treated with respect and they, or their families, were involved in decisions about their daily care and support needs.
The provider is compliant with this outcome.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
During our visit on 6 October 2011, we were unable to speak with people who use the service about their care and welfare as many of the people living in the home were unable to communicate verbally. We spent time observing and listening to the care people received.

Other evidence
During our visit we reviewed personal care records, observed practice and considered the findings from the Mental Health and Learning Disabilities team who have been working with the home. They identified concerns about the accuracy and accessibility of care records. We found not all information was up to date and that the individual files were cumbersome to manage, they were very full of information and it was hard to find relevant information.
The manager informed us that the company are introducing new paperwork for the care planning process but it was not clear when this would be happening.
We looked at the records for two people and found that the contained lots of different plans, these included keeping safe, personal hygiene, skin care, moving around, eating and drinking. One persons information included they liked a daily walk but there was no mention within the plan how they are supported and the daily records did not demonstrate if this happens. Another person's eating and drinking plan made no reference to the nutritional supplements they were taking. We saw the plans were reviewed monthly but did not reflect the aims of the plan. For example, for eating and drinking it made no mention of the person's weight or food intake over the previous month.

Although there were charts in use to help monitor people's food and fluid requirements, we found that these had not been consistently completed and therefore failed to give an accurate account of the care delivered. For instance, we found that where food was recorded it did not give the amounts eaten. On one chart we saw that at a supper time it stated 'in bed'. We were unclear if this meant they had been offered supper or that they went without food. This could potentially put people at risk of not receiving the care required and not providing other professionals with information on how to support individuals.
A daily activity co-ordinator is employed but also works some hours in the kitchen. On the day of our visit she was working in the kitchen. Staff told us that some people had been out on trips to Southend and local garden centres recently. They have access to the company's minibus on alternate weeks. Due to people's complex needs trips are only possible for a small number of people.
During this visit, we spent some time observing the care experience of a small number of people who live with dementia or have little verbal communication. We watched how people interacted with each other and with care staff. We saw that although staff were patient and considerate, there was little social interaction between staff and the people in this area. The main focus of staff interactions related to assisting people with eating or supporting them with a personal care task. We were concerned to note that there was no obvious stimulation or social activity in place.

Our judgement
People cannot be assured that their health and personal care needs are met in a consistent and safe manner.
The provider is not compliant with this outcome.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

There are minor concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
During our visit on 6 October 2011, we were unable to speak with people who use the service about whether they are kept safe from abuse as many of the people living in the home were unable to communicate verbally. We spent time observing and listening to the care people received.

Other evidence
During this review records showed that staff had all received training in safeguarding adults within the last year, and allegations of possible abuse had been appropriately reported to the relevant authorities. Staff we spoke with confirmed they had been trained. However, we found that not all staff were able to demonstrate that they could recognise potential signs of abuse. They told us they felt confident enough to talk to and/or report their concerns to the person in charge. The acting manager told us that further training is to be provided on line. The provider will also be introducing the local authority competences for safeguarding, so that staff's competence can be tested. Training for staff on the Mental Capacity Act and the Deprivation of Liberty Standards will also be arranged so that staff know how to support people who do not have capacity to make decisions.

Our judgement
The provider is non compliant with this outcome. Not all staff were able to demonstrate they could recognise potential abuse which could put people at risk of not receiving the appropriate care at all times.

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
* Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

There are major concerns with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
During our visit on 6 October 2011, we were unable to speak with people who use the service about the safety and suitability of the premises as many of the people living in the home were unable to communicate verbally. We spent time observing and listening to the care people received.

Other evidence
During this visit we looked around most areas of the home. The environment, especially the woodwork and paintwork, was in a poor state of decoration which made the home feel neither welcoming nor homely. Some of the paintwork on the walls was patchy, some of the carpets were stained and very worn and some of the seats were worn and stained. The manager was unable to provide us with any evidence that a redecoration plan with timescales was in place.
The lighting in the home was poor and it was not helped by the dark fabric curtains that were in place. This could pose a risk as people walk around the home.
Staff told us the bathing facilities are not adequate and limit people's choice. Most people prefer to shower, however there is only one shower available in the home. When people are being supported to use the shower the room becomes extremely hot and humid as the extractor for the shower room is inadequate. This does not provide a relaxed and pleasant experience for people. Two assisted bathrooms were available. Staff told us that one bathroom is not used due to fact that people did not like the style of assisted bath, as it tips them backwards (Parker bath). The other assisted bath is used occasionally on request. We found that this room compromised people's dignity. Although the window had frosted glass, it faced the main car park to the home and if used at night there was no blind or curtain at the window.

A fire safety inspection took place during our visit. The fire safety officer found that his requirements were not being met in a number of areas. For instance, the loft hatches need to meet fire standards and there was no record that the PAT (portable appliance testing) or emergency lighting testing had been carried out. The records need to be simplified and more staff to be trained as fire marshals. The fire safety officer will produce a report in due course which will include timescales for the actions required.

Our judgement
People do not live in a safe, well decorated home; it compromises their privacy and dignity and does not promote their wellbeing. The provider is non compliant with this outcome.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are minor concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
During our visit on 6 October 2011, we were unable to speak with people who use the service about staffing as many of the people living in the home were unable to communicate verbally. We spent time observing and listening to the care people received.

Other evidence
During our visit we observed that there were sufficient staff on duty to meet people's basic care needs, but staff were unable to spend time interacting with people and providing regular stimulating social activities. Staff we spoke with told us they felt that there was enough staff on duty to cover the personal care and support tasks for the people living at the home.
Although an activities co-ordinator is employed in the home, this staff member also covers the kitchen when the cook is not on duty. She was working in the kitchen on the day of our visit. The acting manager told us this staff member requires training in providing activities especially for those people who have dementia.
We also observed that relatives come in to support their loved ones at mealtimes. They told us they felt they are helping staff at what is usually a busy time, and that it was something they were able to do for their loved one that did not require the use of handling equipment.

Our judgement
Whilst there is sufficient staff available to meet people's basic personal care needs, there is a lack of staff to provide social activities on a regular basis. The provider is non

compliant with this outcome.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are moderate concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
During our visit on 6 October 2011, we were unable to speak with people who use the service about assessing and monitoring the quality of service provision as many of the people living in the home were unable to communicate verbally. We spent time observing and listening to the care people received.

Other evidence
During our discussions with the manager we found that the service does not have a sufficiently robust formal quality assurance process in place to ensure that any shortfalls in the service are rectified. The provider had carried out a monitoring visit to the service on 16 September 2011. The report of this visit identified a number of shortfalls, such as the home had not yet commenced using the new paperwork; there was limited access to the intranet; care plans needed to be reviewed; more staff required First Aid training to ensure sufficient staff to be able to respond to an emergency 24 hours a day; and full auditing systems were not yet in place. The provider's report did not assess the safety and maintenance of the environment.
An action plan was set up following the provider's visit. However, this did not provide any timescales for the identified failings and therefore did not prioritise how and when the work should be completed by.
The relatives we spoke with told us they attend the relatives meeting and feel they are able to raise any concerns and are assured they will be listened to. They feel that staff keep them informed and are involved in their relatives care and support.

Our judgement

The provider does not have a sufficiently robust quality assurance system in place to ensure that the service provided is safe and of the highest possible quality. The provider is non compliant with this outcome.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People cannot be assured that their health and personal care needs are met in a consistent and safe manner.	
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: Not all staff were able to demonstrate they could recognise potential abuse which could put people at risk of not receiving the appropriate care at all times.	
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met: People do not live in a safe, well decorated home; it compromises their privacy and dignity and does not promote their wellbeing.	
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities)	Outcome 13: Staffing

	Regulations 2010	
	How the regulation is not being met: Whilst there is sufficient staff available to meet people's basic personal care needs, there is a lack of staff to provide social activities on a regular basis.	
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: The provider does not have a sufficiently robust quality assurance system in place to ensure that the service provided is safe and of the highest possible quality	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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