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:	May 2012
Overview of the service:	Orchid Lawns is registered with the Care Quality Commission as a care home with nursing. It provides accommodation, care, treatment and support for up to 24 older people.

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. Action is 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 to check whether Orchid Lawns had taken action in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 04 - Care and welfare of people who use services
Outcome 05 - Meeting nutritional needs
Outcome 07 - Safeguarding people who use services from abuse
Outcome 09 - Management of medicines
Outcome 13 - Staffing
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 2 May 2012, observed how people were being cared for, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

When we visited Orchid Lawns on 02 May 2012 we found that people had varying levels of communication which made it difficult for us to discuss their care with them in any depth. Therefore we used a number of different methods including observations, and talking with people's relatives, to help us understand their experiences.

There was a calm and relaxed atmosphere in the home, and we observed that people looked clean and comfortable. When people required assistance and support this was recognised and addressed by staff, who we noted were caring and respectful in the way they delivered care.

We observed that people looked at ease in the company of the staff who cared for them, and the relative of one person who used this service told us. "They are absolutely brilliant here, people are always treated with dignity, it couldn't be better". We also spoke with someone from the advocacy service, who visited Orchid Lawns once a fortnight. They told us. "The care is always very good here, there is a strong forum of relatives who are also very happy with the service".

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

The provider was meeting this standard.

People were treated with dignity and respect, and their views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

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

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Outcome 05: Food and drink should meet people's individual dietary needs

The provider was meeting this standard

People were protected from the risks of inadequate nutrition and dehydration.

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

The provider was meeting this standard.

People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. The provider responded appropriately to any allegation of abuse.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

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

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

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 was meeting this standard.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

Other information

In a previous review, we found that action was needed for the following essential standards:

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

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.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

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
When we visited Orchid Lawns on 02 May 2012 we found that people were treated with dignity and respect, and were assisted to make choices about their care whenever possible.

We noted that everyone who lived at the home, had conditions which affected their cognitive functioning. This meant that their ability to communicate with, and understand us was very limited. However we observed that people looked content and comfortable, and where they required attention and support from staff this was recognised and addressed swiftly.

People were appropriately dressed and looked clean and well cared for. Where they needed support or assistance with personal care, this was done in the privacy of their room or the bathroom to protect their dignity. We observed that the staff interacted with people in a caring and respectful way. When they engaged with people verbally, this was done slowly and clearly to help people understand them more easily.

People were given support and encouragement to maintain their independence, and offered choices whenever possible. The relative of one person who lived in the home told us. "They are always treated with dignity, it couldn't be better".

There was a vast array of information displayed on notice boards in the reception area, which related to the home and the facilities that were available. This included groups and leisure activities for the forthcoming weeks, as well as helpful information and telephone numbers.

Other evidence
When we visit Orchid Lawns on 02 May 2012, the staff that we spoke with told us that every effort was made to ensure that people were encouraged to maintain their independence wherever possible, and make choices about the support and care that they needed and how it was delivered.

As all of the people in this home suffered with dementia and had very limited communication skills, life story books had been completed for people by their families. These ensured that staff had a good knowledge of people's interests, personal preferences and how they liked things to be done.

Where possible people were involved in making decisions about things such as menus, and we observed that some people's bedrooms were decorated and furnished reflecting personal taste and choices.

This home held regular meetings for the relatives of people who lived there. This enabled people to voice their views and advocate for their family member.

Our judgement
The provider was meeting this standard.

People were treated with dignity and respect, and their views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

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

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We found that people's needs were assessed, and care and treatment was planned and delivered in line with their individual care plans. Due to the varying levels of communication that people in Orchid Lawns had, it was difficult to discuss their care with them in any depth. Therefore we used a number of different methods including observations, and talking with people's relatives, to help us understand the experiences of people using the service.

We observed that staff were caring in their approach to people, and when they engaged with people verbally, this was done slowly and clearly to help people understand them more easily. People were given their medication when they needed it and records showed that the doctor was called for them if they were unwell. Appointments with other health professionals such as dentists and chiropodists were made for them at regular intervals, and consequently people were satisfied with the care provided in this home.

The relative of one person who used this service told us. "They are absolutely brilliant here" and went on to tell us how much the activities had improved in the home since the new activity worker had joined the team.

Other evidence
During our visit on 02 May 2012 we looked at the care files of two people who lived at Orchid Lawns in detail.

We found that each file contained care plans that had been very clearly written in a

personalised way, and referred to the individual's personal choices and preferences. There were 'life stories' in place that had been written by people's families. These provided personal information including people's life experiences, and promoted a holistic approach to care. People's relatives had signed their care plans, which indicated that involvement had been encourage by the home, and that people recognised and agreed with the care that was required.

The care plans that we saw contained specific information regarding the level of support people required. This included the use of different moving and handling equipment, and specific instructions which related to the management of long term medical conditions such as diabetes. They provided staff with clear guidance to follow when giving support and care, which ensured that it was done with continuity. We found that the care plans had been regularly reviewed and amended where people's needs had changed, and that short term care plans had been introduced as and when required. In each of the files we looked at, we found that risk assessments had been completed with regards to nutrition, falls and pressure area care. These had been reviewed at least monthly, and where a score which indicated high risk had been identified, additional processes and documentation had been introduced. This included increased weight monitoring, turn charts and dietary intake charts. These all provided a system to monitor people at a higher risk more closely. We found that these had been appropriately introduced and completed as required.

Individual's daily records gave a clear account of their activity and well being during each shift. Where someone had a care plan which involved one to one support, we saw that records were completed at regular intervals throughout the day and night. This meant that their progress was closely monitored and the level of support was kept under review to ensure their needs were met safely.

Our judgement
The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
* Are supported to have adequate nutrition and hydration.

What we found

Our judgement

The provider is compliant with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
We observed that people were assisted at meal times to ensure that they were given sufficient time and support to enjoy their food.

Other evidence
When we visited Orchid Lawns on 02 May 2012 we spoke with staff who worked in the kitchen. They told us that there had been a recent change of produce supplier to improve the quality of some of the food provided to the home.

There was a four week rolling menu in place, which offered a wide choice of nutritious main meals and daily alternatives were also available. The kitchen staff demonstrated a good understanding of the dietary needs, and the likes and dislikes of all 16 people who were in the home at the time of out visit. They talked with us about the importance of the nutritious value of the food they served to people in the home, as well as serving appropriate sized portions to encourage people to eat.

During this visit we observed the lunch time service and noted that the meals had been nicely presented. We saw that the staff sat with people, and gave them encouragement and assistance in an unhurried way, so that they had time to enjoy their meals.

Where people had specific dietary needs, for example a soft or pureed diet, this was clearly identified in their care plans. We looked at the monthly "weight tracker" sheet for everyone who lived in the home. This showed that at the time of this review, no one had had any significant weight loss over the past two months. There was no one who required dietary or fluid intake monitoring at this time.

Our judgement
The provider was meeting this standard

People were protected from the risks of inadequate nutrition and dehydration.

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

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
People who lived at Orchid Lawns were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Everyone who lived at this home had conditions that affected their cognitive functioning. This meant that their ability to communicate with, and understand us was very limited, however we observed that people looked content, comfortable and at ease in the company of the staff who cared for them.

Other evidence
When we visited Orchid Lawns on 02 May 2012, we spoke with four of the six care staff that were on duty at that time. They all knew where the safeguarding policy was located, and said that that they had completed safeguarding training this year. We confirmed this by looking at staff training records.

All the staff that we spoke with were able to demonstrate a clear understanding of safeguarding processes, and gave us examples of incidents or concerns that they would report to their manager. They were also aware that they could raise concerns directly with the local authority safeguarding team, if for any reason they were unable to make an alert through the management of the home.

The qualified staff that we spoke with were able to tell us exactly what action they would take if they were in charge of the home when allegations of abuse were made. They

were familiar with the documentation that they needed to complete and where to send it. There was a file in the nursing office which contained the safeguarding policy and copies of these forms.

We were aware from information held by the CQC that the home had reported safeguarding alerts to the appropriate organisations in a timely way. We also observed that there were posters displayed around the home, which advised staff and visitors of the numbers that they could call if they required any advice or guidance on matters relating to the protection of people in this home.

Our judgement
The provider was meeting this standard.

People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. The provider responded appropriately to any allegation of abuse.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

The provider is compliant with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
We spoke with people using the services but their feedback did not relate to this standard.

Other evidence
When we visited Orchid Lawns on 02 May 2012, we found that medicines were prescribed and given to people appropriately. All of the people who lived at this home were prescribed regular medication, and we could see from the care documentation that we looked at that it was reviewed regularly by the doctor.

We looked at the Medication Administration Record (MAR) sheets for all sixteen people who lived in Orchid Lawns at the time of our visit, and checked them against the stock that was prescribed for them in the home. We found that the stock for each person corresponded accurately with their records. Medication was clearly signed in each month when it was delivered, and where stock was carried forward from one month to another, this was also recorded. The MAR sheets were appropriately completed with staff signatures, or omission codes if for any reason it had not been given.

We found that medication was safely stored in a locked trolley, which was kept in the medication room. This room was kept locked at all times. There was a double locked cabinet in place for controlled drugs (CDs) and a register which monitored the used of any CDs in the home. We found these stock records to be correct and appropriately completed. Where there were specific instructions for the storage of medication, such

as in the fridge, these were being carried out correctly. We noted that stock had the date it was opened written on it.

We observed staff administering medication to people during our visit, and noted that they took time to ensure that medication was taken appropriately.

Our judgement
The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

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

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
We did not speak with the people who lived at Orchid Lawns about staffing as part of this review. However we noted that there was a relaxed atmosphere and people were comfortable and at ease in the company of the staff who were caring for them.

Visitors who we spoke with during our visit, told us that they were very happy with the standard of care people received in this home. They praised the staff, and told us that the staff morale had improved since our last visit in March 2012.

Other evidence
Our inspection of 13 March 2012 found that the staffing levels were inconsistent and did not always effectively meet the health and welfare needs of people in this home safely. We made a compliance action in this regard, and the provider took immediate action to increase the number of staff on duty.

During our last visit we spoke with a number of staff and visitors at the home, who had all commented on the low staff moral in the home, and the negative impact that this had had on the atmosphere in the home. When we revisited Orchid Lawns on 02 May 2012 we found the staff were more enthusiastic, and although everyone was busy, there was a calm and relaxed atmosphere. We also spoke with someone from the advocacy service, who was visited Orchid Lawns once a fortnight. They told us. "The care is always very good here, there is a strong forum of relatives who are also very happy with the service".

We spoke with four members of the care staff who told us that morale had improved following the changes that had been implemented after our last review. This had included a change in management and an increase in staffing numbers from five to six staff per shift in the day time. We looked at the rotas for the four weeks preceding our visit, and these confirmed the increase in staffing levels. We observed that the staff responded to people's needs swiftly, and that where the use of equipment such as hoists was involved, this was done safely, and demonstrated that staff were competent in this regard.

We spoke with the new regional manager who had just taken over the supporting role for this home. They advised us that interviews for a new home manager were planned, and they expected that this appointment would progress quickly. They demonstrated a focus on providing a stable leadership for the home to secure the improvements that had been made over the past six months.

We discussed staff training with them and noted from records, that although they were not up to date, most staff had completed training in dementia, safeguarding, moving and handling and medication practices where appropriate. The regional manager explained that the implementation of the ongoing e learning programme for staff had been delayed in this home and remained work in progress. They showed us that they were collecting data from the training system of the previous provider of this service, in order to ascertain exactly what training was outstanding for individual staff. At this time we could not confirm where the gaps in training were, however we did not see any care practices which put people at risk or gave us cause for concern during this review.

The provider should note that it is essential that the training system is fully implemented without further delay and that any gaps in training are identified and addressed. This is to ensure that people in this home receive care and support from staff who are appropriately trained.

Our judgement
The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

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

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We spoke with people using the services but their feedback did not relate to this standard.

Other evidence
During our visit on 02 May 2012 we looked at the systems that were in place to asses and monitor the quality of service provision in Orchid Lawns. We found that people who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on.

Monthly meetings were held to enable people who use the service and their relatives to share there views and opinions, and make suggestions for improvements. These meetings were recorded and provided an audit trail of how people's opinions and ideas contributed to changes in the home. We were told that activity mats had been introduced as a result of relatives' suggestions, and was now providing an enhanced level of stimulation for some people in the home.

We looked at the audit folder for the home and saw that a provider's audit report had been completed each month by a senior member of staff from the company. It showed that checks had been carried out on care documentation, medication records, accidents and incidents forms, as well as environmental issues such as cleanliness and maintenance. We could see from the previous two audits that had been completed, that although some areas of improvement had been noted, others areas such as staff supervision and training had recommendations and actions in place which needed to be

addressed. We discussed these issues with the regional manager and the senior staff member who had completed the last audit. They confirmed the actions they had taken to date, for example they had set up a supervision plan to support staff following the departure of the previous manager. This showed that the system was being used effectively at this time.

In addition to the provider's monthly audit, there were other audits in place to monitor specific risks in the home. These included environmental checks such as water temperatures, fire call point and emergency lighting tests that were carried out either weekly or monthly by the maintenance staff.

Our judgement
The provider was meeting this standard.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

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.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. 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

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
Copyright	

Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA