Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Orchid Lawns

Steppingley Hospital Grounds, Ampthill Road, Steppingley, MK45 1AB

Tel: 01525713630

Date of Inspection: 23 April 2013

Date of Publication: May 2013

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✔ Met this standard
Safety and suitability of premises	✔ Met this standard
Safety, availability and suitability of equipment	✔ Met this standard
Staffing	✖ Action needed

Details about this location

Registered Provider	Health & Care Services (NW) Limited
Overview of the service	Orchid Lawns is registered with the Care Quality Commission to provide accommodation, treatment and care for up to 24 older people with dementia and needs relating to their mental health.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 23 April 2013, observed how people were being cared for and talked with people who use the service. We talked with staff.

What people told us and what we found

This inspection of Orchid Lawns was carried out in response to information of concern received by the Care Quality Commission (CQC). The information alleged there was insufficient personal protective equipment (PPE) made available to night staff, and that night care routines were not focused on the needs or wishes of people who used the service. This visit took place on the 23 April 2013 at 5am.

On arrival we found there was insufficient staff available to protect the health safety and well being of people at Orchid Lawns, because two of the three staff on duty were asleep.

As part of this inspection we reviewed the care documentation for four people in this home. We found care plans and risk assessments were detailed and kept under review and reflected people's changing needs. We noted people's personal preferences and wishes had been sought and were recorded, however we observed these were not always considered when care was delivered.

We spoke with two people who used the service, and observed staff interactions with people throughout this inspection. We observed staff were respectful and treated people with dignity. One person told us, "I came here not expecting friendship, but it's alright here."

This home provided a safe and secure premises for the people who lived there. The manager told us a refurbishment programme was due to commence, which would replace furniture and fittings which were old or damaged.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 25 May 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People's privacy, dignity and independence were respected; however their personal choices about their care were not always sought.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Prior to this inspection the CQC received information, alleging that night staff were given instructions to get specific people who used the service, up and dressed in the mornings, against their will. They alleged that from 5.30 am people were woken from their sleep to get up. This was done to lighten the workload for the day staff. We conducted this inspection at 5 am so we could observe early morning care practices.

We spoke with the three staff on duty at the time of this visit. All three, individually, gave us a list of the same five people that they got up every morning. This suggested that people were not given a choice on a daily basis. Although two of the three staff told us they did not wake people if they were sleeping, we did not find this to be the case.

At 5.30am as the night staff commenced their 'rounds'; we also visited all 18 occupied bedrooms and found that without exception everyone was sleeping soundly. Despite this, staff proceeded to wake people, and the five individuals that had been identified to us earlier, were dressed by 6.30 am. One person told us they liked to get up early, and staff explained that another was prone to wandering, and therefore being appropriately dressed protected their dignity. However, in two cases the individuals were put back to bed in their day clothes. There was no evidence in care records to indicate that this was the individual's choice, and we could not see any benefit to the individual through this action.

We observed the interactions of staff and people in this home throughout our inspection. We found that most staff were polite and courteous in their approach to people. They treated people in a dignified way, and where possible encouraged independence. Care was carried out in an unhurried way, and most staff demonstrated good interaction skills. However we observed a qualified nurse carrying out a procedure for someone without any communication or explanation of what they were doing.

Although we could see from people's care documentation that their personal preferences

and wishes had been sought and recorded. These were not always taken into consideration when care was delivered, and the practice of offering people choices on an ongoing basis was not consistent.

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Peoples' needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We looked in detail at the care files for four people who lived at Orchid Lawns.

We observed that care plans contained information regarding the level of support people wanted and required. This included information which related to the management of long term conditions, which affected people's mental and physical health as well as their general well being. We noted that care plans were regularly reviewed to ensure peoples' changing needs were managed appropriately.

The care plans provided staff with guidance to follow when giving support and care, and in some cases identified warning signs to help staff recognise early signs of deterioration in people's health. This meant that care was delivered with continuity, and where necessary, intervention or support from specialist health professionals or doctors could be sought to prevent further deterioration.

Peoples' care plans were linked to risk assessments which were also reviewed on a monthly basis. These assessments identified the hazards people who used the service faced, and provided staff with guidance on how to manage and minimise any risk of harm to each individual.

Safety and suitability of premises ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

Reasons for our judgement

We found that these premises provided a secure and spacious environment, which enabled people who used the service, most of whom had dementia, to wander around the home safely. During the previous year a refurbishment programme had included, replacing flooring, furniture and general decoration, to make it more suitable for people in this home.

At our inspection in 2012, a programme to enhance the environment for people had been introduced. This involved introducing personal effects and memorabilia into the home, to promote positive mental stimulation and meaningful engagement for people. The provider might find it useful to note that we found little evidence that this had continued, and observed many of the bedrooms we visited were bare.

There was a member of staff employed to provide ongoing maintenance of the home, and we noted they addressed identified issues swiftly. However, the provider might find it useful to note that where curtains had been pulled down, they had been left in this state. We were told this could not be resolved without specific funding and therefore was not part of the day to day maintenance of the home. We discussed this with the manager who told us the annual refurbishment programme was due to begin. We saw a list of work required, and noted it included replacing some of the furniture and fittings we had identified as worn or in need of repair.

Safety, availability and suitability of equipment ✓ Met this standard

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was meeting this standard.

People were protected from unsafe or unsuitable equipment.

Reasons for our judgement

Prior to our inspection on the 23 April 2013, CQC had received information from a whistle blower. They had alleged there was insufficient PPE made available to night staff. Specific concerns were raised in relation to disposable aprons, gloves and body wipes.

We carried out this inspection at 5 am, which enabled us to see exactly what equipment was available to night staff. We found that at the time of this inspection there were sufficient PPE provisions available. We discussed this matter with the staff on duty and the home manager. We were informed that although only a specific amount of disposable gloves and wipes was made readily available to each shift, the qualified nurse did have access to further stock if it was required. We noted there were ample aprons available.

As part of this inspection we also checked all the hoists and the three assisted bath facilities in this home. We found people were protected from unsafe or unsuitable equipment, because the provider ensured regular service checks by the manufacturers were carried out. We also observed the moving and handling equipment was used safely by staff. However the provider might find it useful to note that there was a deep chip in the enamel on the seat of one of the mechanical baths; this could potentially cause skin damage to anyone sitting on it.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

There was insufficient staff that had been appropriately trained, available at all times, to safeguard the health, safety and welfare of people who used this service.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We found that there was sufficient staff rostered on duty to appropriately care for the 18 people who lived at Orchid Lawns. During the day there were six care staff, including at least one qualified nurse each shift. They were supported by the home manager, domestic, kitchen and administration staff.

During the night, three staff, including one qualified nurse, were rostered on duty. However when we arrived at 5 am to conduct this inspection on 23 April 2013, we found the qualified nurse and one of the care staff were asleep. This meant there was only one care staff awake and alert, to monitor people during this period, and deliver immediate or emergency care to people had it been required.

All of the people who lived at the home, were confused and unable to maintain their own safety, and many had a tendency to wander. Therefore the actions of these staff presented an unnecessary, increased risk to people's safety. We discussed this matter with the home manager, who confirmed all staff on duty should be awake and alert throughout their shift. They told us the staff concerned would be suspended pending further investigation.

The provider had an ongoing e learning programme in place, and staff were responsible for ensuring their own mandatory training was kept up to date. The manager told us they had an overview of this through the provision of training statistics provided electronically from head office. We looked at a report, generated on the day of our inspection, relating to the training progress of the staff at Orchid Lawns. This showed that staff were attending training as required. However we found staff had not all been trained in the use of specific equipment. For example, despite staff stating they assisted people to bathe using specific facilities, only one out of five staff was able to demonstrate, in the presence of the manager, how to safely and efficiently work the two mechanical baths in this home.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: The registered person failed to make suitable arrangements to ensure that where appropriate, service users were involved in making decisions about how their care was delivered. This is a breach of regulation 17(2)(f) of the Health and Social Care Act 2008 (Regulated Activities)Regulations 2010.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: The registered person had failed to ensure, that at all times, there were sufficient staff, appropriately trained to safeguard the health, safety and welfare of people in this home. This is a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities)Regulations 2010.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008

This section is primarily information for the provider

(Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 25 May 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – 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.

Moderate impact – 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.

Major impact – 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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk