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: 13 December 2013

Date of Publication: January 2014

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

Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✖ Action needed
Safety, availability and suitability of equipment	✓ Met this standard
Supporting workers	✖ Action needed
Records	✖ Action needed

Details about this location

Registered Provider	Health & Care Services (NW) Limited
Registered Manager	Mrs. Jacqueline Williams
Overview of the service	Orchid Lawns provides nursing care and support 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 13 December 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information sent to us by commissioners of services and talked with other authorities.

What people told us and what we found

Prior to our inspection the Care Quality Commission received information of concern about the care and welfare of people at Orchid Lawns and the systems in place for the support and treatment of people. It was alleged that some people were not supported to receive effective personal care and that staff did not always undertake manual handling using best practice techniques or appropriate equipment. The allegations stated people were not given sufficient stimulation and were left unattended for periods of time without being given pressure care.

Further allegations included concerns about the accurate completion of care records and the training staff received to enable them to undertake their roles effectively. Whilst we had no information relating to any specific harm caused to people, it was suggested the systems in place and the care provided could pose a risk to people.

People told us they were happy and we observed they were calm and relaxed in the presence of staff. We did however find that the care records were not always reflective of the current care needs.

Although there was manual handling equipment within the home, staff reported there was not sufficient available for the amount of people required to use this. We found out of three bathrooms, only one of the baths was in working order, with parts being required for two of them.

We found staff had received appropriate training but were not always supported with regular supervision or staff meetings.

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 23 January 2014, 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

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Care and treatment was not planned and delivered consistently in a way that was intended to ensure people's safety and welfare.

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

People's care was assessed and planned. However, it was not always delivered appropriately, in a way as to meet their individual needs and ensure that care and welfare was promoted. We looked at the care records for seven people who received care at Orchid Lawns. People did not always experience the support they needed from staff to meet their needs. This was because there was a lack of detailed information relating to some areas of their care and treatment.

We saw that people's care needs had been assessed, and care plans and some risk assessments were in place. We found that some of the care plans had been signed by people's representatives who received care, an indication that they had been involved in the planning of their care. However, the provider might like to note that care plans were not consistently signed by the person or their representative. This meant that not all people had been involved in planning required care.

We noted some of the care plans had been recently reviewed. The manager told us that all care plans were reviewed yearly or when people's needs changed. However, this practice was not consistent. For example, in one person's records we found a care needs assessment had not been updated for three months. When we spoke with staff, two of them gave this person's care management as an example of how people's changing care needs were not being addressed. They told us they had brought this to the attention of the nursing staff, but no prompt action had been taken to reassess the person's needs and put appropriate care plans in place. This meant that without appropriate care plans, there was a risk people would receive inappropriate or unsafe care.

When we discussed this with management, we were informed that work would continue on improving the content of care files to ensure they were more personalised and that

appropriate strategies were incorporated to provide guidance for staff to support people.

In the seven care plans we examined we found inconsistent information. For example, in one file it was recorded that the individual was at risk of falls but the risk assessment contained no action to prevent a fall. For another person, the care plan stated they could be challenging in their behaviour. However, there was no specific behavioural management plan in place for this person. For other people who experienced episodes of unsettled behaviour, we found little guidance within the care plans in respect of appropriate strategies or distraction techniques that could be used by staff to reduce such behaviour. This meant the service was failing to provide staff with clear guidance on the safe and consistent management of these behaviours.

We reviewed the daily records for 20 people who used the service. We were told that these were completed on a shift by shift basis by care staff and included information on the personal care that had been given, and pressure care charts for some people. We found that for one person on two occasions the daily report had not been dated. We also saw gaps in people's monthly weight records. Although we found that people were being monitored on a daily basis for their food and fluid intake, the irregular monitoring of their weight could place people at further risk of poor nutrition and hydration.

Visual observations of people showed that most were clean and well dressed. One person we spoke with had stains on their clothes. Another person we observed had their underwear exposed. This meant that people's dignity and privacy was not always respected.

During our observations, we saw three examples of poor manual handling. In one case, two staff were assisting someone to walk by holding their arms and pulling them, rather than guiding them. The other incident we observed was of a similar nature and meant that staff were not always using safe methods of care for people. We were aware that there was a manual handling belt available to use, as we had seen this within the store cupboard. Therefore, although appropriate equipment was available for use, not all staff followed the appropriate manual handling procedures. Although the people involved in these incidents did not appear distressed, these moving and handling practices did not promote peoples' safety and put staff and people at risk.

We observed peoples' needs were not consistently met. For example people were not offered the opportunity to go to the toilet and were left sitting in the lounge areas with nothing to occupy their time except listen to the radio. In one lounge area, the music was not age appropriate for the people who lived at Orchid Lawns.

We did not see any meaningful activities being offered to people during this inspection. The registered manager told us that the activity coordinator was on leave on the day of our visit. When asked if staff would provide activities for people, we were told that this was dependent upon the time they had. We found that the staff were too busy attending to people and their care needs to be able to undertake activities and provide effective stimulation for people on the day of our visit. Staff we spoke to told us they felt they did not do their best for people as they did not have enough time. One said, "We often stay behind at the end of a shift to complete records."

We spoke with one relative who told us," We are extremely happy with the care, we have no complaints ….has been here for two years and the staff are all caring and understanding. A visiting professional said about the home," On the whole they try to

promote a family atmosphere." These comments and our observations confirmed the inconsistencies within the care provided to people and demonstrated that people did not always receive effective care.

Safeguarding people who use services from abuse ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People who use the service were not protected from the risk of abuse, because the provider had not always taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

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

During our inspection, we reviewed the processes in place for identifying and protecting people from the risk of abuse and harm. We reviewed the provider's Safeguarding of Vulnerable Adults (SOVA) records. We found that although the provider had a system in place to ensure that people who used the service were protected from the risk of abuse, this was not consistently used.

We received information that some safeguarding investigations were taking place and we reviewed the supporting documentation in relation to these. Some of the incidents had not been raised as a concern by the provider but by other agencies, although we were made aware that the provider was working in conjunction with these agencies in addressing these matters.

During this inspection, we spoke with three members of staff that were on duty. They knew there was a safeguarding policy and protocols that they should follow, and were able to identify where the information was kept. We reviewed this policy and found that it was reflective of changes in legislation and best practice, for example the Mental Capacity Act 2005. Staff were familiar with the whistleblowing procedure and named the Care Quality Commission as one of the organisations they could report any concerns to. This meant that staff had appropriate guidance to refer to when required in respect of people's safeguarding.

Staff were able to demonstrate a basic understanding of safeguarding processes which they demonstrated by telling us what sort of incidents or concerns they would report. They were aware that they should raise concerns to the registered manager or nurse in charge in the first instance, but some were unsure what action they would take in their absence. This meant that there was a risk that people may not be effectively safeguarded when the registered manager was not on site.

Whilst people who lived at the home had expressed they felt safe, the lack of staff

knowledge and awareness about procedures for safeguarding vulnerable people could mean people may be at risk of harm or abuse. We looked at the available daily care records for people living in the home and found that some people had been 'found on the floor' following unobserved falls, some of whom had sustained injuries. Staff did not consider this to be a cause for concern or a risk of abuse through neglect or omissions in care. We were shown a number of completed accident forms, but through discussions with identified that no review of these records had been made. This meant that no processes were in place to address the identified issues.

Staff had been unaware of these errors through a lack of monitoring processes in place. When the local authority spoke with them, they did not know these constituted a safeguarding concern which should have been reported. The local authority made the safeguarding alerts themselves. Evidence was found of recurrent falls, potentially putting people at risk of being inadequately cared for. The provider was therefore not able to demonstrate that they were responding appropriately to all allegations of abuse.

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

During this inspection we found that the equipment in place safe and suitable to ensure that people's needs were met safely and effectively. We observed that staff recognised where equipment was unsuitable or unsafe and did not proceed to use it, so that people's health, safety and wellbeing was not compromised. We were told that people had their own individual slings and found that these were clearly labelled.

We found that wheelchairs had footplates and that brakes on wheelchairs worked effectively. We were concerned that out of the three bathrooms, only two baths were in working order following a recent maintenance check. We spoke to the registered manager about this and were told that the parts were on order and that timely action would be taken to address this issue. We asked to be kept informed about this because this left only one working bathroom for 21 people until the repairs had taken place.

We also found that the home only had access to one full body hoist and one standing hoist. Staff told us that this was not always sufficient to meet the needs of the people who lived at Orchid Lawns and gave the example of an incident whereby one person had fallen and required the hoist to be helped up safely. As the full body hoist was in use, the person who had fallen was required to wait before they could be supported to get up. This meant that the person was not afforded assistance in a timely manner because of the lack of appropriate equipment in place. The provider might like to note that staff felt the home would benefit from the addition of an extra hoist so that people were not affected when other equipment was in use.

Supporting workers ✖ Action needed

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was not meeting this standard.

People were not consistently cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

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

During our visit to Orchid Lawns, we looked at how staff were trained and supported, so that they could provide safe care that met people's assessed needs. We spoke with three of the staff on duty and they told us the training they had received prepared them for their role, but did not always enable them to appropriately meet the needs of the people using the service. This was because much of the training was in the form of e-learning, which was not always beneficial as some topics were better taught on a face to face basis.

We viewed a current training plan which clearly indicated the training that staff, had received and the training that was due within the next month. We saw that most staff had received recent training in core subjects such as safeguarding, infection prevention and control, manual handling, medication and first aid. Those that had not were scheduled to receive this in the near future. This meant that people were cared for and supported by appropriately trained staff.

The staff we spoke with told us that important information was not always shared between all staff within the home as part of general communication during each shift. We were told that no formal staff meetings had taken place recently. Staff felt this was an issue because they felt that communication between the team was not always consistent. We were told that the manager had been away at another home for a few weeks and that it had not always been possible to receive support when required.

Some staff told us they felt unsupported and that when they told a more senior person about their issues, no action seemed to have been taken. On the day of our inspection, one person told us they had resigned, as they felt they could not deliver effective care to people anymore. Another member of staff said they had reduced their working hours as they were tired of working with a lack of support. This meant that some staff did not feel supported to deliver effective and appropriate care to people.

Staff confirmed that although there was a supervision process, some had not received regular and formal recorded supervision for some months. This meant that it was not

consistently possible to monitor their performance and consider developmental needs. We were told by staff that informal guidance was sometimes given when required although this was dependent upon which staff were on duty. We reviewed staff supervision schedules which showed that some staff had not received formal supervision for some time. The provider policy stated that supervision should take place six times per year and this was confirmed by the registered manager. We saw that some staff had only received three supervision sessions within the year. This was a concern, particularly as staff had told us they did not always feel supported.

Without regular supervision there was a risk that people who lived at Orchid Lawns may not be cared for by staff safely and appropriately. It may also mean that staff performance issues or concerns were not addressed in a timely manner.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not always protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not consistently maintained.

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

We saw that care plans and risk assessments were not always updated regularly. For example, one pressure care record we reviewed did not have an updated Waterlow (skin assessment) score or falls risk assessment in place. We found that the last time the record had been reviewed was in October 2013. This meant that although staff had been providing ongoing care, there was not the appropriate documentation to support this.

We reviewed two further files where the pressure area charts had not been updated since October 2013. In one file, we noted that the daily progress notes were not up to date. In another file, one person had experienced three falls and we found that the notes were poorly recorded and not reflective of the care required. The care records did not consistently provide staff guidance as to what intervention they should take in the event of deterioration.

Although people whose care plans and risk assessments were not up to date had appropriate pressure relieving equipment in place, the gaps in records meant that there was a risk that people may not have received safe or appropriate care.

We also found that some daily records were kept on view, in the communal lounge area, We were told that this made it easier for care staff to make entries within the notes. It also meant that the people who lived at Orchid Lawns could not be confident their personal records were properly managed because the service did not have clear procedures for storing and maintaining the care records for each person who used the service.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The provider did not consistently take appropriate steps to ensure that each service user was protected against the risks of receiving care that was inappropriate or unsafe by not consistently planning and delivering care in such a way as to meet the service user's individual needs or to ensure their welfare and safety. This is a breach of regulation 9 (1)(b)(i)(ii).
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: The registered person had failed to make suitable arrangements to ensure that service users were safeguarded against any risk of abuse by means of ;(a) taking reasonable steps to identify the possibility of abuse and prevent it before it occurs. This is a breach of regulation 11 (1) (a)

This section is primarily information for the provider

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: The provider did not always have suitable arrangements in place to ensure that staff were appropriately supported to enable them to deliver care safely and to an appropriate standard, by receiving appropriate training and regular supervision. This is a breach of regulation 23 (1) (a)

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: The registered person has not consistently ensured that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of- (a) an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided. This is a breach of regulation 20 (1) (a)

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 by 23 January 2014.

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 other services less often. 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.

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. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). 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

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