Prasur Investments Limited

Sandrock Nursing Home

Inspection report

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08 January 2022
10 January 2022

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Sandrock Nursing Home provides accommodation for up to 28 people who need help with nursing or personal care. At the time of the inspection 22 people lived in the home. Some of the people living in the home, lived with dementia.

People's experience of using this service
At the last inspection, we identified serious concerns with the management of risk, care planning, the delivery of care, medicines, infection control, staff recruitment and training, the implementation of the Mental Capacity Act, record keeping, leadership and governance. At this inspection we found the same.

Information relating to people's needs and risks remained insufficient and unclear. This meant staff lacked adequate guidance on how to provide safe and appropriate care. Records relating to the care people received were not always accurate and did not show that people received the support they needed to mitigate risks or keep them safe and well.

Medication management was unsafe and placed people at risk of significant harm. Basic good practice guidance was not being followed. People did not always receive the medicines they needed. Medicines could not always be accounted for, and were not always given safely. Safeguards in respect of controlled drugs were not adhered to.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the systems and practices employed in the service did not support this practice.

The recruitment and selection of staff was not robust and there still remained staff who had not completed the provider's mandatory training modules or whose training had not been refreshed appropriately.

On the day of inspection, there appeared to be enough staff on duty. However, staffing levels were not consistent and the provider failed to have a system in place to determine what staffing levels should be, based on people's needs.

There were some improvements with infection control and COVID-19 management, but these improvements were insufficient to ensure risks were adequately mitigated in the day to day delivery of the service.

Accident and incidents and safeguarding events were recorded. However, some of these incidents had not been properly investigated by the manager or reported to CQC as required.

The systems in place to monitor quality and safety were ineffective. The management of the service remained ad hoc, with no adequate oversight of care delivery. This is the fourth time, the service has been

rated inadequate. The provider and manager lack an understanding of their regulatory requirements and how to provide people with safe and appropriate care.

Staff were observed to be kind and caring, and people told us they felt safe. People and the relatives, we spoke with were positive about the service and had no complaints.

Rating at last inspection
The last rating for this service was inadequate (published 18 June 2020).

Why we inspected
At the last inspection, the provider was found to be in breach of regulations 11 (Need for Consent), 12 (Safe Care and Treatment), 17 (Good Governance), 18 (staffing) and regulation 19 (Fit and proper persons) were found.

We undertook this inspection to follow up on the action we had previously told the provider to take and to check whether the provider was now compliant with the health and social care regulations in the domains of Safe, Effective and Well-led.

During this inspection, we looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

At this inspection, we found that the provider and manager had failed to make sufficient improvements. This meant the service remained in continued breach of regulations 11, 12, 17, 18 and 19. The overall rating for the service has therefore not changed and remains inadequate. This is based on the findings at this inspection.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

At this inspection, we found continued breaches of regulations 11 (Need for Consent), 12 (Safe care and treatment), 17 (Good governance) 18 (Staffing) and 19 (Fit and Proper Persons). Enforcement action was commenced by CQC following the previous inspection in April 2021 and is still in progress.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will work with the local authority to monitor progress. If we receive any concerning information, we may return to re-inspect whilst CQC enforcement action is in progress.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures

At this inspection, the provider had not made enough improvement to meet regulatory requirements. At the time of this inspection, enforcement action is still in progress.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Details are in our Safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our Effective findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our Well Led findings below.

Sandrock Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this focused inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act under the domains of safe and well-led, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was undertaken by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Service and service type
Sandrock Nursing Home is a care home. People in care homes receive accommodation with nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. Inspectors were on site on the 16 and 20 December 2021 with the remainder of the inspection completed remotely.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used all this information to plan our inspection. The provider was not asked to complete a provider information return

prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with the manager, the associate manager, two nurses, a care assistant and an administration assistant. We reviewed a range of records. This included four people's care records, a sample of medication records, four staff recruitment files and records relating to the management of the service.

We also spoke with two people using the service and three relatives, by telephone, to seek feedback about their experiences of the care provided.

After the inspection visit
Due to the impact of the COVID-19 pandemic we limited the time we spent on site. Therefore, we requested records and documentation to be sent to us and reviewed these following the inspection visit remotely. We continued to seek clarification from the manager and provider to validate evidence.

We referred five people to the local authority safeguarding team during the inspection as we had concerns about their safety.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection, this key question was rated as inadequate. At this inspection, this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At the last inspection, the management of medication was unsafe. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, minimal improvements had been made and the provider remained in breach of regulation 12

• Some people did not always receive the medicines they needed either, because there was no stock of the medicine in the home or nursing staff were unaware people had been prescribed certain medicines, For example, one person's end of life medicines could not be given at the right time as there was no stock available. Another person's cream for a fungal infection had not been applied for three days because nursing staff did not know they had been prescribed it.
• Some people were not given their medicines in accordance with the prescriber's instructions. For example, one person was only given half the prescribed dose of antibiotic on three occasions which meant their infection was not treated properly.
• Some people were at risk of being given doses of their medicines too close together or at the wrong time because there were limited systems in place to ensure medicines were given safely. For example, the time that one person's strong painkilling medication was administered, was not recorded. This meant it was impossible to tell if the required four hourly time gap between doses had been observed to prevent the person receiving too much medication at any one time.
•Medicines could not always be accounted for because medication records were inaccurate or not in place at all. Nursing staff failed to consistently record if people were allergic to medicines which placed them at risk of being given a medicine they were allergic to.
•Guidance for medicines to be given 'as and when required' such as painkillers were not always sufficiently detailed to ensure they were given safely, or the guidance was missing.
•People with swallowing difficulties did not have checks in place to make sure their medicines were in a suitable formulation for example, liquid format to mitigate the risk of choking.
•The manager and the nursing team did not demonstrate that they were competent in the management of medicines including the administration of end of life medication via a syringe driver.

The management of medication remained unsafe. This was a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection, the provider failed to ensure that people's risks were properly assessed, monitored and managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, improvements had not been made and the provider remained in breach of regulation 12

● Adequate and accurate information on people's needs, risks and care was still not available for staff to follow in the delivery of care. This placed people at significant risk of inappropriate and unsafe care. For example, one person's moving and handling assessment indicated they were immobile, unable to weight bear and required the use of the hoist for personal care. Whilst the same person's mobility plan indicated they had limited mobility, could weight bear and use a stand hoist for manoeuvres.
● Records in relation to people's care were poorly maintained and did not show people received the care they needed. People's care was also not properly monitored by nursing staff or the manager to ensure people were cared for appropriately. These concerns were raised with the provider and manager at the last inspection but little effective action had been taken. For example, one person's diet and fluid records indicated that on some days they did not drink enough to prevent dehydration. This person's daily recommended intake was 1500mls per day, on some days records showed they had only drank 200mls of fluids in 24 hours.
● Wound assessment and management by nursing staff was inadequate and did not adhere to required nursing standards. Wounds were not properly monitored or cared for which placed people at increased risk of infection such as Sepsis. For example, one person had pressure sores in place that required special dressings to be applied. Their care plan stated these dressings were to be changed every other day. Records showed that dressings were not changed at this frequency. Tissue Viability advice on how to record and monitor these wounds had also not been followed
●We had serious concerns about the safety of the people whose care records we looked at. We made referrals to the Local Authority Safeguarding Team immediately following the inspection to protect them from avoidable harm.
● Accidents and incidents were not always been properly investigated or reviewed by the manager to identify how they occurred so that staff could learn from and prevent them happening again. For example, one person's physical safety was compromised as staff had not followed the person's care plan in relation to their mobility requirements. This incident had not been properly investigated to mitigate the risk of this type of incident happening again.

People's risks were not adequately assessed, monitored and managed to prevent avoidable harm. This was a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●We saw that accidents and incidents were recorded, with appropriate action taken to seek medical attention when required.

Preventing and controlling infection

At the last inspection, Infection control did not adhere to government guidelines to protect people from the risk of, or, spread of infection. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, some improvements had been made but they were insufficient, and the provider remained in breach of regulation 12.

● The provider was still not adhering in full to the best practice guidance issued by the government in respect of COVID-19. For example, government guidelines state people living in a care home should have a COVID-19 PCR test every 28 days; have their temperature checked twice a day and have their individual risks of COVID-19 assessed and mitigated. This guidance was not being followed.
●The risks posed to individual staff members had not been assessed and managed in order to protect them from preventable harm or, to mitigate the risk of service disruption.
●Improvements to the management of staff testing had been made, but records showed gaps in the testing of some staff members, which meant that not all staff were adhering to government guidelines.
●No evidence of the cleaning of frequently touched surfaces or shared equipment were provided to show that risks in relation to cross contamination were effectively managed. Deep cleaning records pertaining to people's bedrooms were available but did not show that all bedrooms were deep cleaned.

Infection control did not adhere to government guidelines to protect people from the risk of, or, spread of infection. This was a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Improvements to the safety of visiting had been made which complied with government guidelines. Some of the provider's infection control policies and procedures had also been updated with more information about COVID-19 and its management.

Staffing and recruitment

At the last inspection, the provider's recruitment procedures were not robust. This was a breach of Regulation 19 (Fit and Proper Persons) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, improvements had not been made and the provider remained in breach of regulation 19

● Records relating to the recruitment of staff did not show that a stringent recruitment and selection process was followed. Only one out of the three files looked at where two previous employer references were required, had them in place, to demonstrate that the staff member had satisfactory conduct and experience.
● Some staff references were not properly verified or objective. For instance, one staff member's previous employer reference was sent from a personal email address. The person's position and authority to provide this reference had not been checked.
● Two staff members had references from staff already employed in the home. This did not show an objective recruitment process was in place. In one instance, the manager was acting as both the recruiter (the interviewer) and as a named referee on the person's application form, raising concerns over potential bias. This was not good practice.
● One staff member was working in a much more senior position than the position they applied for, with no specific job description or contract of employment in place. Two other staff did not have contracts of employment in place either.

The provider's recruitment procedures were not robust or objective to enable them to be assured only safe and proper persons were employed. This was a continued breach of Regulation 19 (Fit and proper persons) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● The majority of safeguarding events had been reported accordingly. One person however, had alleged another person had pushed them over, causing them injury. The manager had not investigated this allegation or referred them to the local authority safeguarding team or CQC. We spoke with the manager about this and asked them to investigate this incident.

● The people and relatives we spoke with felt they were safe living in the home. Their comments included, "It is a lovely place to be, and the staff are perfect." and "Staff treat [Name of person] really well".

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated inadequate. At this inspection, this key question has remained the same. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

At the last inspection, people's needs were not adequately assessed, monitored and managed to ensure the care provided was effective. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, improvements had not been made and the provider remained in breach of regulation 12

● Information about people's needs and risks was not sufficient to ensure care was delivered effectively. For example, one person's care plan did not accurately describe the pressure sores they had and had not been updated with professional advice provided by the Tissue Viability Service on how to mitigate further risk of skin breakdown.
● The delivery of care did not follow best practice guidance or professional guidance given in respect of people's individual needs. For example, pressure sore prevention, wound management and nutritional care.

● Care was not properly monitored to ensure it was effective. There was little evidence of any clinical or managerial oversight of the quality of the care people received. For example, there was no oversight of people's dietary and fluid intake to ensure people were eating and drinking enough. People's repositioning support had also not been provided consistently or at recommended intervals.

People's needs were not properly considered, monitored or managed in the delivery of care to ensure the care provided was effective. This was a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

At the last inspection, people's nutrition and hydration needs and risks were not safely met or monitored. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, improvements had not been made and the provider remained in breach of regulation 12

● People's nutrition and hydration needs were assessed but their dietary intake was not consistently or adequately monitored to ensure they were eating and drink enough to maintain their health.
● People's special dietary requirements were not always adhered to. One person with swallowing difficulties required their drinks to be thickened with a special medicine to prevent them from choking. Guidance for staff to follow in relation to this was unclear, and records showed that staff did not always thicken the person's drinks to the right consistency. This increased their risk of choking or aspiration pneumonia.

People's nutrition and hydration needs, and risks were not safely met or monitored to prevent avoidable harm. This was a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At the last inspection, People's legal right to consent to their care were not always protected in accordance with the Mental Capacity Act 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection improvements had not been made and the provider remained in breach of regulation 11

● Where there were concerns about a person's capacity to consent to a particular decision or to understand the risks of refusing consent, the MCA was not always followed.
● One person was being deprived of a personal possession, despite them having capacity to make their own decisions. When asked, the manager could offer no satisfactory explanation as to why this practice was in the person's best interests. We had discussed this practice with the manager at the last inspection, yet this poor practice was still being allowed. We observed the person was distressed by this practice at both inspections.
● Generic statements about people's capacity to make decisions were still being made. Where MCA assessments had been done, they lacked adequate detail of how the assessment had been conducted and the best interest process. Some assessments were also generic, 'catch all' assessments for decisions relating to people's care and treatment. This was not in accordance with the MCA.

People's legal right to consent to their care were not always protected in accordance with the Mental Capacity Act 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At the last inspection, staff training was not always sufficient or up to date to ensure staff had the skills and knowledge to provide effective care. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, not enough improvement had been made and the provider was still in breach of regulation 18.

● Staff training was still not up to date. Whilst some improvements had been made, 65% of staff had still not completed all of the provider's mandatory training or refreshed their training in accordance with the provider's timescales.
● There was no evidence that staff had received an annual appraisal of their skills and abilities.
● Staff had received supervision from a newly appointed manager within the organisation. This person was still in their probationary period. They had not completed any of the provider's mandatory training and had not received supervision themselves from either the registered manager or the provider since they commenced in employment
● The provider and manager had not ensured there was a system in place to determine what safe staffing levels were. Rota's showed that two or three days a week, the number of staff on duty was lower than other days with the same number of people to care for. This did not make sense. It was impossible to tell if staffing levels remained safe at these lower levels without a system in place to show what safe staffing levels should be.

The system and practice of staff training and support was not robust. There was also no system in place to determine safe staffing levels. This was a continued breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On the day we visited, there were enough staff on duty to meet people's needs. People's relatives told us they felt there were enough staff on duty, when they had visited.

Adapting service, design, decoration to meet people's needs
● The communal lounge in the home was a busy area and had not been set up to accommodate social distancing in all areas. We drew this to the manager's attention at the last inspection but no changes to the environment had been made.
● The home was adequately maintained, and people's bedrooms were decorated according to their preferences.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

At the last inspection this key question was rated inadequate. At this inspection, this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At the last inspection, the governance arrangements in place were not robust, managerial oversight was poor and record keeping poorly maintained. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, improvements had not been made and the provider remained in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- This is the fourth time the service has received a rating of inadequate since 2017.
- During the inspection, the registered manager failed to demonstrate that they understood the health and social care regulations or recognised best practice guidance in the provision of nursing and personal care.
- The were a range of audits in checks in place, for example, care plan audits and medication audits, but these were ineffective in driving up improvements and managerial oversight of the day to day delivery of care was inadequate. The regulations breached at the last inspection, had not been addressed and the service remained in breach.
- Staff recruitment and staff support was not properly facilitated to ensure that only suitable staff with the skills and experience to provide good care were employed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;

- Record keeping in respect of the service, people's needs and the care they required was very poor. It was not contemporaneous or accurate. The records that were in place showed that people did not receive the care and support they needed, to achieve good outcomes. For example, records in relation to people's care did not give sufficient detail of the care people received, showed gaps in the care provided and were not always completed at the time, people's care had been provided.
- There was little evidence that the manager or provider systematically reviewed the support people received or took appropriate action when people's care did not meet the standards required. For example, there were significant gaps in the repositioning support given to one person which should have been provided at two hourly intervals. This did not show the culture of the service promoted good outcomes for people.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

● Some but not all notifiable incidents had been reported to CQC in accordance with the regulations.
● There was little evidence that the manager and provider had taken robust action to ensure people's care and the service had improved since the last inspection. This did not show a culture of continuous learning and improvement.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Some people received support from other health and social care professionals such as the district nurse teams, local GP and mental health services, as required. However, other people's necessary health checks had not always taken place. For example, some people's critical diabetic checks.

The governance arrangements in place were not robust. Managerial oversight remained poor and record keeping was inadequate. This was a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives told us that staff at the home kept them up to date on their loved one's well-being and engaged with them well.
● People and relatives said the manager was approachable and listened if they had any concerns. All of the people and relatives we spoke with were positive about the home.