Prasur Investments Limited

Sandrock Nursing Home

Inspection report

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Date of inspection visit:
28 April 2021
30 April 2021
05 May 2021
13 May 2021

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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 27 people lived in the home. Some of the people living in the home, lived with dementia.

People's experience of using this service
At this 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 and leadership and governance.

Staff did not always have sufficient or accurate information about people's needs and lacked guidance on how to provide safe and appropriate care. Medication management was unsafe and placed people at risk of avoidable harm.

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 policies and systems in the service did not support this practice.

There was little evidence to show that infection control protocols were in line with government guidance or that they were followed to protect people and staff from the risk of infections such as COVID-19.

We found that staff members were not always recruited safely. Some staff training was out of date and some staff had not completed the provider's mandatory training modules. This meant there was a risk that some staff did not have the up to date knowledge and skills to provide safe and appropriate care.

Record keeping in relation to people's care and the management of the service were poor. It was difficult to see what support people needed and what support they received. We found that some people did not receive the right diet or fluids to mitigate risks to their health and wellbeing. Some people's clinical needs were not properly monitored to keep them safe and where professional advice had been given, this had not always been followed.

Accident and incidents and safeguarding events were recorded. However, some of these incidents required notification to CQC in accordance with the regulations but had not been reported appropriately.

The systems in place to monitor quality and safety were ineffective. The management of the service was ad hoc, with no adequate oversight of care delivery. The manager did not demonstrate they understood the requirements of the health and social care regulations in respect of providing safe and appropriate care.

This is the third time, since 2017 that the service has been rated inadequate since 2017 and despite

improvements being made at the last inspection, these have not been sustained. It was clear that both the provider and manager lacked an understanding of regulatory requirements and how to ensure people received safe and appropriate care. This placed people at significant risk of avoidable harm.

There were enough staff on duty to support people. Staff were observed to be kind and caring and people told us they felt safe. People and relatives we spoke with were positive about the service.

Rating at last inspection
The last rating for this service was good (published 25 April 2019).

Why we inspected
This focused inspection followed a CQC infection control visit that raised serious concerns about infection control and the management and governance of the service overall. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We looked again at infection prevention and control measures under the Safe key question. We saw that the manager had put an action plan in place following CQC infection control visit to drive up improvements in this area.

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.

The overall rating for the service has changed from good to 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.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our Effective findings below.	**Inadequate**
Is the service well-led? The service was not well led. Details are in our Well Led findings below.	**Inadequate**

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
We conducted an infection control inspection on the 28 April 2021 and completed this on the 30 April 2021. We announced this inspection from the car park on the day of the inspection.

Due to the concerns found at this inspection, we advised the manager we would be returning to the service the following week but did not provide a specific date for the inspection. We returned to the service on the

05 May 2021 for the purposes of conducting a focused inspection.

What we did before the inspection
We reviewed information we had received about the service since the last 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. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We spoke with the manager, the nurse on duty, a care assistant, a domestic member of staff and the cook. We reviewed a range of records. This included five people's care records, a sample of medication records, three staff recruitment files and records relating to the management of the service.

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. We contacted people using the service and their relatives by telephone to seek feedback about their experiences of the care provided. We continued to seek clarification from the provider to validate evidence. We also liaised with the Local Authority to share information about the service and our inspection. We concluded the inspection on 13 May 2021.

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 good. At this inspection, this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

● Medicines were not always properly labelled to ensure the right person received the right medication. Records about medicines and creams were not always completed properly and did not always show medicines were administered as prescribed.

●The quantity of medication in the home was not always recorded so it was impossible to determine if people had received the medication they needed.

● Medication allergies were not always accurately recorded. This placed people at risk of being given a medication they were allergic to.

● People were at risk of receiving some doses of their medication too close together or, at the wrong times because there were limited systems in place to ensure timeframes were adhered to.

●The guidance for staff to follow when administering 'when required' medicines such as painkillers or creams was not sufficiently detailed to ensure these were administered safely.

● People with swallowing difficulties did not have checks in place to ensure medicines were in a suitable formulation to mitigate the risk of choking.

● Critical information on the administration of diabetic medication was missing, which meant it was difficult to tell if people's diabetes was managed properly.

● Medicines were not always stored safely or at the right temperature. The medication fridge was dirty and needed defrosting. Records detailing the temperature at which medicines were stored were not clear or consistently completed.

●Waste and unwanted medicines were not stored safely in line with current guidance.

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.

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

● Staff did not have adequate information or guidance about people's needs, risks or the care they required in order to ensure their health and safety was maintained. This placed people at significant risk of receiving inappropriate and unsafe care.

● People's care was not properly monitored to ensure their needs were met. It was impossible to tell if people had received the care they needed to keep them safe and well.

● Professional advice in respect of people's risks was not always adhered to. For example, one person required thickening medication to be added to their drinks to prevent them from choking. Staff had not followed this up with the person's GP to ensure they had this medication in stock so that their drinks were thickened accordingly. This person was subject to a CQC safeguarding referral following the inspection.

● People had personal emergency evacuation plans in place to advise staff and emergency personnel how to evacuate them safely in the event of a fire or other emergency. However some plans were not up to date or accurate.

The provider had not ensured people's risks were 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.

● Accidents and incidents were recorded, and we saw that appropriate action had been taken to seek medical attention when required.

Preventing and controlling infection
● Appropriate Infection prevention control policies and procedures (IPC) in respect of COVID-19 were not in place.
● Records in relation to staff and visitor testing and temperature checks had not been properly maintained. This meant it was impossible to tell staff and visitors to the home were appropriately checked for COVID-19 prior to entering the home.
● Personal Protective Equipment was in use but not always worn appropriately. Clinical waste bins for the donning and doffing of PPE was not available in some parts of the home.
● Records relating to the cleaning of the home showed gaps and were disorganised. It was impossible to track what areas had been cleaned appropriately for infection control purposes.

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.

Staffing and recruitment
● Records relating to the recruitment of staff were not properly maintained. The dates of people's employment, interview dates and induction did not always correspond, so it was impossible to tell if a robust recruitment process had been followed.
● Gaps in the employment history of staff members had not been properly explored and some previous employer references had either not been sought appropriately or were received after the staff member commenced in employment. This was not good practice.

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.

● On the day we visited, there were enough staff on duty to meet people's needs.

Systems and processes to safeguard people from the risk of abuse
● The manager logged and reported safeguarding incidents to the Local Authority however they were not always reported to CQC, in accordance with the regulations.
● People and their relative felt they were safe living in the home.

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 good. At this inspection, this key question has deteriorated to inadequate. 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

- People's needs, risks and choices were not always assessed in a timely manner on admission to the home. This meant staff lacked critical information about any new people in their care. This placed them at risk of avoidable harm.
- People's needs and choices about their care were not always reflected in their care plans in accordance with best practice standards. Information was very limited and did not ensure staff delivering care knew how to meet people's needs and choices.
- Care plan reviews failed to adequately review and identify changes in people's needs and care. This resulted in information about some people's needs being out of date and inaccurate.
- People had access to healthcare services when they needed it. However, where professional advice had been given, this had not always been adhered to or followed up appropriately.
- The professional advice of other health and social care professionals was not always properly documented in people's care plans. This increased the risk of professional advice not being followed.

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.

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

- People's nutrition and hydration needs and how they were to be met were not properly assessed or documented.
- People's special dietary requirements were not always adhered to. One person lived with swallowing difficulties. Records showed that staff had given them inappropriate food items to eat which increased their risk of choking or aspiration pneumonia.
- Some people's care plans stated they needed their nutrition and hydration to be monitored to ensure their intake was sufficient. This was not always done appropriately.

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

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.

● Where there were concerns about a person's capacity to consent to a particular decision, the MCA was not always followed. For example, a decision that a person would not receive a specific medical treatment had been made without seeking the person's consent or by ensuring a best interest process was followed.
● Some people had 'do not resuscitate' records in their care file with no evidence that the person had the capacity to consent to this or that it was in their best interests.
● Some people had bed rails in place on their bed. Bed rails are used to prevent people accidentally falling, or slipping, out of bed but require formal consent for use, as they are considered a form or restraint. Despite this, there was no evidence that people's capacity to consent to bed rails had been sought.
● In some cases, statements made in relation to people's capacity were not accurate. Some care plans suggested people's capacity was impaired with no evidence to back this up. Some people's care plans advised staff to assess capacity when there were no concerns over the person's ability to understand and make their own decisions.

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
● New staff had not always completed an induction in accordance with recognised standards for care staff.
● Some staff training was not up to date and new staff had not always completed sufficient training to do their job role effectively.

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 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager had a schedule in place to plan and deliver staff supervision and appraisals.

Adapting service, design, decoration to meet people's needs
● There was only one communal lounge in the home. This was a busy area and it was difficult for people and staff to social distance in accordance with government guidelines. We drew this to the manager's attention.

● The home was adequately maintained. Bedrooms were designed and decorated to meet people's personal taste and preference.
● The provider had set up a separate 'visitor pod' in the garden area to enable visitors to visit their loved ones, without having to enter the home.

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 good. At this inspection, this key question has deteriorated to inadequate. 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.

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

- The provider achieved a good rating at the last inspection in 2019. However, standards of quality and safety had not been, maintained. This is the third time the provider and manager have received a rating of inadequate since 2019
- During the inspection, the manager failed to demonstrate that they understood the health and social care regulations and best practice guidance.
- The governance systems in place were not robust. For example, care plan audits failed to identify that people's needs and risks were not properly assessed or managed. Medication audits failed to identify the serious concerns we found at this inspection.
- Provider and managerial oversight of the service were inadequate. As a result, the provider and manager failed to ensure the service met its regulatory requirements and failed to ensure risks to people's health, safety and welfare were properly mitigated.

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 were not sufficient, contemporaneous or accurate. It was impossible to tell what care people needed or received.
- There was no evidence that the manager or provider reviewed the support people received to ensure they received the care they needed and at the standard required. This increased the risk of people experiencing poor outcomes.

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

- The manager had not always reported notifiable incidents to CQC as required. For example, safeguarding events and accident and incidents had not always been reported.
- There was little evidence that any learning was gained and shared with the staff team from the manager's quality assurance checks or from other aspects of service delivery.

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

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 professional advice in relation to this had not always acted upon.

● 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.