Prasur Investments Limited

Sandrock Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 7 and 15 June 2017 and was unannounced. The service is registered to provide accommodation with nursing care for up to 28 people and 27 people were living there when we visited.

The home had a manager who was registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our last inspection of the service was on 2 August 2016 and we found breaches of Regulations 15 and 17 of the Health and Social Care Act 2008 because the provider had not ensured that the environment was properly renewed and the provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service.

During this inspection we found that some improvements had been made to the décor of the home and to the home's quality assurance processes, however we found breaches of Regulations 9, 11, 12, 13, 17, 18 and 19 of the Health and Social Care Act because: people were not kept safe; people's capacity to consent to their care had not been assessed; safeguarding incidents had not been reported; there was inadequate information to show that staff employed were of good character; not all staff had received training; people's care records were incomplete; and the provider's quality assurance processes had failed to identify and address these issues.

We found that most people did not have access to a nurse call bell either in their bedroom, in toilets or in the lounge. Some people told us they would 'shout' if they wanted to ask for support.

When we opened a fire exit leading into the back garden this did not activate any alarm. The back garden was overgrown and contained rubbish and the gate leading to the road was unsecured. This meant that people who may not be safe to do so could leave the building without staff being aware.

Personal emergency evacuation plans, to show how people should be supported to leave the building in case of emergency, were not fit for purpose, for example they did not specify either the floor of the building or the bedroom number. A significant number of staff had no date recorded for fire safety training.

Care plans did not provide sufficient risk management advice. This led to unsafe moving and handling practices and lack of clarity regarding the use of thickeners in people's drinks. Only six members of staff had attended practical moving and handling training in 2016 and none in 2017.

Accidents and safeguarding incidents had been reported and investigated internally but had not been reported to external bodies.

Personnel files for two new staff did not contain verified references and 17 members of staff had a criminal records disclosure that was more than ten years old. This meant that we could not be sure that all of the staff team were safe to work with vulnerable people.

In general, medication was managed safely, however two people's eye drops had not been dated on opening and another bottle of eye drops was dated February 2017, which meant they were past their expiry time.

We found a lack of information about people's ability to make decisions and people's mental capacity had not been assessed as required by the Mental Capacity Act. The manager was unclear about her responsibility with regard to mental capacity assessments. Consent to care had been obtained from people's relatives who did not have Power of Attorney to give them legal power to do this.

Some staff had completed the home's electronic training programme, but others had very little training recorded. This meant that staff may not know how to provide support to people in a safe manner. We found a similar situation during our last two inspections of the home.

People did not have the mobility equipment they needed nearby and were discouraged from mobilising independently. Several people who could potentially use walking aids needed to rely on carers to support them in moving around. This did not uphold their human rights.

Care plans were not person centred and information given to staff was often generic. Personal care records in people's rooms showed gaps in the care provided.
People we spoke with said they or their relatives/friends felt safe there and all said they thought the home was kept clean. The home looked clean, although some places would be difficult to completely clean owing to wear and tear.

During the inspection we saw that there were enough staff to support people and meet their needs. Everyone we spoke with said there were usually enough staff around but several people said that they felt that staff were very busy.

People we spoke with were very happy with the staff and with the care provided to them. Everyone reported that the staff spoke to them in a courteous way. Everyone was very positive about the attitude and kindness of the staff and considered that staff preserved people's privacy and dignity.

Visitors were welcome at any time. Social activities to provide entertainment or stimulation were planned throughout the week, and trips out took place regularly.

Everybody we spoke to said they or their relatives/friends had plenty to eat and drink and comments about the quality of the food were mostly positive, however most people did not have the opportunity to have their meals at a dining table.

It was evident that people were comfortable speaking to the manager. There was a low staff turnover and staff told us they felt supported in their work. The manager and all of the staff we spoke with were pleasant and helpful.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that

providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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.

Most people did not have access to a staff call bell either in their bedroom, in toilets or in the lounge.

A fire exit leading into the back garden did not activate any alarm which meant that people who may not be safe to do so could leave the premises without staff being aware.

Personal emergency evacuation plans were not fit for purpose. A significant number of staff had no date recorded for fire safety training.

Care plans did not provide sufficient risk management advice. This led to unsafe moving and handling practices and lack of clarity regarding the use of thickeners in people's drinks.

Personnel files for two new staff did not contain verified references and 17 members of staff had a criminal records disclosure that was more than ten years old and therefore out of date.

Is the service effective?

Inadequate

The service was not effective.

We found a lack of information about people's ability to make decisions. The manager was unclear about her responsibility with regard to mental capacity assessments. This meant people's consent was not obtained in accordance with the Mental Capacity Act and Deprivation of Liberty Safeguards legislation.

Consent to care had been obtained from people's relatives who did not have Power of Attorney to give them legal power to do this.

Some staff had completed the home's training programme, but others had very little training recorded.

Everybody we spoke to said they or their relatives/friends had

plenty to eat and drink and comments about the quality of the food were mostly positive.

Is the service caring?

Requires Improvement

The service was not entirely caring.

People we spoke with were very happy with the staff and with the care provided to them.

Everyone reported that the staff spoke to them and behaved towards them in a courteous way and considered that the staff preserved people's privacy and dignity.

People did not have the mobility equipment they need nearby and were discouraged from mobilising independently.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not person centred and information given to staff was often generic.

Personal care records in people's rooms showed gaps in the care provided.

Social activities to provide entertainment or stimulation were planned throughout the week and trips out took place regularly.

Is the service well-led?

Inadequate

The service was not well led.

Accidents and safeguarding incidents had been reported and investigated internally but had not been reported to external bodies,

There was a programme of quality audits, however these had not identified the issues we found during the inspection.

The home had a manager who was registered with CQC and people were comfortable speaking to the manager.

There was a low staff turnover and staff told us they felt supported in their work.

Sandrock Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 7 and 15 June 2017 and was unannounced. The first day was carried out by two adult social care 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 care service. On the second day, the lead inspector returned to the service.

Before the inspection we looked at all of the information that CQC had received about, and from, the service since the last inspection in August 2016. We asked the local authority about their quality monitoring visits to the home.

During the inspection we looked at all parts of the premises including some bedrooms. We spoke with the provider, six members of staff, six people who lived at the home, four relatives, and a visiting professional. We observed staff providing support for people in the lounge.

We looked at medication storage and records. We looked at staff rotas, training and supervision records, and recruitment records. We looked at maintenance records and care records for five people who lived at the home and records of audits that the manager had carried out.

Inadequate

Is the service safe?

Our findings

Everyone we spoke with said they felt the home was a safe place. They told us "The people and the place itself help me to feel safe. I can speak to the staff."; "Oh yes I feel safe, no problem. There are little incidents sometimes but they are always dealt with. I can talk to the staff no problem." and "Yes I do feel safe and if ever I'm frightened, the staff help me."

During our last inspection we had some concerns regarding fire precautions in the building and we referred these concerns to the fire service. Following a fire safety visit, work had been carried out, for example emergency lighting had been fitted to the external fire escape route and a new door fitted to the boiler room.

The fire officer also required that regular refresher training must be given to members of staff, including practical training. The training record provided by the manager showed that 15 staff had no date recorded for fire training. A fire drill had been held on 9 September attended by 11 members of staff and another fire drill had been held on 6 April 2017 attended by 13 members of staff. This meant that not all staff would be aware of the action to take in case of fire and that the fire officer's advice in relation to staff training had not been followed.

We asked about personal emergency evacuation plans (PEEPs) that are required to ensure that people can be supported to leave the building safely in an emergency. The manager gave us a 'grab bag' that contained PEEPs. These were not fit for purpose. They did not identify the person's room number or even which floor of the home their room was on and did not identify which people were high, medium or low risk in terms of their mobility. This meant that the information needed was not available for emergency services.

When we opened a fire exit door leading into the back garden this did not activate any alarm. The back garden was overgrown and contained rubbish and the gate leading to the road was unsecured. This meant that people who may not be safe to do so could leave the premises without staff being alerted.

We noticed trailing wires in some bedrooms and in the lounge there was a wooden ledge across middle of the floor which could present a trip hazard as it was not clearly marked. It could also make mobilising with a mobility aid difficult.

We noticed that most people did not have a call bell to use when they needed assistance. A list in the lounge identified only nine people with access to a call bell. On the morning of our inspection, approximately five people were in bed with no ability to call for help and there were also no call bells in the toilets. The manager explained that call bells were remote (portable boxes) and they had enough call bell remotes for everyone to have one, but the majority of people were unable to use them.

There were no risk assessments in any of the care files we looked at to show how people's ability to use the call bell remote had been assessed, and no risk assessments relating to managing the risk of people not being able to summon staff. Both the manager and a nurse who we spoke with said that staff checked

people every two hours, but the care charts in people's bedrooms did not always reflect this.

We asked one person, who was in their bedroom on the top floor, how they called for staff help and they replied "Don't know". In one person's room, there was a call bell cord but this was beyond the person's reach. The person said they would 'shout' if they needed anything. This person's room was on the first floor and had the door closed throughout the day. In the lounge, people also said they would 'shout' if they wanted to ask for support.

There was only one call bell display, which was in the lounge on the ground floor. This meant that staff working on first or second floors would not be alerted that someone required attention. The manager told us that the lounge was always staffed 24 hours a day.

We noticed walking aids in people's bedrooms when the people were in the lounge. The manager told us that walking aids were 'not encouraged' as she preferred people to walk with a member of staff and felt this was safer. We saw no mobility equipment in the lounge, however two people appeared to be trying to use portable tables to walk with and one of these people had a wound on their forehead that we were told was as a result of a fall.

Information received from the manager was that six members of staff had attended practical moving and handling training in 2016 and none in 2017. This meant most of the staff team had not had recent training to ensure they knew how to support people safely with mobility.

We spoke with the manager about how risks to people's safety and well-being were identified and managed. Risk assessments relating to nutrition, pressure areas, moving and handling, and falls were recorded in people's care plans but were not always up to date. The care records for one person stated on 1 February 2017 that it was not safe to use a stand aid when transferring this person as they slipped out of the sling, however daily notes indicated that staff were continuing to use a stand aid for some transfers and two staff members we spoke with confirmed this. Daily notes showed that on at least two subsequent occasions the person had slid out of the sling. These incidents had not been recorded on the accident and incident recording system.

These examples are breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 because the provider had not ensured that people were kept safe.

We looked at records of accidents and incidents. An audit of the records was done monthly and included an analysis that looked at types of accidents and incidents, the time that they occurred, potential injuries and people who experienced successive falls. The audit was accompanied by a computer printout of the accident and incident records for each person.

Some of this information was concerning as it related to incidents that were of a safeguarding nature, for example incidents of aggression that had been categorised as 'assault'. The manager confirmed that none of these incidents had been reported to the local authority or to CQC. We checked CQC records which showed that no accidents or safeguarding concerns had been reported to CQC since 2014. This did not show that there were robust systems in place to protect people from abuse

Two staff members we spoke with had good knowledge of abuse and said they would report any potential abuse to the manager. There was information about safeguarding in the entrance area of the home. Training records provided by the manager showed that 14 staff had no date recorded for safeguarding training. This meant that they may not be aware of their responsibility with regard to protecting people from

abuse.

These are breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13 because the provider had not ensured that people were protected from abuse.

We looked at the maintenance file and saw that regular checks of the water temperatures, fire alarms, emergency lighting systems and mobility equipment were carried out. The checks of mobility equipment, ie wheelchairs and walking aids lacked any detail to show which pieces of equipment had been checked and what they had been checked for. We saw that gas, electric, moving and handling equipment, the passenger lift and portable appliances had all recently been tested to ensure that they were safe, and up to date certificates were available.

Everyone we spoke with said they were happy with the cleanliness at the home. One person said "My room is cleaned every day." and a visitor replied "Yes the home is clean. I've never noticed any urine smell. It's fairly fresh when you come in, including in their room. Nothing untoward at all." During our visit we found that the home was clean but there was an unpleasant smell in three bedrooms. Paper towels and liquid soap were provided in all hand washing areas and there were gloves and aprons available for staff to use. An NHS infection control audit carried out in January 2016 recorded a score of 87%, which was a small improvement on the previous rating, and a self-audit in June 2017 recorded a score of 98%. The kitchen had a five star food hygiene rating.

During most of the day there seemed to be enough staff members around the shared spaces to meet people's needs and respond to requests for support. For a period during the afternoon the only staff member in the lounge was the activities coordinator. Most people said they thought there were enough staff around, although two people commented that staff could sometimes be "very, very busy/too busy to give support". One person said "I think they could do with one extra. At times they're almost overwhelmed by what they've got to do." Another person commented "There are times when there's nobody around." Visitors said "There always seem to be plenty of staff around." and "Oh yes – always a lot of staff knocking about."

We looked at staff rotas which showed the staffing levels at the home. There was always a registered nurse on duty over 24 hours. The manager, who was a registered nurse, was supernumerary to the staff rota on most days. There were five care staff on duty in a morning, three in an afternoon and evening, and two at night. We asked the manager about the reduction of staff by two for the afternoon and evening shift and she told us that this was a sufficient number to meet people's needs, however she said she could put an extra member of staff on the afternoon/evening shift if this was needed.

We looked at records for three new members of staff who had been recruited since our last inspection. The records for one person showed that all of the required checks had been carried out to confirm that the candidate was of good character, however the records for the other two members of staff did not have verifiable references in place. The manager provided evidence that she had requested employer references, but there was no evidence that the initial email request had been followed up. This meant that the references on file did not provide information about the person's employment record.

The manager provided a list of Criminal Records Bureau and Disclosure and Barring Service checks for all of the staff team and we found that 17 of these were more than ten years old. These should be updated to ensure that staff remain safe to work with vulnerable people.

This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 19 because the provider had not ensured that robust recruitment procedures were followed including the

relevant checks.

People we spoke with were all happy with the way their medication was managed. A visitor told us "[Person's] meds were all over the place when they came and they were sorted out early on, so [person] is much happier now."

We looked at the arrangements for the management of people's medicines. Medicines were only handled by registered nurses. Adequate storage was provided in a locked room. The room and fridge temperatures were recorded daily to monitor that medicines were kept at the correct temperature. Monthly repeat medicines were dispensed mainly in a pod system and a running total was maintained for all tablets that were not in the pods. A record was kept of any items carried forward from one month to the next. In general, the records we looked at and checks of the items in the medicine trolley, showed that people received their medication as prescribed.

At our last inspection we found that the manager had written protocols to ensure consistent administration of 'as required' medicines, but these lacked any detail. They were kept in a separate folder and not with the medication administration record (MAR) sheets and the nurse we spoke with at the time appeared not to be aware of them. During this inspection we found that these were now included in the MAR folder and had been improved.

The manager told us that one person received their medication covertly, which meant that it was given to them without their knowledge, however the nurse we spoke with stated that the medication was not disguised but was given at the same time as the person was having a drink. There was a letter on file from the person's doctor dated 2015 stating that the person lacked capacity and medication could be given covertly, however there was no evidence of any mental capacity assessment or best interest decision relating to any aspect of this person's care. There was also no evidence that the covert administration of medication had been discussed with a pharmacist.

This is a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11 because where people's capacity to give consent to care and treatment was in doubt, it had not been assessed in accordance with the Mental Capacity Act 2005.

We noticed that, in the medicine's fridge, two people's eye drops had not been dated on opening and another person's eye drops (which were used as required) were dated as having been opened in February 2017. The maximum length of time for the eye drops to be used after opening was one month. This meant there was a risk that they could not be safe to use.

We found unclear information regarding three people who had a thickening agent added to their drinks. There was conflicting information regarding what amount of the thickener should be added to what quantity of liquid. For example, one person's care plan stated "Her swallowing to be observed and use of thickener to be used if prescribed. She is to have 0.5 – 1 scoop of Nautilus Clear in 200mls fluid." This meant that the person was at risk of not receiving fluids of a consistency that was safe for them.

We looked at the care file for one of these people who was identified as at risk of aspiration and choking due to a poor swallow. The care plan stated that the person required a "soft or pureed diet". We asked the manager whether it was soft or pureed and what consistency was safe and she was unable to tell us. We did not see any evidence that the person had been assessed by a speech and language therapist (SALT) prior to, or subsequent to, admission to home. There was no choking risk assessment and no risk management advice for staff on how to minimise the risk of choking. Following the inspection, the manager informed us

that all of the people who had a thickening agent prescribed had been seen by a SALT.

These examples are breaches of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 because the provider had not ensured that medication was used safely.

Following the inspection we asked the nurse in charge to refer five people who lived in the home to the local safeguarding unit as the care that they were receiving was unsafe and placed them at potential risk from harm.

Inadequate

Is the service effective?

Our findings

Most people said they felt that staff asked for their consent before support was provided and we heard several staff members offering support and asking for people's consent, For example, a carer supporting someone with their breakfast asked "Can I just put this bib around you? Do you want me to give you a hand?" Another carer, noticing someone had a lot of food crumbs on their chair, asked "Is it all right if I just get rid of these bits of food?"

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

The nurse in charge of the home when we arrived did not know who had a DoLS but thought there were "lots". There was no list available in the office to show who had a DoLS or a 'do not attempt resuscitation' decision and when these were due for renewal. We found no mental capacity assessments in people's care plans. The manager told us that these were done in conjunction with a GP or social worker. She told us that social workers told them if people had capacity or not when the person went to live at the home, however we saw no formal documentation from GPs or social workers in relation to capacity assessments. The manager confirmed that she had not completed any MCA assessments herself in relation to any aspects of people's care and we saw that the capacity assessment tool on the home's computer system was difficult to understand. This meant that the manager had not followed MCA and DoLS legislation to ensure people's legal right to consent was protected.

One person's care assessment stated that they were able to consent to simple day to day activities but for more complex decisions they required a mental capacity assessment. No capacity assessment was recorded for any decisions relating to care, including the use of bed rails which may be a form of restraint, and there was no evidence of any best interest meetings or discussions.

Consent was not always obtained legally. We saw examples of where consent had been obtained from relatives in relation to aspects of people's care. Relatives can only legally consent on behalf of another person when they have Lasting Power of Attorney (LPA) rights to do so. We did not find evidence people's relatives were acting as LPAs. For example, one person had no window they could look out of in their bedroom as the window had been boarded up following an incident. The manager told us that the person's family wanted it this left like this. The family did not have power of attorney and there was no logical reason or evidence in the person's care file that this was necessary. Following the inspection, we received evidence that the window had been reinstated.

This is a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11 because where people's capacity to give consent to care and treatment was in doubt, it had not been assessed in accordance with the Mental Capacity Act 2005.

Everybody we spoke with said they thought staff had the right training to support people. A person who lived at the home commented "They do, yes, I used to do the job myself, so I know." and a visitor replied "Yes, definitely. When the staff are using a hoist, it's always used correctly."

All of the staff were required to complete an e-learning programme comprising a number of modules relevant to the care and support of the people who used the service. They were able to do this using a computer in the office in the basement of the home, or in their own home if they had internet access. The subjects covered included safeguarding, CoSHH, infection control, food hygiene, fire safety, mental capacity and dignity in care. Some staff had made good progress and had completed the training programme, but others had very little training recorded. The lack of training about subjects such as moving and handling and fire safety potentially put people at risk. We found a similar situation during our last two inspections of the home.

This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18 because the provider had not ensured that staff received adequate training needed to carry out their role.

Prior to the inspection, the manager informed us that 12 staff had completed the Care Certificate and 20 staff had a national vocational qualification. Records showed that all members of staff had a one to one supervision meeting with the manager, or with one of the nurses, every two months. All staff had an appraisal since our last inspection.

We asked people what they thought of the quality, quantity, frequency and choice of food and drink available and their responses were generally positive. One person said the food was "very good – excellent" and another "The food's good – bacon and egg for breakfast – and there's always more if you want it. You can choose what you like." A third person replied "It's okay – enough, sometimes too much. Sometimes we have a choice, it's not too bad." A visitor explained "When [person] came in, they were really skinny but have filled out really well – their weight is up." The manager told us that the main meal of the day had been moved to 5pm because a number of people enjoyed a cooked breakfast so were not ready for a big meal at midday.

There was only one copy of the menu which was in the kitchen, so people did not know what their meal would be. The menu showed a choice of cooked or cereal-based breakfasts, snack-based lunches and cooked evening meals. For lunch and evening meal there was no choice. People told us that if they didn't want what was on offer they could ask for something else. We asked how people made their choices and the chef told us that staff generally knew if a person wouldn't want or like what was being offered and they would often ask for a variation on the person's behalf.

We observed some people having a late breakfast and having lunch at midday. A small number of people needed support with eating and this support was given appropriately by carers, who maintained a commentary and personal contact with each person being supported.

The food served at lunchtime was sandwiches, on white or wholemeal bread, followed by cake or ice cream. People were offered both cold and hot drinks and we saw these on offer at points throughout the day to people in the lounge. A person who chose to stay in their own room had to ask for fresh water in their jug at the end of the morning as this hadn't been refreshed.

Most people were sitting in chairs around the lounge; these were in many cases the chairs they sat in during most of the morning. Two wooden tables were available to sit at, one at the centre of the large 'conservatory' space where most people were sitting, and one at the other side of the lounge. Neither table was set with anything that suggested they were dining tables, and they were used at points in the day by visitors and by staff needing a place to work at. Each table had four wooden chairs around it, with no arms and no cushioning. There was no sense of a shared meal taking place, nor any sense of meals being a social occasion rather than a solitary, functional activity.

Everybody we asked about access to a doctor or other medical professionals was confident that this would happen if necessary. One person said "The doctor seems to be on tap all the time – they're always here." and a visitor told us "[Person] has seen an optician and a dentist here since coming, because they lost their glasses and a set of teeth around the same time." Care files we looked at showed that some referrals had been made to relevant health professionals, however we did not find evidence that a person prescribed a thickening agent for drinks had been referred to either a dietician or a speech and language therapist (SALT). Another person had issues regarding moving and handling but we saw no evidence that any professional advice had been sought.

Following the inspection, the manager informed us that all of the people who had a thickening agent prescribed had been seen by a SALT. However, we did not see any mention of a SALT referral or a record of the advice given by a SALT in the three nutrition care plans we looked at.

At our last inspection we found a breach of Regulation 15 of the Health and Social Care Act 2008 because the provider had not ensured that the environment was properly renewed. We looked around the premises and saw that there had been some improvement to décor and flooring, however many areas of the building were outdated and 'tired'. There was some signage around the home, with pictures as well as words for bathrooms and toilets. People's bedroom doors had names and photographs as well as numbers on them. People were provided with pressure relieving mattresses and adjustable beds and there was plenty of moving and handling equipment.

Requires Improvement

Is the service caring?

Our findings

People said they thought that staff were kind and caring. We observed that when staff were supporting people with mobility, eating, or speaking to them in passing, they were unfailingly pleasant, kind and respectful towards the people in their care. One person told us "Staff are friendly, kind - not a lot of time to sit and chat but very pleasant." and another person said "They're prepared to talk to you personally, that makes all the difference. Generally, if they've got the time, you can talk to them but they've got an awful lot of jobs to do." A visitor commented "I find them fine. They seem to keep their cool with the more demanding people."

The expert by experience commented "People living at Sandrock seemed quite contented and calm and relationships appeared good between people living there as well as between people and staff. Relationships between people living at the home and the staff seemed positive, relaxed and mutually respectful. I observed one carer taking time to support a person who was distressed, asking them what the matter was, then listening and responding kindly."

Everybody we spoke with was happy that staff did what was needed to protect people's dignity and privacy, mentioning staff knocking on their doors and saying that they felt completely at ease when being given personal care. We noticed that in one person's room, their window was protected by a net curtain, as it was overlooked by a house close by. One person told us "They shut the doors and curtains when they're with you." However, we found that there was no lock on some of the toilet doors and nothing to indicate if the room was vacant or occupied, which did not protect people's dignity. We also found some examples of inappropriate language used in care documents, for example an entry in one person's daily notes stated "She was co-operative and willing to do as she was told."

The home had six shared bedrooms and we found no evidence in people's care files that people had consented to share and no evidence that people had been appropriately matched.

During the morning people sat in seating that was mostly placed around the sides of the lounge. None of the chairs were placed in groups that would promote social interaction and people did not talk to anyone other than carers or visitors who came directly to speak with them. A television was playing in one corner but we saw nobody watching it, and it was not within sight of most people; the sound was low enough not to interfere with conversation but as a result not loud enough for most people to hear with ease.

A number of people told us they needed help from one or two carers to move from place to place but that they didn't have a walking aid. A visitor expressed concern that their relative did not yet have a walking frame since entering the home, having used one previously at their own home. One person said "I use a wheelchair to get around or the zimmer if I'm strong enough. But if they're busy, it's advisable to do as they say." Another person told us "I have to have somebody with me to move around. No, I don't have a walking frame." This did not protect people's human rights.

Visitors were able to visit when they wished and could visit in people's own rooms or the lounge. People we

spoke with said they could go out or could take their family member out for meals, shopping etc.

Requires Improvement

Is the service responsive?

Our findings

A professional visitor told us that they visited Sandrock regularly. They said "I can't fault it, they are very accommodating and the staff are lovely. I have never had any problems, they always follow instructions."

We looked at care records for five people who lived at the home. These were recorded on an electronic system. The care plans focussed on people's health and personal care needs following an 'activities of daily living' model. An 'About Me' document recorded details of the person's life history but there was no evidence that this was used to inform the plans for people's care. The plans we looked at were not person-centred and the information given to staff was often generic, for example the nutrition care plan for one person stated "Ensure nutritional status is not compromised.", which does not provide any meaningful guidance for staff.

A recent monthly review for one person recorded that they were "Non-compliant with care at times, lashing out at carers, has spent some days in bed, refused to co-operate when being handled, so it's not safe to move her". There was no further information or evidence that this had been investigated. The guidance available to staff in the behaviour care plan did not show how to support the person safely or how to minimise the person's distress or risk of harm during care interventions and did not make any reference to seeking professional medical advice.

The monthly evaluations we looked at were often repetitive and uninformative about people's needs and any changes that had occurred in their care . The risk assessments we looked at were often out of date and some had not been reviewed since January 2017. Some information in people's care files was contradictory regarding their level of risk. This meant that staff may not have the information they need to provide care and support safely and in the way that the person preferred.

Charts were in place in the bedrooms of the more frail people who were being looked after in bed. The charts recorded repositioning, continence, and food and fluids taken, however there was no information for staff on the charts about how often the person should be repositioned. Completion of the charts was inconsistent and showed gaps in the care provided. For example, one person's chart recorded that they had been repositioned onto their right side at 5am and had been "checked" at 6:35am. At 10:25am no further entries had been made and the person was lying on their right side. Another person's food and drink charts did not show that they always received enough to eat and drink to keep them well. This was because information in respect of some mealtimes was blank. It was unclear whether this was a recording issue or whether the person had actually not received anything to eat and drink.

We discussed this with the manager who told us that care charts were "a nightmare". Following the first day of our inspection she had been addressing this issue with the staff and had separated day and night charts.

These are beaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9 because people the provider had not made sure that each person received appropriate person-centred care and treatment that was based on an assessment of their needs and preferences.

Since our last inspection, a new member of staff had been employed to plan and coordinate social activities. The activities coordinator was able to tell us about the people sitting in the lounge and talked in general terms about what people liked. We saw a programme of planned activities on the notice-board and these included a variety of outside entertainers coming into the home. In the afternoon, a singer/keyboard player provided musical entertainment, which several people appeared to enjoy. The activities coordinator sat with people in the conservatory encouraging them to sing and clap along. A 'Pets As Therapy' dog also visited during the afternoon, which people appeared to enjoy.

A visitor told us "There's always something, trips out and 'Alzheimer's mornings' at the cinema. Some people love doing arts and crafts." We noticed that dolls and soft toys were available for people who wanted them. One person spent some time talking to their toy and later went to sleep holding it. There was a budgerigar in a cage in the conservatory and two fish tanks (one empty) but nobody appeared to pay any attention to these.

We asked people who lived at the home if they had ever needed to make a complaint or if they knew how to. Everybody asked said they had no complaints but felt able to speak to staff members if they were ever unhappy with anything. Two visitors said they had no concerns and one said they had raised a specific concern which had been addressed.

A copy of the home's complaints procedure was hanging on the wall in the reception area of the home. The procedure did not give the names or contact details of either the manager or the provider but did give people contact details for social services and CQC. The manager told us that no complaints had been recorded for a number of years.

Inadequate

Is the service well-led?

Our findings

People who lived at the home told us "The manager is good and approachable, if they're available." and "Matron is a very nice person – very pleasant." Visitors commented "Matron is always very willing to listen to anything you say." and "Things are always dealt with straight away." We observed that people who lived at the home and family members were comfortable in approaching the manager. During the inspection the manager and all of the staff were consistently helpful and pleasant.

A person who lived at the home considered "There's a good atmosphere here." and visitors said "The welcome here for both of us was lovely."; "It's sometimes very quiet, a lot of people sleeping, but it seems okay." and "Always happy when I come in the afternoon."

The manager was registered with the Care Quality Commission and had been in post for more than 13 years. The home did not have a deputy manager. Many of the staff had worked at Sandrock for a long time. A member of staff we spoke with said they felt supported. They told us "There is good support, good team work".

We inspected Sandrock Nursing Home on 26 November and 1 December 2014, and on 2 August 2016. On both occasions we found that the service required improvement. At our inspection on 2 August 2016 we found breaches of Regulation 17 of the Health and Social Care Act 2008 because the provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service.

We asked the manager about the systems she had in place to monitor the quality of the service. The manager had introduced some new auditing documents since our last inspection but the monitoring systems in place had not identified issues we found during this inspection

The monthly medication audit was very general and did not look at medication management for individual people. Issues regarding people's eye drops had not been noticed. A monthly environment check produced a long list of issues for the maintenance person to address, however the environment checks had not identified important health and safety issues that we found during the inspection.

We asked the manager if there was a development plan to show how the service would improve. The improvement plan provided was dated April to June 2016. Following the inspection, the manager informed us that the development plans related to 2017 and not to 2016 as written on the document. An extension at the back of the home, which was being built when we inspected the home in August 2016, remained uncompleted with building rubble in the back garden.

There were no care plan audits. This meant that inconsistencies were not recognised and people were at risk from receiving inappropriate care.

Accidents and safeguarding incidents had been reported and investigated internally but serious incidents had not been reported to external bodies. The requirements of the Mental Capacity Act were not adhered to.

This meant that people were at risk from harm and from not having their rights protected.

These are continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 because the provider did not have systems in place to ensure effective governance of the service.

A governance meeting had been held on 11 May 2017 involving the provider, the manager, the administrator and the maintenance manager. During the meeting the provider had advised that new kitchen and domestic staff should have a standard DBS check and care staff an enhanced check, which is incorrect. We saw no recognition that many staff had an out of date criminal records check.

This was followed by a staff meeting with the provider on 19 May 2017 which 18 members of staff attended. Issues regarding care charts were discussed and the provider stated that nurses did not have to do care during the night as it was not in their job description. This raised concerns about the provider's understanding of the role of care staff to meet people's needs safely.

A meeting had been held on 18 May 2017 for relatives of people who lived at the home. An invitation to the meeting was dated 15 May 2017 and gave an incorrect date, stating Thursday 19 May instead of Thursday 18 May. Three families had attended but others may not have known about the meeting given the short notice and incorrect date. There was no indication that people who lived at the home had been invited to attend.

Satisfaction questionnaires had been sent out during 2016 and a summary was displayed on the noticeboard. People had made some very positive comments including "Everyone is brilliant with me." and "By and large I think the home is well run and consider the staff do their best for the residents."