Hudson (Sandiacre) Limited

Sandiacre Court Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Sandiacre Court Care Centre is a nursing and residential care home providing personal and nursing care to 53 people aged 65 and over at the time of the inspection. The service can support up to 81 people. Accommodation was provided in a purpose-built home across three floors, with communal areas on each floor. However, at the time of our inspection the top floor was not in use.

People's experience of using this service and what we found

The provider had not ensured good oversight of the home in maintaining peoples care and safety. The new manager had only been in post for three weeks and was dealing with a COVID-19 outbreak. Audits had not been completed to consider how to mitigate risk or to drive improvement.
Staff and people's views were not always listened to, especially in relation to staffing and deployment.

Risk to people were not always assessed and actions taken to mitigate the impact. There were not always enough staff to support people's needs. The provider used the domestic staff to support when there was a shortage of care staff, however this then impacted on the domestic support of the home.

Training was not in place for all areas to support the staff in their role. Safeguarding was not always reported and consideration of how to protect people from harm.

Medication was managed safely. Where people had behaviours which challenged, there were no consistent care plans or guidance for staff to know how to effectively support difficult situations.

Relatives commented positively about the care their relative received. They commented on kind and caring staff.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection and update The last rating for this service was good (published 28 March 2018).

Why we inspected
The inspection was prompted in part due to concerns received about staffing and the safety of some people. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service is requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Sandiacre Court Care Centre on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to risk of harm, people's safety and governance of the service at this inspection.

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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Sandiacre Court Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

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 completed by three inspectors, and a nurse specialist. A nurse specialist has nursing knowledge to review these areas of the service.

Service and service type
Sandiacre Court Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The manager had commenced their registration with the Care Quality Commission. Until we receive this registration the nominated individual 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.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We spoke with local commissioners and health care professionals and used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service about their experience of the care provided. We spoke with eleven members of staff including the manager, nurses, senior care workers, care workers, domestic staff and the chef.

We reviewed a range of records. This included six people's care records, incident reports and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and further quality assurance records. We requested policies and additional information from the provider. We also contacted family members by telephone to obtain their view of the care their relative was receiving.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
- People were not always protected from the risk of harm. Staff had received online safeguard training, however not all staff we spoke with were aware of all the areas which should be reported.
- We found safeguarding incidents which had occurred at the home, which placed people at risk of harm had not been reported, and the ongoing risks to people had not been mitigated. Measures had not been taken to address the safety of the person or those living with them.
- This meant lessons had not been learnt or shared and measures had not been put in place to reduce the risk of possible harm.

The provider had failed to ensure that people were protected from the risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection to put in safeguarding training and procedures to improve reporting measures.

Assessing risk, safety monitoring and management
- People were not always protected from potential risks.
- When people's needs changed reviews were not always completed in a timely manner to reduce the risks or to support staff to understand how to manage behaviours which challenged.
- We found mattresses had not been checked correctly to ensure they were in full working order with no breakthrough of the covers. We found four mattresses required immediate replacement and following a full check of the mattresses more were replaced. This meant we could not be assured of the processes in place to check mattresses maintained their integrity, to protect people's skin.

The provider had failed to ensure that people were protected from the risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection, to address the replacement of mattresses.

Staffing and recruitment

● There was not always enough staff to support the needs of people.

● During our inspection concerns were raised as to the number of staff to support people needs. We found the numbers on site did not match the providers rota. During the inspection additional staff were deployed to support the staff team, from the providers existing staff team not currently on duty.

● The provider agreed to review their staffing numbers and ensure the required levels of staff were available to meet the care needs.

● On some occasions domestic staff had been used to support the care requirements and they had received training in these areas of care. However, this meant on these occasions some areas of cleaning had not been covered.

● The provider had a process for ensuring that staff were recruited safely. However, some records showed not all checks had not been completed in relation to rights to work documentation. The provider responded to these concerns and reviewed the records and made the appropriate checks. Other pre-employment checks had been undertaken prior to staff commencing employment. Staff had Disclosure and Baring Service (DBS) checks in place. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection

● The provider had ensured most areas had been considered in relation to following the guidance in accordance with managing infections and COVID-19. However, we had concerns in relation to some hygiene practices for equipment. This meant we were not always assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service, however at the time of our inspection there was a restriction on admission due to an outbreak.

● We were assured that the provider was using personal protective equipment (PPE) effectively and safely. We observed PPE stations around the home and staff using the PPE effectively.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● The provider was facilitating visits for people living in the home in accordance with the current guidance and some relatives were essential care givers to enable them to support people using the service.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement. We found the service had effective measures in place to make sure this requirement was being met.

Using medicines safely

● Medicines were managed safely.

● Staff took time to explain to people their medicine and stayed with the person until the medicine was taken.

● As and when required medicine was available and staff knew the signs of when this should be offered to support peoples with pain or anxiety.

● Measures were in place to ensure the stock was correct and that the medicine was kept at the correct temperature.

Requires Improvement

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 our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
- The governance oversight was not always in place to ensure a robust and consistent approach to managing risks and ongoing improvements.
- Audits had not been used to drive improvements. For example, we saw when safeguarding incidents had occurred these had not been reviewed and actions taken to reduce ongoing risks. Other audits, for example in relation to mattresses had not identified areas where equipment required replacement or additional cleaning.
- Maintenance checks had not been recorded to ensure the home was safe and complied with health and safety guidance, for example, in relation to recording the water temperatures.
- The quality audit had not identified the medicine room was not on a cleaning schedule and some aspects within the room placed a risk to staff health and safety. For example, emergency medicine kits on a high shelf and inappropriate equipment being stored in this room.
- Incidents had not been reviewed in detail to ensure any mitigation measures had been implemented to reduce risks.
- Staff had not always received the required training when supporting people with behaviours that challenge. This meant there was an inconsistent approach in managing the risks.

The provider had failed to ensure that systems and processes were in place to drive quality and improvements. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
- The culture of the home had been impacted by the lack of staff and inconsistent provider support.
- Relatives we spoke with said staff were kind and responsive.
- We saw people had a choice of meals and all dietary needs were being met.

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

● The provider had sent us notifications which related to events at the service. However, as not all incidents had been recorded, we could not be assured we had received all the notifications in relation to all the incidents which had taken place..
● We saw the last rating had been displayed in the home and on the providers website.
● Relatives felt any concerns they had were addressed and responded to.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff felt they had not always been supported over the last six months and this had impacted on the culture of the home. Staff had raised concerns about staffing with the provider at a meeting in November 2021, however there was no indication this had been addressed or responded to in providing staff with reassurance.
● We reviewed the supervision matrix, some staff had received individual meetings, however other staff had not received any meetings within the last three months. This supports the concerns raised in relation to the providers communication and offering support.
● Relatives felt they had been consulted and many had become essential care givers which provided them with some additional freedom around visiting.
● We saw regular communication had been provided to family members in relation to COVID-19 guidance and changes in the management.

Working in partnership with others
● Partnerships had been established with health and social care professionals.
● The provider was working with health and social care in relation to developments with the service and the proposed changes to the providers registration.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured equipment in use was maintained. Risk had not been reviewed to protect people from harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured their processes were robust to protect people from harm. Staff had not always received training relevant to their role to enable them to recognise different types of abuse and how to report concerns.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have established systems and processes to ensure the safety of the services being provided. These services had not been assessed, monitored and ongoing improvements made. Risks had not been reviewed placing individuals and others at risk of harm.

The enforcement action we took:

WN areas of concern to be addressed by the end of March 2022