Amberbrook Management Limited

Sandridge House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**

Summary of findings

Overall summary

Sandridge House is a care home with nursing that is based in a busy area of Ascot, Berkshire. The care home is set back from the street, close to the High Street of Ascot and nearby Heatherwood Hospital. The location is registered to provide care and support for up to 38 people. At the time of the inspection there were 33 people accommodated. Sandridge House is located in an older style premises with two floors and a number of outbuildings. There is an expansive garden around the care home.

At the time of the inspection, there was no registered manager. 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. The last registered manager left their position in April 2015. A home manager commenced in post in April 2015 and had applied to CQC to become the registered manager. The person was awaiting an interview with our registration inspectors on 22 January 2016.

The previous inspection of Sandridge House occurred on 2 December and 3 December 2015. At that inspection, there were eight breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. The location was rated "inadequate" overall and placed into 'special measures'.

We were concerned during the inspection on 2 December and 3 December 2015 that people's care was seriously unsafe and ineffective. The provider agreed to take immediate steps to safeguard people. This included sending an urgent action plan to us by 7 December 2015. Due to the concerns about safe night-time care for people, effective from 4 December 2015 the provider agreed to deploy a fourth staff member and provided evidence to the us to show this had occurred.

We also contacted local authorities on 4 December 2015 regarding people's welfare and they decided to commence conducting unannounced checks at the location to ensure that people received safe and effective care, particularly on weekends. These visits commenced on 5 December 2015 and continued.

We received the provider's action plan on 7 December 2015. However, the action plan was not robust, did not sufficiently demonstrate how people were being protected and contained some timeframes for completion of actions that were too long. We asked how the provider was protecting people and what actions they had taken to make improvements to care that assessed, prevented and mitigated risks. The provider submitted a revised and detailed action plan to us on December 2015. Once we had assessed the revised action plan, and determined it had satisfactorily documented the provider's actions to ensure people's safety, the provider agreed to submit the updated action plan to us each Monday. This was so that we could regularly monitor the safety and welfare of people who lived at Sandridge House. The provider sent their action plan to us four times between the last inspection and this inspection; sometimes with documents attached that supported the action plan's contents.

We received information of concern from other organisations following the December 2015 inspection. This information indicated that people at Sandridge House were still at risk of harm due to failure to make necessary improvements or that the care people received continued to remain unsafe. The inspection by us on 6 January 2016 was necessary to again assess the safety and effectiveness of people's care.

People did not receive safe care. Hazards that were highlighted in the December 2015 inspection feedback were not addressed quickly enough to prevent the risk still existing for people who used the service. This included the risk and continued occurrence of falls, the deployment of staff to ensure people's continuous safety, the maintenance of a safe environment and care planning. People continued to have injuries resulting from falls. We observed this occurred due to failure to assess, mitigate and review risks for people at high risk of falling. Care plans were being reviewed, but these were not specific enough for individual risks and person centred care provision. Although numbers of staff present on shifts were maintained, this was not linked to the dependency of people and some staff worked high numbers of hours in given weeks. The environment had some modifications to address risks, but risks from fire safety and Legionella prevention and control continued.

People did not consistently receive effective care. There was mixed evidence that people's food and fluid provision was sufficient for their needs. There was improved recording of people's fluid using the intake charts. Our observation showed that more offers of fluids were made to people, although there were some periods where people failed to pay attention and focussed on tasks instead. People with challenging behaviours, especially those with dementia diagnoses, posed the highest risk of malnutrition and dehydration. This was due to the increased difficulty in convincing them to consume food or fluids, their behaviour when they were provided with nutrition or hydration, and staff ability to use suitable or alternate ways of assisting the person.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we took at the back of this report.

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.

Risk assessments and care plans did not consistently assess, mitigate and monitor people's unique risks of receiving care at the service.

Safe staffing levels were not established from people's level of dependency. Some care staff worked a high number of hours per week.

People were at risk of, and had sustained injuries, because of falls and repeated falls.

Environmental risks to people continued and were not quickly resolved by the provider.

Risks to people from fire and Legionella were present, although some action was taken to mitigate the risks.

Is the service effective?

Inadequate

The service was not consistently effective.

The recording of people's food and fluid intake had improved, but the tools used to record this were ineffective.

People's dining experience was not always a pleasant experience, to encourage their intake of food.

Staff displayed difficulty in dealing with people who exhibited challenging behaviours and enabling them to eat and drink sufficient quantities.

Sandridge House

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.

This was a focussed inspection due to concerning information. The inspection took place on 6 January 2016 and was unannounced.

The inspection team consisted of two inspectors. Both inspectors work in inspecting adult social care locations. One inspector is a registered nurse.

This inspection took place after the 2 December and 3 December 2015 comprehensive inspection. This inspection looked at only two key questions; "Is the service safe?" and "Is the service effective?"

Before the inspection, we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was not required for this type of inspection.

We reviewed the information we held about the service and notifications of incidents we had received. A notification is information about important events which the service is required to send us by law. We reviewed weekly action plans sent to us by the provider, and information received from local authorities.

During the inspection some people who used the service did not have the capacity to express their views. However, we were able to speak with two people. We also looked at the premises and observed care practices by staff on the day of our visit.

We spoke with the nominated individual, the operations manager, home manager, five care staff, the nurse in charge, two activities coordinators, the maintenance person and a cleaner. We looked at seven records relating to the care of individuals, staff duty rosters and other records relating to the running of the service.

After the inspection, we asked the provider to send us further information and evidence.

Inadequate

Is the service safe?

Our findings

We asked people who used the service about their experience of care since the last inspection on 2 December and 3 December 2015. One person stated: "(I'm) happy with the care and have no concerns". Another person explained that sometimes they had to wait a longer than expected for their call bell in the bedroom to be answered by staff. Not everyone who lived at Sandridge House was able to verbally communicate with us, and we used observation, documentation and other forms of evidence to evaluate the safety of their care.

We also spoke with staff to ask their opinion about whether the care of people was improving. One staff member told us: "I think it is improving". Another staff member said: "We are paying more attention". One staff told us that they had resigned. However, staff told us that following the last inspection, the management had held a series of meetings to discuss how they could improve the care of people and therefore the safety. At the inspection, we saw meeting minutes that confirmed these discussions with staff occurred at least five times in December 2015. Not all of the meeting minutes we reviewed documented that the risks about dehydration and fluid provision to people were discussed.

We found people were still at risk of harm due to the outcomes of poor care. This was due to a number of basic care provisions that had not sufficiently improved since the last inspection in December 2015. These included assessing and managing people's individual risks, deployment of staff, maintenance of a safe environment and falls risks.

Prior to the last inspection, Sandridge House commenced transferring and updating people's risk assessments and care plans to a new format. This process was required to take time over a number of weeks. We observed that not all people had care folders rewritten at this inspection, so some risk assessments and care plans were not created for particular areas of their care. At this inspection, we determined that care plans were being re-written by a support worker, rather than the registered nurses. Effectively the support worker was undertaking a duty in this setting limited to nurses, for which they were not trained or assessed.

We looked at four people's care documentation during the inspection. The care plans were inadequate in identifying the needs and care required for people with high dependency or at increased risks from certain aspects of their daily care. Individual risks for people were still not adequately assessed or mitigated, We found risk assessments for example falls risks and the malnutrition universal screening tool (MUST) completed but not routinely reviewed. Care plans contained the same points for each person despite their individual unique risks. Reviews of some risk assessments and care plans were still not undertaken since their initial completion.

The risks for people were not adequately captured in the risk assessments and care plans. An example was where people were identified at risk of malnutrition or dehydration and there was no risk management plans. We saw one person's care plan showed they were at high risk of malnutrition and dehydration. There was no risk management plan in place to show what action the service had taken to reduce or minimise the

risk. When we asked, the home manager was not able to given an explanation for this.

Another person's care plan dated 25 November 2015 stated they were at a high risk for falls injuries. There was no signature on the care plan. Although there was a risk assessment dated 5 May 2015 to determine the level of the person's falls risk, the scoring showed the person's risk was 'medium', not 'high' as recorded on the care plan. We found there was no routine review of the person's care plan in December 2015. Furthermore, no additional information was added to the person's falls care plan or risk assessment in January 2016. This was despite the fact the person had sustained further falls during the time in between. The person's moving and handling 'profile' was also not reviewed after 6 May 2015.

This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staffing deployment continued to impact the safe care of people at Sandridge House in some regards. In the weekly action plan received by us on 4 January 2016, the provider documented that a dependency tool to assess people's care needs would be implemented. A dependency tool would be used to assess people's individual care needs and the hours necessary for their safe care on a daily and weekly basis. With the action plan, the provider submitted the tool that they proposed to implement. The provider's own deadline for this was documented as 14 December 2015. The dependency assessments of people and determination of the right skill mix at the inspection was not completed.

The local authority met with the provider on 22 December 2015 to determine that a safe number of staff were planned to work the shifts during bank holidays in December 2015 and January 2016, and that contingency plans were in place if the number of staff fell short. We examined the rotas for the period 21 December 2015 to 5 January 2016. We found that the provider had maintained their planned numbers of staff on the rota. This included, according to the records, having a fourth member of staff working night shifts. However, there was evidence of unsafe staff deployment. We saw one support worker had worked five, 12-hour day shifts in one week. Two permanent support workers had worked six 12-hour day shifts in one week. A support worker who worked only night shifts had worked six 12-hour night shifts in a single week. Although staff can sign a waiver regarding the maximum weekly working hours, the risk of staff fatigue in undertaking high numbers of shifts could affect people's safety in the care home.

We observed the home manager was still expected or chose to work on the floor as a nurse most of the time in addition to working as the manager, leaving no time for staff supervision or monitoring and no time to complete some leadership functions. Registered nurses were not performing as registered nurses for same routine aspects for care of people, for example being their 'named nurse' in order to support the home manager in their function as a leader of the service. Support workers we observed continued to be almost entirely focussed on task-based care which was not personalised for people. The provider planned to increase managerial staffing to support the home manager in effective achievement of their role. The provider's action plan from 4 January 2016 showed that a new deputy manager and staff trainer were to be employed. At the inspection, these staff had not commenced.

This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There was a continued failure to maintain of a safe environment. Environmental risks for people, previously pointed out to the provider at the December 2015 inspection continued. An example included a bedbound person's bedroom door (a fire door) being held back by a chair which stopped the function of the fire door and also blocked access to the room for emergencies. Another example we observed was that a magnetic fire door at the top of the staircase in reception was continually closing and not able to be held back by the magnets. Some people were unable to push the door open due to the weight of the door and their frailty.

Water temperatures in some handwashing sinks of bedrooms were also not warm for people to use. We found the medication room door open and unlocked, which was a security risk and also a risk for people whose conditions meant they might wander about the care home.

Our report from the December 2015 inspection stated that we would contact the local fire authority and the Health and Safety Executive (HSE) due to concerns about the risks to people from the premises. We contacted both organisations and shared the information about risks we found at the December 2015 inspection. In the weekly action plans submitted to us, the provider confirmed they were taking action to address the environmental risks. One of the risks to people's safety was evacuation in the event of a fire. At a meeting with the local authority on 15 December 2015, the provider confirmed that a mock fire drill conducted since the last inspection demonstrated that staff were not effective in the event and had a delayed response time. However, the provider had taken some steps to mitigate fire risks. The provider's action plan from 4 January 2016 showed that a new fire risk assessment was booked with a contractor for completion. An update of the fire policy was completed and some building works to improve fire safety on a set of stairs was underway. Better signage for evacuations of people was installed.

Sandridge House previously had Legionella present in the pipework of the care home. The HSE still had an outstanding 'improvement notice' in place for Legionella prevention and control at the time of our 6 January 2016 inspection. The HSE inspector required that water for people clear of Legionella needed to be sustained over a longer term. At this inspection, the provider confirmed that a recent water sample detected the reappearance of Legionella in the water supply of the location. This was after two prior water samples showed that no Legionella was present in the supply. On the provider's action plan for 4 January 2016, Legionella was not listed as an item to address. Following this inspection, on 7 January 2016 the provider sent an update of their action plan to us. Again, Legionella was not listed as a risk that needed to be managed. We reported our findings regarding Legionella to the HSE, who advised that they would investigate.

This was a breach of Regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Some action regarding people's slips, trips and falls was documented in the provider's action plan dated 4 January 2016. Falls was one of the risk areas that was listed in the action plan. These included reviewing the location's policy in December 2015 and the home manager communicating with staff about reporting of all incidents. We looked at the incident reports from 4 December 2015 to 5 January 2016. There were nine falls since the last inspection and another two people were reported as sustaining bruising with an unknown mechanism of injury. Although recorded on the forms as "resident found on floor" and "no apparent injury", we found no attempts by staff to mitigate the risks based on the injuries sustained. For example, there was no record of a nursing assessment of any potential or actual injuries, no recording of neurological observations, no body maps to show where any injury occurred, no photographs of bruises, and no review of falls risk assessments or care plans following the fall. The provider could have considered people's referral to alternative sources of intervention, such as falls risk clinics, an occupational therapist or a physiotherapist.

Further action by the provider was needed to address the extreme risks of people falling and the injuries they sustained as a result. At this inspection, we reviewed a form dated 15 December 2015 which was a monthly report on accidents and incidents for people who used the service. There were tallies of the number of incidents that had occurred, related to the times of the day or night when the event happened. Falls rates or frequency for individuals was still unknown by staff and precipitating factors for falls were not examined or analysed. At the inspection, we found that despite commencing some monitoring of falls and incidents, people were still placed at risk for further falls by staff. An example was a person in sandshoes which had

been inappropriately altered by staff and the alterations creating an increased risk of the person falling. We had pointed out to staff at the 6 January 2016 inspection that the shoes were an unacceptable safety risk for the person. However social work teams reported to us they had found the same thing had been done with the shoes on 7 January 2016 when they visited. At the inspection, we found the person had frequent falls and two black eyes from falls. We observed that people seated in communal dining rooms and lounges did not always have their mobility aids (walking sticks and frames) within close reach. This meant they would attempt to mobilise themselves, increasing the risk they would fall.

This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At the previous inspection, we found staff did not always have the training they needed to perform their roles appropriately and to ensure people's safety. At this inspection, we found new staff members continued commencing at Sandridge House without appropriate inductions or training. One staff member who had started approximately three weeks before the inspection told us they did not know what to do in the event of a fire, as they had not received fire training yet. When we spoke with the staff member, they stated they: "Effectively (had) no induction".

We had previously observed that call bells were not answered promptly and people told us this again at this inspection. We requested the call bell records from the provider's system at the inspection, to determine whether people's requests for help were adequately attended to. The provider sent the records to us on 7 January 2016. We looked at the response times for staff to people's requests for help in the period 4 December 2015 to 6 January 2016 inclusive. We found the majority of call bells were answered within less than five minutes. There were fewer examples of call bells being answered by staff exceeding five minutes, although a common occurrence was people waiting about 10 to 12 minutes during the morning shift. The morning shift is often the busiest, when people are assisted to get out of bed, have a bath or shower and have breakfast, as well as move to communal spaces in the care home. There were limited instances where people's call bells were answered after waiting for 20 minutes. The provider did not routinely monitor call bell wait times, or undertake checks to see any themes or trends across the shifts or days of the week.

Inadequate

Is the service effective?

Our findings

When we asked, two people told us they were given enough fluids and were happy with the care received. We did not speak to further people who used the service or relatives about effective care at this inspection. Instead we closely observed the provision of fluids for and to people, and checked how they were recorded. However, we spoke to some staff about effective care. Two staff explained that meetings were held with the operations manager at the start of morning shifts in December 2015 where the importance of people's hydration and nutrition was discussed. From the handover meeting notes, we observed that the need for staff to offer and accurately record people's food and fluid intakes was reiterated on several occasions. The operations manager mentioned at the 31 December 2015 staff meeting that better specificity in the recording of people's food consumed was still required.

Since the December 2015 inspection, the provider had implemented and progressed minor improvements in the provision of effective care for food and fluids. An overall action plan was sent weekly to us, as well as some associated documents to demonstrate whether people's nutrition and hydration was an area for improvement. We monitored the progress in the provider's action plan and via the feedback from and content of people's regular welfare check reports from the local authorities. The provider demonstrated that better supervision and monitoring of staff involvement with people's nutrition and hydration was planned. However, at this inspection, we found people did not consistently receive effective care and were sometimes at risk of harm. Again, this was due to basic care provision that had not sufficiently improved since the last inspection. These included the offer of and recording of fluids to people, and the way that staff ensured people had enough to eat.

On 9 December 2015, the care home was required to confirm to us which staff member(s) would monitor people's intake of fluids. On 22 December 2015, the provider contacted us to inform that the nurse in charge of each shift would monitor the fluid balance charts, and this would be overseen by the home manager. This step was not evident in subsequent action plans submitted to us. The action plan from the provider dated 4 January 2016 contained little information about actions the provider was taking to ensure people effectively received food and fluids, despite feedback about people's risk of dehydration from our December 2015 inspection and the local authorities who visited the care home regularly. The content of this action plan showed that staff were due to receive further training and supervision regarding people's food and fluid intakes. The local authority visited Sandridge House on 5 January 2016 and informed us that four people they observed had their drinks out of reach. The social worker that visited provided feedback to the managers after their visit. The provider's action plan received by us on 7 January 2016 did not demonstrate an increased importance for people's food and fluid provision. This was despite our feedback at the inspection the previous day.

This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We reviewed the food and fluid intake charts for seven people who were, due to their health conditions, restricted to their rooms. We looked at the records for the period 22 December 2015 to 6 January 2016 inclusive. The charts showed that staff recorded people receiving adequate amounts of food and fluid

throughout the day. Offers to people where they refused fluids were not recorded at all. We observed there was an over-reliance on providing tea, squash and juice. This meant people were not regularly offered water, which should be part of healthy hydration for older adults. We saw the charts were now easily accessible and kept in people's rooms. At the previous inspection, the charts for people were not stored in the person's room, which meant recording of people's food and fluid was remote to where the provision occurred. We observed drinks were replenished throughout the day and were sometimes placed within easy reach, although we found some examples of people not being able to reach them.

We noted the intake charts used were not effective. This was because there was no place for staff to put their names or initials after they had completed the tasks and no recorded calculation of food and fluid intake over a 24 hour period. We brought this to the attention of home manager who agreed the format of the forms needed to be changed.

Nutritional and hydration assessment had been carried out and where appropriate people had eating and drinking care plans. These showed people's dietary needs and instructions for care staff on how to support them. We noted the service sought professional advice in order to ensure peoples' nutritional and hydration needs were met. For example, one person's care record showed the recommendations given by a dietician. We noted the advice given was also reflected in the person's eating and drinking care plan. However, this did not consistently occur for everyone. For instance, another person's care record noted a person who was considered at high risk of malnutrition was seen by a dietician. There was no record to evidence what the dietician had advised. We asked the home manager to help us find this information but they too were unable to locate the information. This meant there was a potential for staff to deliver inappropriate care, as specialist nutritional advice given was not accessible for the care staff to follow.

Throughout the inspection we observed people were occasionally offered drinks and snacks. We observed people's lunch time in the care home's lounge and dining room. During this time, we observed some people who chose to have their meals in the main lounge. Some people in the lounge who were able to eat their meals independently did so at their own pace without any interruption. We noted drinks were made available and were within easy reach. Jugs of juice were available in the room and we saw some people were able to get more drinks for themselves as and when they wanted. There was only one staff member in the lounge at lunchtime, and this was due to them assisting a person with their meal. After the staff member had finished this task they left the lounge and did not return. Staff who did enter the lounge only came for short periods either to bring meals or collect cutlery. We observed two people in the lounge who waited for the meals. During a 30 minute period we noted although the individuals had juice available, but there was no interaction with staff and their meals had still not been delivered.

People's experience in the dining room however was different. At 12.30pm we observed one person's chair side on to the dining table while they were attempting to eat soup. We saw two people with their soup in front of them were asleep without interaction from staff. One person woke up and placed the bowl aside. A support worker came to the person and asked if they wanted the soup, he said "no". The support worker took the soup away. For another person, the support worker took their empty bowl away but failed to speak with them. We saw the main course served to people which happened to be chicken curry. One person who was asleep was awoken by the support worker and there was no communication. The person shouted: "Stop manhandling me". We observed that during the 30 minute period we observed people in the dining room, no one received a top up of their drinks on the table. One person frequently tried to get up from the table. A support worker assisted them to sit down and moved away. The person left the table again, and a support worker helping other people yelled at the person to "sit down". We observed another two support workers standing up assisting people with their meals, but they did not sit down beside them. This meant people's opportunity to eat was not appropriately managed to ensure they consumed enough food during

the service of food.

This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users were not appropriate, did not meet their needs or reflect their preferences.

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users. The registered person did not assess the risks to the health and safety of service users receiving care or treatment. The registered person did not do all that was reasonably practicable to mitigate such risks.

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment All premises and equipment used by the service provider were not clean, suitable for the purpose for which they were being used, properly used or properly maintained.

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed. Persons employed by the service

provider in the provision of the regulated activity did not receive such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry our the duties they were employed to perform.

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration.