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# SONACare

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

About the service
SONACare is a residential care home providing personal care to 13 people aged 65 and over at the time of the inspection. The service can support up to 15 people in one adapted building.

People's experience of using this service and what we found
People could not be assured they would receive support from staff when they needed this as staff were not effectively deployed. During the inspection inspector's alerted staff to the support a person needed to prevent the risk of avoidable harm. Infection control processes were in place to limit the risk and spread of infection, however these were not consistently followed by staff. People were placed at risk of avoidable harm due to some areas of the home being unclean, and poor practice by some staff. Medicines were managed safely, and staff had been trained in medicines management.

People were not always supported in a dignified manner that empowered decision making and inclusion. Staff did not always seek consent and provided care and support when it was unwanted. Care records were not secured to ensure people's private information was protected and records were not always accurate. Audit systems were not always effective in identifying where areas of improvement were required. Meetings took place with staff and people to share information and gain views.

The provider and manager took swift action during the inspection process to reduce risks and improve the service.

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

Rating at last inspection
The last rating for this service was good (published 12 January 2019).

Why we inspected
We undertook a focused inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about medicines, the provision of meals, the environment and care provided. A decision was made for us to inspect and examine those risks. We looked at the key questions of safe and well-led.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

We discussed our concerns with the provider who took action to ensure improvements were made and risks minimised.

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

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

We have identified a breach of regulations in relation to the safe care and treatment, staffing and good governance. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good . We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

The service was not safe.

Details are in our safe findings below.

**Inadequate**

**Is the service well-led?**

The service was not always well-led.

Details are in our well-led findings below.

**Requires Improvement**

# SONACare

**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 Care Act 2014.

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

Inspection team
The inspection was carried out by two inspectors.

Service and service type
SONACare 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 service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was not present during the inspection visit and the provider told us they would be deregistering as registered manager. There was a manager in place who was in the process of registering with the CQC to become the registered manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed information we held about the service. The provider was not asked to complete a provider information return prior to the inspection. This is information we require providers to send us to give us key information about the service, what the service does well and improvements they

plan to make. We took this into account when we inspected the service and made judgements in this report. We sought feedback from the local authority commissioners of the service to help us plan the inspection effectively. We used all this information to plan our inspection

During the inspection
We spoke with three people who used the service and one relative shared their views of the service. We spoke with four members of staff, the provider and the manager. During the inspection we reviewed multiple medicine administration records, medicines stocks and storage and observed medicines administration. We looked at three records linked to people's care and the management of the service. Following the inspection, we requested additional information including policies and equipment certification.

After the inspection
We continued to communicate with the provider and manager, and further information was sent to us in response to the feedback provided during the inspection visit.

Inadequate

# Is the service safe?

## Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management;

- Nutritional risk assessments were in place to guide staff on how to support people to meet their nutritional and hydration needs safely. There was a menu available with alternatives meals for people to choose from. However, staff did not always ensure people had enough to eat. One person had difficulty eating their meal and was not supported by staff. The care plan recorded the person required a enriched diet to prevent weight loss but staff offered no encouragement and the person did not eat their lunch. This placed the person at risk of avoidable harm.
- Staff did not follow the care plans in place. A person was eating biscuits and their care plan recorded they should not have hard foods following SALT assessment. The manager and provider told us the person dipped biscuits in their drink and staff should be present when the person ate. On one occasion, we saw the person was left alone while they ate a hard biscuit which they had not dipped in their drink. This placed the person at risk of avoidable harm.
- Staff did not always support people with personal care, a person at the home was left in soiled clothing when their care plan recorded they sometimes needed support. This placed the person at increased risk of skin damage.
- Locks on safety doors to prevent people from accessing the stairs unsupported, could not always be opened by staff. This posed the risk of people being unable to evacuate the home safely in an emergency if staff were unable to open the gates to get to the upper floor. A fire detector was seen to be hanging from the ceiling, we could not be assured this would operate in the event of a fire. A cupboard with combustible materials had a fire sign saying it should be kept locked. This was unlocked and open.
- The rear of the lounge held long cardboard boxes, a weighing chair, two wheelchairs and three walking frames. These were accessible if people walked to the rear of the lounge. This posed a risk of falls if people entered the area.

We found no evidence that people had been harmed, however this was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were placed at risk of avoidable harm.

We referred our findings to the Lancashire Fire Authority, Infection Prevention and Control Team and Environmental Health.

We discussed our concerns with the provider who sent us an action plan telling us how they would improve and they took swift action to rectify the areas of concern we identified on inspection.

Preventing and controlling infection

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● Staff did not always protect people from the risk and spread of infection. A staff member was seen using a communal hand basin to clean a used commode and at lunch time we saw they blew on a person's meal to cool it, before they supported them to eat. The home was visibly unclean in some areas. For example, a pull cord for a light was dirty, a divan base had brown stains on it and the kitchen required cleaning. Dried chewing gum was seen to be stuck to the underneath of a dining table. This placed people at risk of avoidable harm as infection control processes were not being followed and the home required cleaning.

● We were somewhat assured that the provider's infection prevention and control policy was up to date. The policy in place contained brief information regarding the practices and processes at the home. National information was available with the policy.

We have also signposted the provider to resources to develop their approach.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● 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.

● We were assured that the provider was using PPE effectively and safely.

● 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.

Staffing and recruitment
● Staff were not always available to help people if they needed help. For example, one person was seen to be kneeling on a chair. There were no staff in the area to support or protect the person from harm and the area was cluttered with mobility equipment, placing the person at risk of falling. We alerted staff who attended the area and supported the person to get off the chair safely.
● At lunchtime a person did not eat their meal as staff were not present with the person to prompt them. The person was seen to be having difficulty eating and other people offered their support. Staff did not intervene to encourage the person.
● In the morning we saw people sat in the lounge area and watching television. Staff did not sit with them, chat with them or spend time with them. Staff told us they were busy and we observed staff carrying out cleaning and cooking duties when they were not with people.

We found no evidence that people had been harmed, however this was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were placed at risk of avoidable harm.

The provider took immediate action by reviewing the number and deployment of the staffing to address the concerns we had identified. Additional staff were deployed so people could be helped quickly.

● Staff spent time with people in the afternoon. We observed activities taking place, which were enjoyed by

those who participated.

Systems and processes to safeguard people from the risk of abuse

● The provider and manager referred three safeguarding incidents to the Lancashire Safeguarding Authorities during the inspection visit at the home to help ensure people were protected.

● Staff were able to explain the action they would take if people were at risk of harm or abuse. Training in safeguarding had taken place to help ensure staff understood their responsibilities to raise concerns with the management team and external bodies. Staff told us they were confident the manager and provider would respond to concerns.

● We had serious concerns about the conduct of a staff member on inspection, for example they did not sufficiently intervene to protect a person at the home from verbal abuse from another person at the home. They also continued to help them a person eat when the help was declined. We spoke with the person who told us they wanted and were able to support themselves to eat. We shared our concerns with the provider who took immediate action to minimise the risk of harm by referring the concerns to the Lancashire Safeguarding Authorities and temporarily stopping the staff member from working at the home.

Using medicines safely

● Staff administered medicines safely. There were processes in place to ensure people received their medicines safely and when they needed them. Staff had been trained in medicines processes and their competency had been checked. Medicines were administered in a person-centred way. The staff member administering medicines spent time with people and was gentle in their approach.

Learning lessons when things go wrong

● The management team reviewed incidents to ensure risks were reassessed to prevent reoccurrence. However, we discussed with the provider the introduction of further systems to be in place, to ensure risks are minimised and discussed when improvements could be made. Such systems enable the service to reflect, evaluate incidents and learn from them.

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated 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.

Continuous learning and improving care, Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider and manager completed audits to check where improvements were required. The audits we viewed had not consistently driven improvement. For example, infection control audits had not identified some areas of the home required cleaning or the poor practice we observed. In addition, we observed broken furniture in use in the home and dried chewing gum stuck to the underneath of a dining table where people ate lunch.
- The provider had failed to meet the requirements of regulations.
- Staff stored care records in a communal area in an unlocked cupboard, with further personal care records stored on top of the cupboard. This meant private and sensitive information was accessible to people who were not authorised to read it.
- Care records did not always contain sufficient information to enable staff to give the care people needed. For example, the amount of thickener a person required in their drinks to support safe swallowing was not included in the person's care plan or risk assessments. In addition, if a person's health condition changed there was no person-centred information to support staff's understanding of what symptoms they may display.
- Staff had completed an activity record in advance. We saw no activities took place on the morning of the inspection, however the activity record recorded activities had taken place.

We found no evidence that people had been harmed, however this was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as audits did not consistently drive improvements, records were not stored securely and were not always accurate.

The provider took prompt action to ensure records were stored securely and addressed some records. They sent us an action plan explaining how further improvements would be made.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider had not ensured a person centred and empowering culture. For example, a person's withdrawal of consent was not respected and a staff member stood over the person when they supported them to eat.

● Staff did not always interact with people in a positive way. Staff placed protective clothing onto people at lunch time. Staff did not seek consent, explain what they were doing, or offer people the opportunity to do this for themselves.

● People were able to attend meetings to share their views and gain information about changes at the home. Minutes of the meeting showed people thought the staff were "fantastic" in the way they had responded to the COVID-19 pandemic.

● The provider and manager worked with external agencies and health professionals to help provide a collaborative approach to care.

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<br><br>Regulation 12 1, 2 b, d, h. People were not always protected from the risk of infection and avoidable harm. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Regulation 17 1, 2, b, c, f, 6 ,b. Records were not always stored securely, accurate and contemporaneous. Governance systems and arrangements had failed to identify and rectify the areas of concern we found on inspection. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Regulation 18 1 Staff were not always deployed effectively to support people when they needed help. |