Mr Laurence John Waitt

Shottendane Nursing Home

Inspection report

Shottendane Road
Margate
Kent
CT9 4BS

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Shottendane Nursing Home supports up to 38 people who have nursing needs, dementia and require end of life care. At the time of our inspection they were supporting 36 people. Shottendane Nursing Home is a large building with care being provided over three floors and sitting in large grounds.

People's experience of using this service:
People were not protected from the risk of the spread of infection. Staff did not wear or change their personal protective equipment (PPE) in line with government guidance. The provider did not follow government guidance in relation to visiting or admitting new people into the service.

Risks to people were not always assessed and mitigated. Risk assessments did not contain sufficient information on how to address health risks. Risks relating to thickening powders had not been assessed or mitigated. Environmental risks such as broken window restrictors had not been identified.

There was not sufficient staff; this included nursing, care workers and activity staff. Relatives told us there was a lack of engagement and activities for their loved ones. Some staff lacked understanding of safeguarding principles. When incidents occurred they were not always documented, and action taken to reduce similar incidents re-occurring.

Medicines were not managed safely; there was a lack of guidance to inform staff about some people's medicines.

The oversight and governance systems were ineffective. Some issues identified in audits – such as window restrictors in other parts of the building had been identified as needing action, however there was no information on what action was taken to address shortfalls. Care plans were basic and in some cases did not contain sufficient information on action to take to reduce risks. There was a lack of learning from incidents and oversight of accidents and incidents was not robust. There was no system in place to review accidents and incidents and incidents reoccurred. When we raised issues with the management team, they took action, for example completing an infection control audit, and an audit on all window restrictors.

Relatives told us they felt well informed of the care their loved ones received, however they had not been kept up to date in other matters. For example, when the registered manager left the home, relatives were not informed until the following month. Communication regarding visiting had not been clear, and some relatives were unaware if they could visit their loved ones.

Staff told us Shottendane Nursing Home was a good place to work. Relatives told us the staff were caring and were kind to their loved ones. Staff and the manager had welcomed support from healthcare professionals.

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 30 May 2019).

Why we inspected
We received concerns in relation to safeguarding concerns and people's nursing care needs. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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. This included checking the provider was meeting COVID-19 vaccination requirements.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Shottendane Nursing Home 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 monitor the service and will take further action if needed.

We have identified breaches in relation to infection prevention control measures, medicines, staffing, recruitment of staff and governance systems at this inspection.

Following the inspection, we took immediate action to restrict admissions to Shottendane Nursing Home, and impose urgent conditions on the providers registration in relation to infection prevention and control. We took further action to impose further conditions on the providers registration following the inspection.

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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement

procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Is the service well-led?

Inadequate

The service was not well-led.

Shottendane Nursing Home

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.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Shottendane Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Shottendane Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided. The previous registered manager left the service on 8 February 2022 and the provider was seeking a replacement.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 used all this information to plan our inspection.

During the inspection

During the inspection we spoke with three people that use the service. We spoke with eight members of staff including the manager, nurse and care workers and domestic staff. We reviewed a range of records. This included five people's care records 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 quality assurance records. We spoke with six relatives about the care provided.

Inadequate

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 Inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

- We were not assured by the provider's infection prevention and control processes. At the time of our inspection there was a COVID-19 outbreak at the service. We observed care staff wearing their masks below their nose, and reception staff with no masks on. We raised this with the manager but it was not addressed, and staff continued not to wear masks or to wear them incorrectly.
- One staff member was wearing a fabric mask, which is not in line with government guidance. They spoke with the manager and were not challenged on their incorrect use of personal protective equipment (PPE). Instead the manager directed them further into the home. Another member of staff was observed coming out of the bathroom, not changing their PPE, including mask, gloves and apron and then going into the kitchen.
- Used PPE was not always disposed of in line with guidance. Used PPE had been discarded in open bins, or swing bins. Bins with discarded PPE contained the wrong bin liners. When we asked staff how they disposed of the waste, they confirmed they intended to dispose of it in general waste, not 'offensive waste' in line with guidance.
- Staff collected people's laundry from their rooms and placed their bags within the same laundry bin. This risked anything on the outside of the bag being transferred from contaminated bags to non-contaminated bags.
- The provider had not followed government guidance and admitted two new people during their COVID-19 outbreak. The manager told us they sought advice from healthcare professionals prior to admitting people, however there was no risk assessment to consider the risks to new people moving into the service.
- Some people had signs on their doors to indicate if they were COVID-19 positive, and what date their isolation period began. However, not all information was completed on the signs making it difficult to determine which people had COVID-19, and which did not. Some people who were COVID-19 positive did not have anything to indicate this on their doors.
- The provider was not supporting visiting in line with government guidance. Relatives told us they had been stopped from visiting the service and had time limitations placed on their visits.

Assessing risk, safety monitoring and management

- Thickening powder is used to make fluids thicker so that people with swallowing difficulties can drink safely. If the thickening powder is swallowed without fluid, it can form an obstruction and people would be at risk of choking. We observed thickening powder in people's rooms, accessible to them and anyone who may walk into another person's room, for example someone living with dementia. We asked staff where thickeners were usually kept, and they informed us they were kept in people's rooms. We asked the manager if they had assessed this risk, and they confirmed they had not. Following our inspection the provider's consultant informed us thickeners had now been stored safely and all staff had reviewed guidance on the

use and storage of thickener.
● Risks to people had been identified but care plans and risk assessments to inform staff of what action to take to reduce risks to people were insufficient. For example, one person was identified as being at high risk of falls. Their risk assessment did not detail what to do in the event of a fall, and if any support should be sought from healthcare professionals following a fall, for example the GP or falls team.
● Some people had catheters. A catheter is a tube that is inserted into the bladder, allowing urine to drain freely. There was no risk assessment to inform staff what measures to take if the catheter became blocked or if the area was infected. Staff were required to document the fluid input and urine output of the person to ensure the catheter was working correctly, however the documentation was inconsistent and incorrect on some dates. This had not been identified by the manager.
● Environmental risks had not always been assessed and mitigated. On the first floor there were two rooms which did not have working window restrictors in place. These rooms were unlocked and accessible to people. The provider had not identified this risk or taken any action to reduce the risk to people. Following our inspection the provider completed an audit of all window restrictors and informed us that restrictors were now in place as necessary.
● There was a portable heater in the lounge, which posed a potential fire risk. The manager confirmed there was no risk assessment in place to consider and mitigate any risks to people. People had access to a large garden, which contained a patio area with seating and a pond. The pond had no fence or barrier to mitigate any risk of someone falling in. The manager confirmed there was no risk assessment in place to reduce the risk to people, especially those living with dementia who could be confused and visitors.

Learning lessons when things go wrong
● Accidents and incidents were not always documented to enable staff to learn from instances. For example, one person had removed their catheter, however this was not recorded. When the person removed their catheter for the second time, there were no lessons learnt to try to review why it happened and reduce the likelihood of it re-occurring.
● There was no accident and incident oversight to look for patterns and trends and implement improvements. For example, when a person fell there was no analysis completed to establish the cause of the fall such as the time of day or the number of staff on duty at the time. When someone did fall, action taken to reduce the risk of a further fall was not documented, such as a referral to the falls team or a review by the GP.

Using medicines safely
● Medicines were not always managed safely. Some people had pain relief patches, which are required to be repositioned to a different site to help prevent skin irritation or possible skin breakdown. Staff did not record the exact position of where the patch was applied and could not demonstrate they were applying the patch in line with best practice.
● There was no guidance to help staff assess if people were in pain. Some people were unable to vocalise their pain verbally, placing them at risk of not receiving the pain relief they required.
● Some people were prescribed medicines on an 'as and when' basis. There was no protocol in place to inform staff the reason for administering the medicine and how to know if it was effective.
● We completed a reconciliation of medicines and found that the stock levels did not match numbers documented on the medicines administration record (MAR). Some people were prescribed thickeners, however we found people using thickeners that had been prescribed for other people. Staff could not be assured that people took their medicines as prescribed.

The provider had failed to assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks. The provider had failed to manage medicines safely. The provider had failed to

assess the risk of, and preventing, detecting and controlling the spread of infections. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There were not always sufficient numbers of nursing staff deployed. The manager told us they needed two nurses on day shifts. On the day of our inspection, and six other instances in March 2022, rotas confirmed there was only one nurse working a day shift. Staff told us, "Sometimes there is just one [nurse] and it is too much," and, "It is a lovely place to work but we need more nurses."

● The manager told us they based the number of staff needed to work each day on their dependency tool. They told us they needed eight care workers each day, however rotas reviewed showed they fell below that number every day on the week prior to our inspection. Staff told us, "There's enough staff if we have the full complement in."

● All relatives we spoke with felt there was not enough staff. One relative told us, "The carers when I go in to visit are lovely. But there is not enough of them. They are busy all the time, it got to the point we told [my relative] to call for the toilet 30 minutes before she needed it." Another relative told us, "It's fairly clear they are understaffed."

● During our inspection, we found everyone to be in their room with their doors shut. Relatives told us there was little engagement or activities for people to take part in. Comments from relatives included, "They don't have the activities like they used to have. They don't get out the chair as much as they used to. [Relative] is getting a bit down about it," and "Just because they are unwell doesn't mean they have to sit in their bed all day." A relative also said, "They keep saying that they are short staffed. When mum asks to get out the chair the carers say they can't do it." The provider had recruited a new activities staff member, and following the inspection sent us photographs of people in the lounge taking part in an activity.

● The manager informed us they were trying to recruit both nurses and care workers. In the meantime, the provider sought support from agency staff, however they were not always able to cover the vacancies.

The provider had failed to deploy enough trained and competent staff. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were not always recruited safely. There were gaps in the employment history for two of the three staff files we reviewed. There was no evidence the provider had explored the gaps with staff prior to them starting work to ensure they were suitable to be employed working with people.

The provider had failed to maintain accurate records relating to people employed at the service. This is a breach of Regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Staff knowledge about safeguarding was inconsistent. Not all staff we spoke with understood the principles of safeguarding, and where to report concerns of abuse.

● Staff told us they had received training in safeguarding; however the provider's training matrix did not include safeguarding for carers, and not all nurses had completed safeguarding training.

● Our inspection was prompted in part by concerns raised by relatives to the local authority safeguarding team, which staff had not identified or reported. Relatives had expressed concerns that basic needs were not being met for example drinks were left out of reach of people, and poor catheter care.

● The manager worked with the local authority safeguarding team when issues were identified, however, these had not been identified by staff and the manager. There was a lack of understanding and reporting of safeguarding.

The provider failed to operate effective systems and processes to protect people from abuse and improper treatment. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The providers oversight and quality assurance was insufficient and had not identified and acted on the failings documented within this report. Since our last inspection the quality of the service had significantly deteriorated. People were at risk of harm; there was a lack of guidance for staff and a lack of action to mitigate known environmental risks.
- There was no registered manager at the time of our inspection. The registered manager left the service in February 2022. Although the provider was sourcing a replacement, the day to day running of the service was the responsibility of the compliance manager and there was insufficient oversight and support.
- There provider had failed to keep clear and accurate records. Care records were not always complete or up to date. For example, one person's personal evacuation plan (PEEP) had not been updated to reflect them changing rooms. Records relating to people's nutrition and supplements were not consistent or recorded in one place, therefore it was difficult to assess if people had received the nutrition they needed.
- The provider failed to introduce measures to reduce or remove risks to people through effective care planning. One person's care plan detailed they needed to be weighed weekly, but they were weighed monthly. They had no weight recorded for some months, and incorrect details completed for other months. Another person's care plan detailed they had a catheter in place, however the manager confirmed this was not the case.
- Care plans were not person centred and lacked basic details, including a photograph of the person.
- The health and safety audit completed in February 2022 detailed that staff knew how and where to report accidents and incidents; we found that staff had not done this. It also identified there were no window restrictors in some rooms, but action to address this was not taken, and no follow up documented.
- The health and safety audit completed in February 2022 also detailed that staff were not carrying out checks on water outlets, to check for and reduce the risk of scalding. No further information was documented on what action had been taken to address this shortfall.
- There was a lack of learning and improvement. Accidents and incidents were not used as an opportunity to implement robust risk mitigation to lower the risk of the incident reoccurring.
- The provider failed to ensure staff training was complete and up to date. The providers training matrix had not been updated in 2022. Staff had not all completed key training including safeguarding, manual handling and falls. Systems to monitor and improve the service were therefore infective.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Information shared with relatives had not been done in a timely manner. For example, the previous registered manager had left the service on 8 February 2022, however relatives were only informed about this in March 2022.
● Relatives told us they had received notification from the service that all visits to their loved ones were to be stopped due to an outbreak of COVID-19. However, there was confusion about when visits could re-commence, with relatives telling us they had not been informed.

The provider failed to assess, monitor and improve the quality and safety of the service. This left people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection, the provider sent a request for feedback from all relatives.
● Staff told us they had regular staff meetings and felt they were well informed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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
● Relatives told us they felt there was a positive culture, and that staff cared for their loved ones. One relative told us the care was good, and other relatives told us staff were kind and caring towards their relative.
● Staff told us there was a good atmosphere within the service; that staff worked together well. Staff told us the manager was approachable and resolved any issues they identified.
● The duty of candour requires that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. We found that the manager had been open and honest, and understood their responsibility to comply with the duty of candour.

Working in partnership with others
● Staff and the manager had worked closely with the local health teams including the GP. The service had also received support from the local clinical nurse advisor and clinical commissioning group.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks. The provider had failed to manage medicines safely. The provider had failed to assess the risk of, and preventing, detecting and controlling the spread of infections.

The enforcement action we took:

We imposed an urgent condition on the providers registration in relation to infection prevention and control.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to operate effective systems and processes to protect people from abuse and improper treatment.

The enforcement action we took:

Imposed condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to assess, monitor and improve the quality and safety of the service. The provider failed to maintain accurate records relating to people employed at the service.

The enforcement action we took:

Impose condition

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

Treatment of disease, disorder or injury

The provider had failed to deploy enough trained and competent staff.

The enforcement action we took:

Impose condition