

# Sanctuary Care (South West) Limited

# Lake and Orchard

# Residential and Nursing

# Home

## Inspection report

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## Ratings

|                                 |                         |
|---------------------------------|-------------------------|
| Overall rating for this service | Inspected but not rated |
| Is the service safe?            | Inspected but not rated |

# Summary of findings

## Overall summary

### About the service

Lake and Orchard Residential and Nursing Home provides nursing and personal care and support up to a maximum of 90 people. There are two separate units within the home divided into nursing care and residential care. At the time of our inspection, the provider was not using one of the units. At the time of this inspection 27 people were accommodated.

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

Despite service users with more complex having moved to alternative accommodation, we continued to identify risks relating to service users' nutrition and hydration needs being met, poor pressure area care, failure to provide effective personal care, poor moving and handling practices, inadequate infection prevention and control and failure to support people appropriately to manage their health conditions.

For more details, please see the full report which is on the Care Quality Commission's (CQC) website at [www.cqc.org.uk](http://www.cqc.org.uk)

### Rating at last inspection and update:

The last overall rating for this service was inadequate (report published 19 August 2020). There were multiple breaches of regulation. We took action to require the provider to seek the express written permission of the Care Quality Commission (CQC) for any new admissions to the home. At this inspection not enough improvement had been made and the provider was still in breach of regulations. The service has been rated requires improvement or inadequate for the last eight consecutive inspections.

### Why we inspected

We undertook this targeted inspection to check on specific, ongoing concerns we had about people's eating and drinking, skin integrity, infection prevention and control and staffing. The overall rating for the service has not changed following this targeted inspection and remains inadequate.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

### 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 breaches in relation to safety, staffing, cleanliness and maintenance of the premises and safeguarding of people from abuse at this inspection.

Because of the serious concerns relating to people's welfare and safety we have taken immediate enforcement action to prevent the provider from operating a regulated service at this location.

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

We always ask the following five questions of services.

### Is the service safe?

At our last inspection we rated this key question inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

### Inspected but not rated

# Lake and Orchard Residential and 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 Care Act 2014.

This was a targeted inspection to check specific concerns we had about people's eating and drinking, skin integrity, infection control and staffing.

### Inspection team

The inspection was carried out by two inspectors and a specialist tissue viability and older people's nurse.

### Service and service type

Lake and Orchard Residential and Nursing Home 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 did not have a manager registered with the CQC. For services with a registered manager, this means they 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

We reviewed feedback from the local authority and professionals who work with the service at daily meetings. The provider was not asked to complete a provider information return before this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took the information we had into account when we inspected the service and made judgements in this report. We used all of this information to plan our inspection.

### During the inspection

We spoke with six people who used the service about their experience of the care provided and we observed staff providing care and support to people. We spoke with 12 members of staff including two representatives from the provider, the manager, deputy manager, three care workers, two domestic staff, a kitchen assistant, chef and maintenance staff member.

We reviewed a range of records. This included six people's care records, a selection of records relating to the management of the service and information relating to staffing.

# 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 inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong

At our last inspection the provider had failed to take all practical action to mitigate risks to people including risks associated with medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Practice continued to place people at risk of avoidable harm and had resulted in actual harm.
- Continued inadequate management of people's skin and tissue viability had resulted in the development of pressure ulcers. Staff had not acted to prevent pressure ulcers from developing and people's care records did not accurately record the skin damage people had sustained.
- Staff completed records for documenting pressure relief for people despite not actually moving people as recorded.
- Throughout the inspection we observed incorrect use of manual handling aids such as hoists, which put people at risk of injury.
- People with swallowing difficulties were put at risk of choking. Staff did not follow people's care plans to provide food and fluids in a form that could be swallowed without aspiration or provide adequate mealtime support to ensure people ate enough. For example, one person who needed a soft diet had chicken, vegetables and potatoes for lunch. Staff provided no support to the person to eat and recorded that they had finished their lunch which they had not.
- Out of date medicines had not been disposed of safely.
- Despite having been made aware of our concerns relating to safety, we found lessons had not been learned and issues persisted.

We found evidence that people had been harmed. Care was being delivered in ways that placed service users at risk of exposure to significant risks to their health, safety and welfare. The provider's systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to have sufficient numbers of competent staff. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

- Staff had been appointed to more senior roles without always having an interview or support to help them understand their new responsibilities. The provider could not be sure these staff had the knowledge, skills and competency to perform their duties.
- The provider had appointed a member of staff as manager without interview, who in turn had appointed a deputy manager, also without interview.
- Staff were stretched in their duties and focused on completing tasks rather than providing person-centred care and support. One person told us, "I rung and rung and rung and no-one came."

Failure to have sufficient numbers of competent staff was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

### Preventing and controlling infection

At our last inspection the provider had failed to maintain clean and properly maintained premises. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 15.

- The call-bell system alerted staff to respond in emergency situations to rooms which did not match the room numbers assigned. Scraps of paper had been stuck behind a display monitor which highlighted the discrepancies though this was contradictory and unclear.
- There was a general disregard for good infection prevention and control practices.
- We found one person's toilet covered in faeces, which was witnessed by staff, who took no action to clean this.
- Staff did not wash their hands or change their gloves and/or aprons in between caring for people or deep cleaning people's bedrooms.

The provider had failed to maintain clean and properly maintained premises. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

### Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to safeguard people from abuse and improper treatment. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Care Quality Commission (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.



- Staff did not protect people from the risk of abuse or improper treatment.
- One staff member had intended to use anti-bacterial hand wash and paper towel to provide personal care to one person who had sustained skin damage.
- One person who had recently moved to a new area of the home had tried to call staff for help with personal care. They told us staff had told them they didn't have time to respond.
- We observed one member of staff remove a cushion from behind one person living with Dementia, for use for another person, without any explanation.

The provider had failed to safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment. 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.

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 12 HSCA RA Regulations 2014 Safe care and treatment  |
| Treatment of disease, disorder or injury                       | Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

### The enforcement action we took:

Urgent action to vary a condition of registration to remove the location

| 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   |
| Treatment of disease, disorder or injury                       | At our last inspection the provider had failed to safeguard people from abuse and improper treatment. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Care Quality Commission (Regulated Activities) Regulations 2014. |

### The enforcement action we took:

Urgent action to vary a condition of registration to remove the location

| Regulated activity   | Regulation  |
|--|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment   |
| Treatment of disease, disorder or injury                       | The provider had failed to maintain clean and properly maintained premises. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

### The enforcement action we took:

Urgent action to vary a condition of registration to remove the location

| Regulated activity   | Regulation   |
|--|--|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing  |
| Treatment of disease, disorder or injury                       | Failure to have sufficient numbers of competent staff was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

**The enforcement action we took:**

Urgent action to vary a condition of registration to remove the location