Sanctuary Care (South West) Limited

Lake and Orchard Residential and Nursing Home

Inspection report

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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
Lake and Orchard Residential and Nursing Home is a care home providing personal and nursing care to 47 people aged 65 and over at the time of the inspection, including those living with dementia. The service can support up to 90 people.

The care home accommodates people across two separate units each has separate adapted facilities. At the time of our inspection, the provider was not using one of the units.

People's experience of using this service and what we found
The provider had failed to make and sustain improvements following the last inspection. The service did not provide a good level of safe care for people. People were at risk of avoidable harm because risks were not recorded accurately, monitored or managed. People were not safeguarded against the risk of abuse. Staff had not identified or raised concerns we identified in relation to administration of medicines, people's care, including pressure area care. We raised safeguarding concerns for three people as a result of the inspection, as we could not be sure their care had been managed appropriately and sufficient action put in place to keep them safe.

Health and safety was not well managed. This put people at risk of potential harm. Sufficient planning and preparations had not been made to support the safe evacuation of people in the event of a fire. We contacted the local fire service to request a visit to the service and support the provider.

Medicines were not managed safely. We could not be sure people received their medicines as prescribed. Medicines were not always returned to the pharmacist when no-longer required.

There were not always enough staff to give people the care and support they needed. The provider had not staffed the service in-line with people's assessed dependency levels.

Audits were ineffective. They had not identified the issues we found, including with health and safety and staffing. The provider had not always worked openly and acted on requests made by the Care Quality Commission (CQC).

People had been moved to a different unit in the service or in some cases, moved floors without consultation. The moves were poorly planned and carried out, causing significant distress and upheaval for people. People, relatives and staff feedback about this experience was negative.

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 overall rating for this service was requires improvement (report published 16 March 2020). There

were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do, and by when, to improve. 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
The inspection was prompted in part due to concerns received about management of people's pressure areas, catheter care, medicines and care needs. A decision was made for us to inspect and examine those risks. We carried out a focused inspection to review the key questions of safe and well-led only.

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. Rating from the previous comprehensive inspection for those key questions were used in calculating the overall rating at this inspection.

The overall rating for this service has changed from requires improvement to inadequate. 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.

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 as 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 person-centred care, safe care and treatment, safeguarding service users from abuse and improper treatment, premises and equipment, good governance and staffing.

Because of the serious concerns relating to people's welfare and safety we have taken 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

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.

Inspection team
The inspection site visit was carried out by one inspector. Two inspectors supported the inspection remotely by speaking to relatives and staff.

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.

At the time of our inspection one of the units at the service was being used. The provider had taken the decision to close one of the units to refurbish it. One floor specialised in providing nursing care, the other provided residential care.

The service did not have a manager registered with the CQC. A manager was working at the service, they left the service following our site visit. We have referred to them as 'the manager' throughout this report. 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 announced less than 24 hours prior to arriving at the service.

What we did before the inspection
We reviewed information we had received about the service and the information the provider had sent us since the last inspection. We sought feedback from the local authority, clinical commissioning group and professionals who work with the service. The provider was not asked to complete a provider information return prior to 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 the judgements in this report. We also used all of this information to plan our inspection.

During the inspection
The inspection was carried out by conducting a site visit, speaking to relatives and staff remotely and reviewing a range of records remotely. We spoke with three people who used the service and four relatives about their experience of the care provided. We spoke with ten members of staff including the manager, the provider, nurse, care workers, housekeepers and a maintenance worker.

We reviewed a range of records. This included five people's care records in part and three medication records. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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 requires improvement. At this inspection this key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to take all practical action to mitigate risks to people. 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.

- The service had a track record of failing to provide good standards of safety.
- Known risks to people were not managed effectively to keep them safe and meet their care needs. For example, one person had been identified as being at very high risk of weight loss with a weight of 28.8kg and a body mass index of 11.53. Their nutritional intake records showed opportunities to promote their food intake were regularly missed.
- Monitoring records, including pressure area checks and fluid input and output charts were not always in place for those requiring care for these areas. One person had previously been admitted to hospital due to problems with their catheter. During our inspection a nurse told us the person's catheter had recently had further issues. No additional monitoring records or checks had been put in place to reduce the risk to this person.
- People remained at risk of avoidable harm as information about their care needs was not consistently recorded to guide staff in how to care for them.
- Fire safety was not planned for and managed. Night staff had not completed any fire drills between March and July 2020 to prepare them for how to respond in the event of a fire. Following our site visit a night fire drill took place. It took staff 7 minutes to respond. This is longer than advised under best practice guidance.
- The provider's own health and safety policy had not been followed. For example, the provider had a policy of using breathable bumpers for bedrails. Maintenance checks in March 2020 identified these were not in place. This had not been addressed by the provider.
- COVID-19 guidance was not always fully assessed and followed. There had been a delay in the provider testing people for COVID-19 following assurances provided to the CQC that these had taken place.

We found some evidence that people had been harmed. 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.

● We reported our concerns about fire safety to the local fire and rescue service.
● The provider told us replacement bumpers for bedrails were being ordered following our feedback.
● During the inspection managers and administration started wearing surgical face masks following our request to do so.

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.

● The provider had failed to sustain changes and improvements made to staffing levels at the last inspection.
● It was not always clear how decisions about staffing levels and deployment were made. The provider's dependency tool was not being followed or used correctly. This meant staffing was low and not sufficient to meet people's assessed needs.
● Relatives and staff told us staffing levels were not sufficient. People experienced inconsistent standards of care from staff who did not always have time to give people the care and support they needed. One relative told us, "When the A team are on it is evident and shows in [Relative's] demeanour. At other times, the care can be very wanting." Another relative said, "There are times when people are left unsupervised or young staff are left on their own who have to shout for help."

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.

● Recruitment checks were completed prior to staff commencing employment.

Using medicines safely

At our last inspection the provider had failed to take all practical action to manage medicines safely and properly. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation2 2014.

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

● Medicines management systems were not always effective. Medicines were not always stored securely or returned to the pharmacist when no longer needed. We found medicines stored in an unlocked cabinet on one unit that was not currently in use. The medicines had been prescribed for a person who had died in May 2020.
● Medicines were not always managed and administered as prescribed. This increased the risk of people receiving unsafe or ineffective care and support. For example, one person's antibiotics were administered over 22 days rather than the 14 days prescribed.
●Morning medicine rounds varied from being completed at 10am to after 12pm; it was not always clear there was a sufficient gap between medicine doses.

We found no evidence that people had been harmed. However, systems were not robust enough to manage medicines safely and properly. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Competency checks were used to observe staff and support their understanding of medicines systems.

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.

● People's health and safety was at risk because the provider did not always ensure the environment was properly maintained. Water temperature checks showed cold water regularly exceeded the temperature recommended by guidance and had not been assessed by the provider.
● All areas of the home were not always cleaned and checked. On one unit of the house, currently out of use, we found two bedrooms smelt strongly of urine. Bin bags filled with incontinence pads were seen in one of the sluices. The manager was not aware of these issues.

We found no evidence that people had experienced harm. However, systems had failed to ensure premises were clean, properly maintained and suitable for their intended use. 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
● People were at risk of abuse and had not always been safeguarded against improper treatment. One person had no personal belongings in their bedroom as staff identified they would damage these. It was not clear how the provider's response was proportionate to the level of risk identified.
● Staff did not always recognise or respond appropriately when people experienced alleged abuse. One relative told us their family member had items that had gone missing from their bedroom, including clothing and some money. They said, "[Person] has told a care worker but nothing happens, they just said there is nothing they can do, [the person] needs to lock their door. But they can't walk, so, how can they?"

Failure to safeguard people from abuse and improper treatment was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Care Quality Commission (Regulated Activities) Regulations 2014.

● We raised three safeguarding concerns with the local authority following concerns we identified as part of the inspection.

Learning lessons when things go wrong
● When accidents and incidents occurred it was not always clear what steps had been put in place to prevent reoccurrences. One relative said, "I am informed when my family member falls, but it is not clear what changes are made to prevent them."
● A system had been introduced to monitor and review accidents and incidents to understand patterns or trends. Further work was needed to embed this and review and share learning.

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 the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. 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

At our last inspection the provider had failed to operate effective systems to monitor quality, safety and maintain accurate and complete records. This was a breach of regulation 17 (Good governance) 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 17.

● We found repeated and significant shortfalls across the service. Breaches identified at the last inspection had not been met. The provider's action plan had not been effective in addressing these.
● The service had been rated requires improvement or inadequate for the last eight inspections and had failed to provide good care.
● The service had been without a manager registered with CQC since November 2019. A manager was in post at the time of our site visit, shortly after this they left the service.
● People remained at risk of harm as systems to monitor quality and safety were ineffective. The provider had not identified the shortfalls we found with medicines systems, health and safety, safeguarding, staffing and person-centred care.
● When audits highlighted issues, these had not been actioned. For example, incomplete care records had not been followed up due to staff members not being able to identify which people's records the issues related to.
● The manager failed to work openly and act on requests made by CQC. The manager had not raised a safeguarding concern in a timely way when this was requested.

Failure to operate effective systems to assess, monitor and improve quality and maintain accurate and complete records was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Decisions were made about people's care and living arrangements without consulting them. People were

moved to a different unit and different floors to enable a refurbishment to take place without being given information they needed. We could not be assured that similar changes would not take place in the future or that there had been learning from people's experiences.

● People, relatives and staff told us the recent move had been badly planned. One nurse said, "It was all a bit chaotic and not very good." This caused significant distress and upheaval. One person said, "They didn't tell us they were going to move us. All at once at teatime they moved us and told us." The move had meant the person was no-longer able to access bathing or shower facilities in their bedroom, impacting on their dignity. They told us, "I have to be wheeled down the corridor for this."

● Following the move, people found themselves receiving care from staff that were unfamiliar with their care needs and preferences.

● People did not feel engaged in the running of the service. One person said, "We don't have resident's meetings, they don't have time for it."

● There was little evidence of partnership working with other professionals. Views and advice from health and social care professionals was not requested when decisions were being made on people's behalf.

● Staff morale was low as they did not feel their concerns were fully listened to or acted on, including in relation to staffing levels.

Failure to provide people with care and treatment that met their needs and reflected their preferences was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 received an apology and were informed when mistakes occurred. They could not be confident changes would be made to prevent them happening again.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people's care and treatment was appropriate, reflect their preferences and that they were enabled and supported to make or participate in decision making relating to their care and treatment. Regulation 9 (1)(c)(3)(a)(b)(d)(f)(g)

The enforcement action we took:

Notice of decision to impose conditions to restrict admissions. Notice of proposal to vary the provider's conditions to remove the location.

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 take all practical action to mitigate risks to people and ensure the proper and safe management of medicines. The provider had failed to assess the risk of and prevent, detect and control the spread of infections. Regulation 12 (1)(2)(a)(b)(g)(h)

The enforcement action we took:

Notice of decision to impose conditions to restrict admissions. Notice of proposal to vary the provider's conditions to remove the location.

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 had failed to protect service users from abuse and improper treatment and have systems and processes established and operated effectively to prevent abuse of service users. Care included acts intended to control service users that were a proportionate response to the risk of harm and deprived service users of their liberty

	without lawful authority. Regulation 13 (1)(2)(4)(b)(d)(5)

The enforcement action we took:

Notice of decision to impose conditions to restrict admissions. Notice of proposal to vary the provider's conditions to remove the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to maintain clean, properly maintained premises suitable for their intended used. Regulation 15 (1)(a)(c)(e)

The enforcement action we took:

Notice of decision to impose conditions to restrict admissions. Notice of proposal to vary the provider's conditions to remove the location.

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 had failed to operate effective systems to monitor quality and safety and maintain accurate, complete records. Regulation 17 (1)(2)(a)(b)(c)(e)

The enforcement action we took:

Notice of decision to impose conditions to restrict admissions. Notice of proposal to vary the provider's conditions to remove the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient numbers of suitably qualified, competent, skills and experienced staff were deployed. Regulation 18 (1)

The enforcement action we took:

Notice of decision to impose conditions to restrict admissions. Notice of proposal to vary the provider's conditions to remove the location.