Sanctuary Care (South West) Limited

Lake and Orchard Residential and Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
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 64 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 wings, each has separate adapted facilities. One of the wings specialises in providing nursing care.

People's experience of using this service and what we found
People did not receive good quality care. The provider had failed to make improvements and act on recommendations made by professionals following the last inspection. We met with the provider during this inspection to outline the improvements required and to seek assurances of their commitment to making improvements at this service.

We found no evidence people had been harmed but they were at risk of avoidable harm due to the ineffective governance arrangements in place. For example, risks, accidents and incidents were not always managed and monitored effectively to keep people safe and prevent reoccurrences. Medicines were not managed safely due to shortfalls in administration arrangements and records. The environment had not always been properly cleaned and maintained to keep people safe and prevent infection. Care records did not always show checks, including pressure area checks, had been completed to evidence people's care needs were being met. Improvements were needed to records kept about people's care and support.

People's needs were not always met in a timely, responsive way because the provider had not ensured sufficient staff were on shift. Staffing arrangements did not support the delivery of high-quality, dignified care. Feedback from relatives and observations showed us there were times when people had to wait extended periods for support. For example; people did not always receive timely or effective support to eat and drink. The provider reviewed their staffing levels following our inspection and agreed to increase staffing levels.

People were not always offered choices about their care. Family members were not always involved in the care of their relatives. People were therefore not supported to have maximum choice and control of their lives. Staff supported people in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff were not always suitably trained or supported to meet people's needs. For example; staff needed more knowledge in end of life care. All of the staff we met were motivated to provide the best care possible for people and felt frustrated that they were not able to deliver the care and support in a more person-centred way because of the poor staffing levels. The provider's responsiveness following inspection and commitment to increase staffing levels should enable staff to work in a more person-centred way.

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

Rating at last inspection
The last rating for this service was requires improvement (report published 8 February 2019). The service remains rated requires improvement. This service has been rated requires improvement for the last seven consecutive inspections.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to person-centred care, safe care and treatment, premises and equipment, good governance and staffing. Please see the action we have told the provider to take at the end of this report.
The provider had also failed to ensure statutory notifications were submitted to the CQC. This is a breach of regulation Full information about CQC's regulatory response to this is added to reports after our process outside of inspection has been concluded.

Follow up
We wrote to the provider to request an improvement plan to address the shortfalls we found on inspection. We will meet with the provider after publishing this report to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive 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
Three inspectors carried out the inspection on day one along with a specialist infection control and prevention nurse. On day two of the inspection one inspector, an assistant inspector and an Expert by Experience visited. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Day three of the inspection was completed by one inspector and an inspection manager.

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. A manager had recently started at the service and was in the process of applying to register. 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 on the first day. We told the provider we would be visiting on the second and third days.

What we did before the 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. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 11 people who used the service and seven of their relatives. We spoke with 16 staff, including the nominated individual, representatives from the provider, the peripatetic manager, manager, maintenance worker, nurses, senior care workers, care workers and an agency member of staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included six people's care records and 12 medicine records, three staff recruitment files and six staff supervision and appraisal records. We also looked at records relating to the management of the service, including the provider's staffing tool and quality assurance checked.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and a sample of the provider's policies and procedures. We spoke with one professional who regularly visits the service.

Requires Improvement

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 remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk people could be harmed.

Staffing and recruitment

- Staffing levels were not sufficient to meet people's care needs in a timely way. We observed relatives supervising people and offering them reassurance when staff were not present in communal areas.
- The provider had a tool to determine how many staff were needed. The tool was being used incorrectly and this had led to low staffing levels. We found on multiple occasions there were less staff on shift than the provider had identified were needed.
- Feedback from people, relatives and staff consistently identified concerns around staffing levels. One relative described visiting the service each day to feed their family member. They told us, "I don't know how long it would be before [person] was fed if I wasn't here." Another relative said, "I've been here and seen how stretched the staff are, they can't manage the number of people that are very demanding."

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 provider reviewed their staffing levels and following this, an overall increase in staffing levels was agreed.
- Safe processes were followed to ensure appropriate staff were recruited.

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

- People were at risk of avoidable harm because risk assessments did not always describe how to support people safely. For example, wound care plans were not accurate or completed to guide staff in where the pressure damage was, and how to provide appropriate care.
- Care plans did not always refer to people's behavioural needs where people may present with behaviours that challenge the service. This is information to help staff understand how these behaviours may present and strategies for supporting people.
- Accidents and incidents were not monitored effectively or used as learning opportunities to improve the safety of people's care. They had not been reviewed, checked or signed off by management to make sure all appropriate action had been taken.
- Relatives did not always feel confident their family members were safe. One relative told us, "Some of the time I feel [person] is safe, others not."

Failure to take all practical action to mitigate risks to people was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider took action following our feedback on day one and improvements were seen to the monitoring of risk and wound care records on the second and third day of inspection.

Using medicines safely

● Medicines were not managed safely. Peoples health and wellbeing were at risk because we could not always determine if people had always received their medicines as prescribed. Medicine administration records did not always specify when people had taken their medicines.

● Staff had to access some medicines which were stored securely with colleagues from other parts of the service. This caused delays and impacted on people receiving their medicines in a timely way.

We found no evidence 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.

● Improvements were seen to medicines records and administration arrangements on the second day of inspection.

● Medicines were stored appropriately and returned and disposed of when no-longer required.

Preventing and controlling infection

● The environment was not properly maintained and cleaned. Recommendations made by a specialist community infection prevention and control nurse in May 2019 had not been actioned to reduce the risk of infection and improve cleanliness throughout the service. For example, changes to the laundry to ensure there was a clear dirty to clean flow to prevent cross contamination.

● Health and safety checks were not always recorded, and issues were not acted on responsively. For example, emergency lighting check records were missing.

● Work to develop the home environment and address minor maintenance issues had been ongoing since the last inspection with no clear end date. People had not benefited from these planned improvements.

Failure to maintain clean, properly maintained premises suitable for the intended purpose was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some improvements were seen on days two and three of the inspection. The provider planned to introduce an ongoing renovation plan to help maintain the home. They advised all recommendations from the infection control audit had been addressed.

● Staff knew when to use personal protective equipment to reduce the risk of healthcare acquired infections.

Systems and processes to safeguard people from the risk of abuse

● Staff knew how to safeguard people against the risk of abuse. They were able to identify signs of abuse and how to report any concerns.

● The provider did not capture details of all the safeguarding concerns raised to monitor these and prevent reoccurrences.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff did not always receive training and support to assist them in their roles. For example, a high proportion of staff had not received training in end of life care, including most of the nurses working at the service. One person was receiving end of life care at the time of our inspection.
- Staff did not always feel sufficiently trained to support people, including people with behaviours that could challenge. They described learning from experience. One staff member said, "Some of the people are very violent and we probably should have training about what to do."
- Staff had not always received supervisions. Nurses had not received regular clinical supervisions to support their knowledge and professional development. When they had highlighted issues, these had not been followed up.
- Nurses and senior care workers did not always have the training, experience or confidence to delegate care tasks to staff, lead shifts and coordinate people's care effectively.
- People were at risk because agency staff had not always received an induction to help them familiarise themselves with the service and people's care needs prior to working at the service.

Failure to provide staff with appropriate support, training and supervision was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had plans in place for staff to complete training, including end of life training.
- New staff received an induction to help them understand their role and responsibilities.

Supporting people to eat and drink enough to maintain a balanced diet

- People received support to eat and drink, at times this was delayed as staff were busy. One relative said, "[Family member] is unable to feed themselves. They were left in bed with a knife, fork and food and left to eat."
- The provider had not ensured their system to monitor peoples eating and drinking was robust. We found no evidence people were harmed. However, the records relating to people weight and food and fluid intake were not always clear or completed properly. For example, recommended daily amounts were not always detailed or totalled to show whether people's nutrition and hydration needs had been met.

- Staff understood people's food and drink preferences and used this knowledge to serve people meals they would enjoy.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● Staff sought advice from health professionals following changes in people's health needs. Information was shared amongst the staff team at handovers. Staff knew the recommendations made but these were not always recorded in people's care plans to ensure these were followed consistently.

● Care plans and information about people's health conditions were not always in place to guide staff in how they needed to provide support and report changes. For example, there was no diabetes care plan in place for one person on day one of the inspection. Improvements were seen on day three.

Adapting service, design, decoration to meet people's needs

● The environment was not always dementia friendly, making it difficult for people to navigate their way around the service. Dementia friendly signage was discussed with the provider and they agreed to implement this.

● Work had been done to make the service more homely, including games and objects for people to engage with around the home.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's care needs were assessed prior to admission to the service to consider if there needs could be met and the level of care required.

● The provider recognised when they could no-longer safely meet people's care needs and worked with the local authority and relatives to address this.

● Consideration had been given to people's oral health and the support they needed in this area in line with best practice.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Staff were aware of how to seek consent, but they did not always follow this in practice. For example, we observed staff pushing a person in a wheelchair without seeking their permission or asking where they would like to go.

● Managers understood when to apply for DoLS and which people had conditions linked to their DoLS. However, systems were not in place to help monitor DoLS and identify when they were due to expire to support managers to work in line with MCA procedures.

● People's mental capacity to make decisions about their care was assessed. Best interest decisions were made in consultation with their relatives. For example, a best interest decision had been made with family where one person required a sensor mat to reduce the risk of them falling.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- People did not always receive person-centred care because staffing levels did not support the delivery of high quality care.
- Staff were observed to delivery task orientated care which did not take into account people's needs or wellbeing. One staff member said, "I feel rushed and think, I could have sat down and had a conversation with this person, we might be the only person they see all day." Another staff member told us, "I often feel I'm compromising the care, sometimes we can't go that extra mile. Sometimes it feels like we're treading water."
- People were not always encouraged to make choices and decisions about their care because staff were so busy. We observed staff instructing people to do things, without offering choice or explaining the care planned to them. For example, one member of staff told a person, "Sit down in the red chair there."
- It was not clear if people were regularly being supported to use bath or shower facilities to meet their personal care needs. Baths and showers were bone dry when we visited, indicating they had not been used. One relative said, "[Person] was told they were going for a shower and prepared for this and at the last moment staff said they couldn't manage it as they were busy."
- Relatives did not always feel involved in the care of their family members or informed about changes in their health. One relative said, "Staff asked the GP on our request to visit, but there was no feedback to tell us about what was decided, we didn't get told what the results were."

Failing to provide people with appropriate person-centred care to meet their needs and preferences was a breach of regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff were aware of people's mental health and emotional wellbeing and took steps to help minimise any distress or situations that may trigger this.
- Staff were motivated to provide caring support, although the provider's systems around staffing numbers did not always promote this. One care worker said, "I love interacting with people and to hear them laugh." Another care worker told us, "Their smiles are priceless."

Respecting and promoting people's privacy, dignity and independence

- People were not always treated with dignity. One relative told us, "My relative wears glasses and can't see without them, staff have lost two pairs and don't seem particularly bothered. Another family member has

written a poster by [person's] bed to remind staff to make sure they have them on, staff don't seem to care about those sorts of things."

- People were encouraged to be independent where possible.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Shortfalls in staffing meant people did not always receive responsive, person-centred care. One relative said, "There are long waits to get help for [person] to go to the toilet." We observed this person was waiting 45 minutes before two staff were available to support them to use the toilet.
- Staff spoke with people to understand their needs and preferences. They considered this when providing their care but were not always able to meet people's preferences due to the staffing levels at the service. For example, one person was observed calling out for staff and required a lot of reassurance, which staff were not always able to provide.
- Care records did not always show people received checks identified as needed in their care plan. For example, where people required checks to prevent pressure damage. Some improvements were seen on day three following the introduction of an electronic care plan system.
- Information in care plans was not always updated or reviewed consistently following changes in people's needs.

Failing to provide people with appropriate person-centred care to meet their needs and preferences was a breach of regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the introduction of a new electronic care system, care records were being updated on day three of the inspection.
- During the inspection a 'Two Together' meeting was introduced to help staff share information about people's life histories.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Staff were aware of people's communication needs. They used their knowledge of people's verbal and non-verbal communication to understand what support they needed.
- Basic information about people's communication needs was included in their care plans. Further work was needed to show compliance with the AIS. For example, including details of what format people required information in to access it.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People had access to a varied activities programme. This included attending a local memory café for people living with dementia.

● Work was ongoing to review how activities were organised and when activities coordinators worked to help people gain maximum benefit from these.

Improving care quality in response to complaints or concerns

● People and their relatives knew how to raise a complaint if needed.

● Complaints were investigated and responded to appropriately by the provider. Relatives did not always feel confident issues would not reoccur.

End of life care and support

● The provider was not well prepared for caring for people needing end of life care. Staff had not always received training in end of life care to prepare them for providing effective end of life care.

● Staff worked with healthcare professionals to identify people that may be reaching the end of their life due to a deterioration in their health.

● Work was ongoing to improve end of life care records and speak with people and their relatives about any preferences they may have for this life stage.

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 requires improvement. At this inspection this key question has now been rated 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

- People were at risk of harm as effective systems were not in place to monitor quality and safety across the service.
- The service had been rated requires improvement for the last seven inspections and had failed to improve to provide a good level of care.
- Changes in management since the last inspection had led to inconsistent leadership. The service did not have a manager registered with CQC.
- Recommendations and suggestions following visits from the local authority, infection control specialist nurse and our previous inspections had not been acted on to support service improvements.
- The provider's quality assurance checks were ineffective and did not drive improvement. There were gaps in audits and the provider was unable to explain the previous registered manager's systems.
- Audits were not reliable and had not identified the shortfalls we found, including with staffing, medicines systems, care records, the environment, risk management, safeguarding records and statutory notifications.
- When audits had identified issues, these shortfalls had not been addressed. For example, monthly medicines audits from March 2019 onwards identified nurses had not received training in specialist end of life equipment and this equipment was not available at the service. This remained outstanding.

Failure to operate effective systems to monitor quality, safety 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.

- We wrote to the provider following our inspection to seek a response to our concerns.
- The provider was introducing a new electronic care plan system. Initial improvements were seen during the inspection. There were plans for this to improve monitoring of the service. These changes had yet to be embedded in practice.
- Changes were made during the inspection to provide the service with manager support seven days a week. The provider told us they would be reviewing their arrangements for monitoring and supporting the service.
- Statutory notifications for incidents of abuse or allegations of abuse had not been submitted to CQC. Statutory notifications are events providers are legally required to inform CQC of.

Failure to notify CQC of abuse or allegations of abuse was a breach of regulation 18 (Notification of Other

Incidents) of the Care Quality Commission (Registration) Regulations 2009. This is being addressed outside of the inspection process.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The provider's systems and practices did not support the delivery of high quality care.

● Staff morale was low due to staffing pressures and following manager changes. One staff member told us, "We've seen so many changes, this has a knock-on effect for staff." The new manager recognised this was a priority to be addressed and had met with staff to listen to their concerns.

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

● The manager understood their responsibility to be open, honest and apologise to people and relatives if things went wrong.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● It was not always clear how people were involved in the running of the service, provided with updates or included in decision-making about the service. People and their relatives did not know who the manager was following management changes. The manager had plans to meet with relatives.

● Staff meetings were held regularly to engage staff in the running of the service. Staff felt able to voice their opinions and make suggestions. It was not always clear that their views were actioned.

● The manager was working to build relationships with community health services.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to provide people with appropriate person-centred care to meet their needs and preferences. (1)(a)(b)(c)

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. (2)(b)(g)

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 purpose. (1)(a)(c)(e)

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

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, skilled and experienced staff were deployed. They had failed to provide staff with appropriate support, training and supervision. (1)(2)(a)