Amberbrook Management Limited

Sandridge House

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

Sandridge House is a care home with nursing that is based in a busy area of Ascot, Berkshire. The care home is set back from the street, close to the High Street of Ascot and nearby Heatherwood Hospital. The location is registered to provide care and support for up to 38 people. At the time of the inspection there were 33 people accommodated. Sandridge House is located in an older style premises with two floors and a number of outbuildings. There is an expansive garden around the care home.

At the time of the inspection, there was no registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The last registered manager left their position in April 2015. A home manager commenced in post in April 2015 and had applied to CQC to become the registered manager. At the inspection the staff member told us they had resigned from their post and would finish in their role as home manager in one month's time.

The previous inspection of Sandridge House occurred on 2 December and 3 December 2015. At that inspection, there were eight breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. The location was rated 'inadequate' overall and placed into 'special measures'. We inspected the service again on 6 January 2016 following information of concern from other organisations following the December 2015 inspection.

This inspection was carried out in response to further information of concern that we had received which indicated that people at Sandridge House were still at risk of harm due to failure to make necessary improvements or that the care people received continued to remain unsafe. The inspection by us on 7 and 8 February 2016 was necessary to again assess the safety of people's care.

We found that some improvements had been made in relation to the documentation used to record the fluids and food people living at the home received. However, these were not consistent. During the inspection visit we saw fluid charts which weren't tallied up and staff we spoke with were unsure of how much fluid people should be drinking. Therefore, they were unsure when to alert senior staff that someone was not drinking enough fluids.

We were concerned about the providers understanding of risk management in regards to recording people's fluid intake. Staff told us they had been told to record what every person in the home ate and drank. Rather than recording this information for people who had been assessed to be at risk of dehydration or malnutrition. This had led to staff spending a lot of their time completing records for people that did not need them. Staff told us they resented having to spend their time completing records as opposed to providing care and support for people.

We also witnessed unsafe practice in regards to one person being fed by staff whilst they were in a position,

which was not safe for eating or drinking. The person was at risk of choking due to the position they were in. We needed to ask the deputy manager to intervene to ensure this person received their food safely.

During the inspection we found that staffing numbers were adequate to meet the needs of the people living in the home However, we found that one member of staff had not received an adequate induction. We could not be assured that the care that they had been providing to people at the home had been safe care due to them not receiving adequate training.

At this inspection, we found that improvements had been made to the storage of chemicals used in the home. These were safely locked away. Improvements had also been made in the area of Infection prevention and control. At this inspection, we found the commencement of changes by the provider to ensure people's safety from infections. We saw a new dirty utility room had been built on the first floor. However, further changes needed to be implemented to ensure people were fully protected from the risks of infection control.

During this inspection we found that although the provider was taking action to achieve safety for people who used the service, the progress was slower than needed to properly protect people.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we took at the back of this report.

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.

People were not protected from receiving food and fluids safely.

Staffing levels were found to be adequate during our inspection.

Staff had not always received an adequate induction to ensure that they knew how to provide safe care.

Sandridge House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was a focussed inspection due to concerning information. The inspection took place on 7 February and 8 February 2016 and was unannounced.

The inspection team consisted of an inspection manager on 7 February. The inspection manager and another inspector on 8 February 2016. Both the inspection manager and inspector work in inspecting adult social care locations. One inspector is a registered nurse.

This inspection took place after the 6 January 2016 focussed inspection. This inspection looked at only one key question; "Is the service safe?"

Before the inspection, we did not ask the provider to complete a Provider Information Return (PIR). This form asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was not required for this type of inspection.

We reviewed the information we held about the service and notifications of incidents we had received. A notification is information about important events, which the service is required to send us by law. We reviewed weekly action plans sent to us by the provider, and information received from local authorities.

Some people who used the service did not have the capacity to express their views. We looked at the care documents for the people who used the service. We also toured the premises and observed care practices by staff on the day of our visit. We spoke with three people and six relatives of people living in the home.

We spoke with the nominated individual, the operations manager, the home manager, the deputy manager, a project manager, eight care staff, two registered nurses, two activities coordinators, the maintenance person and two cleaners. We looked at nine sets of records relating to the care of individuals, staff duty

rosters and other records relating to the running of the service.

After the inspection, we asked the provider to send us further information and evidence.

Inadequate

Is the service safe?

Our findings

At this inspection, our focus was to look at the welfare and safety of people who lived at Sandridge House, especially those who were most vulnerable. During our inspection, we observed care practices and examined people's documentation. This was so we could thoroughly assess the care and associated documentation for people during the inspection to ensure the care provided was safe. We spoke with three people and six relatives of people who used the service. Two of the relatives we spoke with had concerns about the care and support that their relative received. They told us that they were not confident about the amount of food and fluids that their relative received and that their relative had lost weight whilst being at the home. They told us that their relative was moving to a different service. The other four relatives we spoke with were positive about the service. One relative told us "I visit regularly and they [the staff] let me know how [my relative] is".

Seven people did not leave their bedrooms, for example to go to the communal lounge or dining room. These people stayed in their room and for the majority of time, in their beds. This meant that they were more prone to skin integrity issues and were considered a higher risk for possible inattention by staff and poor care. We had received concerns about the care and support these people received from our external partners who visited the service regularly.

We checked the fluid records of the seven people at the home who stayed in their rooms on both days of the inspection. These had been completed regularly throughout the day and showed that people were receiving regular fluids. Since our inspection in January, the fluid recording forms had been improved. The forms now had a place for the care staff to sign when they had given the fluids. However, we found that the totals of fluids were not consistently tallied up. Therefore, it was difficult for staff to see at a glance the amount of fluids that person had consumed that day. We did see evidence on the fluid charts that the nursing staff were checking the amount of fluid people were having at various times through the day. However, staff we spoke with were unsure how much fluid people should be drinking. Therefore were unsure when to raise concerns with nursing staff.

Staff told us they found completing these forms time consuming and it gave them less time to spend with people. When we asked them about this, it became clear that the care staff were recording what all the 33 people living at the home ate and drank. Rather than just those people that, the provider had assessed as being at risk from dehydration and malnutrition. We discussed this with the provider. It was clear from our discussions that they had not assessed the impact of recording what everyone ate and drank on the care staffs workload. This demonstrated a misunderstanding in relation to risk management in the service by the provider.

We looked at the individual care of people who did not leave their bedroom. The first person we visited was in their bed with a support worker feeding them breakfast. The person was having porridge. The support worker was sitting in a chair feeding the person over the bedrail. When we observed the care, we saw the person was lying almost flat in the bed, with the head of the bed only slightly raised. This meant the person was at increased risk of choking because their position was not appropriate for eating. We raised our

concerns immediately with the deputy manager. They agreed the person's position was unsafe and told the support worker to raise the head of the bed, which they did. This meant that the person could continue to eat their breakfast safely.

This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Three people we spoke with told us that the care staff offered them regular drinks. However, we noticed one of these people who stayed in their room was not able to access their drink. This person had a drink at the side of their bed with a tube, which allowed them to have a drink when they wanted one. We asked the person if they were able to reach the tube but they were not able to and asked us to reposition it so that it was in reach for them. This meant that although this person had a drink available, they were not able to access it.

We looked at another person's fluid chart for the period 6 February to 7 February 2016. During the day shift, the person's record showed they had received 1400mls of fluid. We saw that the person's intake was not tallied for the night shift. We calculated from the entries that they had received 350mls. We then looked at the fluid intake for the person from 7 February to 8 February 2016. We found the person had no fluid offers or intake recorded from 7pm on the 7 February to 8am on the 8 February. This meant the person was at risk of dehydration because adequate fluids were not being offered and recorded.

We looked at the person's record for being turned in their bed for 8 February 2016. We saw the last entry on the form was for 7.45am but that the person was on their back at the time of the observation. This was because the support worker had commenced feeding them their breakfast and had not updated the care record.

The deputy manager told us another person who did not leave their room or bed had developed a pressure ulcer on their sacrum. We saw there had been no referral to a district nurse or tissue viability nurse in order to obtain specialist advice about the wound. However, we saw the person was nursed on an alternating air mattress and had regular turns in their bed. The deputy manager explained that dressings of the wound were replaced every three days. We determined this attention to the wound was satisfactory nursing care for the person.

The deputy manager explained this person was receiving end of life care due to their condition. We looked at the person's fluid balance charts and turn records commencing midnight on 7 February 2016 until the time of the inspection. We saw that during a 24-period, staff recorded the person had received 900mLs of fluids. This was a satisfactory amount of fluid intake for an older adult receiving palliative care. Staff turned the person every two hours during the day and every four hours during the night. However, we observed that for a 12-hour period, the person was not turned to their left side. This meant they spent half the time during this period on their back, which placed pressure on their existing sacral wound.

This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at a another person's fluid intake and turn charts for the same periods. We saw they were turned regularly, every two hours during the day and every four hours at night. Staff had also recorded that the person had consumed 1.7L of fluids during a 24 hour period.

The CQC has an obligation to notify partner agencies of certain events, especially where it may affect the welfare or safety of people who use services. Following our January 2016 inspection, we notified the Health and Safety Executive (HSE) that Legionella was detected in a water sample at Sandridge House. On 28

January 2016, the HSE inspector conducted an inspection of the service to assess Legionella prevention and control. On that date, the HSE prohibited the use of all shower and spray heads in the care home. This was due to the risk of older adults being exposed to Legionella during showers. The HSE provided advice to the service that showers could be used again if they installed special filters on the showers. The provider sent us evidence that these had been installed, that a water management consultancy was taking urgent action and making repairs and modifications to the water supply. At our inspection, we found three showers with the special filters installed, and safe for use. However, one shower hose and head, although unscrewed, did not have the filter attached and could be used. We pointed this out to the maintenance person, who took the shower hose away. At the time of the inspection, the care home was still subject to an 'improvement notice' from the HSE related to Legionella prevention and control, and was scheduled to have another inspection to check compliance.

During the inspection, we found that staffing levels in the home were adequate. For example, we saw there were two registered nurses and six support workers deployed during the morning shift, as well as the home manager and deputy manager. At the December 2015 and January 2016 inspection, people told us they sometime had to wait a long time for staff to attend to their requests for help. Since the January 2016 inspection, the service had one less support worker during the day shift because there were less people living in the service. We asked the maintenance person for the call bell records, and we examined the period 1 February to 7 February 2016 inclusive. We found there were 10 occasions where people waited more than five minutes to have their call answered. The remainder of people's requests for a staff member were answered within five minutes.

When we spoke to staff, we received mixed feedback regarding the provider's communication with them regarding the emphasis on people's care and welfare, the care home's existing rating and the location being in 'special measures'. One staff member told us they had attended a staff meeting that the deputy manager organised. Another staff member we spoke with said they had not attended any meetings regarding the care of people and had not received the information they needed to understand the situation. We asked the operations manager for the minutes of any meetings held with staff since the last inspection. We saw a meeting was held on 26 January 2016. We saw the meeting discussed staffing allocation, measuring people's weights, support workers escalating concerns about people to registered nurses and care planning.

We spoke to one staff member who told us they had not received an adequate induction. They had recently started working in the service, and worked across different functions within the care home. For example, on some days they completed cleaning work and on other days they helped care for people who used the service. When we asked the induction provided to them to learn how to care for people, they told us they had not received an induction for safe care of people. In the prior week they revealed they had worked three shifts helping care for people without an induction. They told us they had never worked in adult social care before. This meant people had received care from a staff member who did not have the necessary knowledge, skills and competency to ensure people received safe care.

This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At a prior inspection, we found some dangerous chemicals had not been secured away, which potentially allowed ingestion by people with dementia. At this inspection, all chemicals were safely locked away. Infection prevention and control at Sandridge House was an issue highlighted in the December 2015 inspection report. At this inspection we found the commencement of changes by the provider to ensure people's safety from infections. We saw a new dirty utility room had been built on the first floor. This included a bed plan washer, racks that could hold clean bed pans and a suitable sink to fill and empty mop buckets. Mops and mop buckets were also stored in the room. We saw that wet mops were stored in the

mop buckets. We showed this to the housekeeper who agreed that this could increase the chance of bacteria contaminating the mops. When we asked the housekeeper and operations manager how often the mop heads were changed or washed, they could not answer. We asked to see records that mop heads were regularly changed in line with the infection control guidelines, but documentation regarding this did not exist at the time of the inspection.

We interviewed a project manager that the provider had engaged to help achieve the results of better care for people in the service and to deal with breaches in regulations. The project manager visited once a week, and this was their third visit. The project manager explained that there were some key areas for the service which required prompt improvement; these included leadership, completion of person-centred documentation and effective supervision of staff. They explained that a full compliance review had been completed on 28 January 2016 and after that date, they completed updates and various audits. They felt the new deputy manager was making a positive influence and was committed to helping improve people's delivery of care.

The project manager's report from 28 January 2016 mirrored the findings in our December 2015 and January 2016 inspection reports. This was that people's welfare was compromised and that improvements in safety were needed, however, the report also included a number of improvements the provider had committed to implement or had achieved. An audit tool on the same date from the project manager which focussed on the 'fundamental standards', showed 79 per cent of items checked were inadequate or required improvement. The provider continued to submit weekly action plans to us after the January 2016 inspection, and we reviewed the findings. On 10 February 2016, the provider's action plan was changed in format and aligned to the known breaches of regulations. This action plan showed a large number of items to implement that had passed the deadline for completion. On 10 February 2016, we also received the provider's updated fire risk assessment dated January 2016. This showed a number of 'significant findings' that required immediate action to prevent potential injury. The provider submitted an additional specific action plan related to the findings of the fire risk assessment. Although the provider was taking action to achieve safety for people who used the service, the progress was slower than needed to properly protect people.

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 Care and treatment was not provided in a safe way for service users. The registered person did not assess the risks to the health and safety of service users receiving care or treatment. The registered person did not do all that was reasonably practicable to mitigate such risks. The registered person did not ensure that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely.

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration.