Care For Your Life Ltd

Sandbeck House Residential Home

Inspection report

77/81 Sandbeck House
Skegness
Lincolnshire
PE25 3JX

Tel: 01754766585
Website: www.sandbeckhousecarehome.com

Date of inspection visit:
09 December 2020
14 December 2020

Date of publication:
31 March 2021

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
Sandbeck House Residential Home is registered to provide accommodation and support for up to 38 older people and people living with dementia. There were 25 people living in the home on the first day of our inspection.

People's experience of using this service and what we found:
The provider was still failing to effectively assess and mitigate a wide range of risks to people's safety and welfare in areas including premises and equipment; infection prevention and control; individual risk assessment and medicines. There was very little evidence of organisational learning from significant incidents. Some care practices put people at risk of harm.

The provider was still failing to effectively assess, monitor and improve the quality of the service. Following the departure of the registered manager in November 2020, the provider had not made adequate alternative arrangements to ensure the safe and effective management of the service.

There were still significant shortfalls in the care planning system and the provider was still failing to maintain full compliance with the Mental Capacity Act (2005).

Notifications about events that had happened in the service had not been submitted to the Care Quality Commission, as required in law.

Care staffing levels were generally sufficient to meet people's needs but action was required to ensure a senior staff member trained to administer medicines was available on every night shift. The provider had failed to properly address staffing absences in the house-keeping team.

More positively, staff were generally happy in their work and spoke highly of the leadership and support provided by the manager. Both the nominated individual and the manager were open to feedback and took immediate action to address many of the issues of concern we identified on our inspection.

Staff recruitment was safe.

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

Rating at last inspection
The last rating for this service was Requires Improvement (published 12 April 2019) and 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 we found insufficient improvement had been made and the provider was still in breach of regulations.

Why we inspected
We received concerns about the safety of care provision and the effectiveness of organisational governance. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led.

We reviewed the information we held about the service. No significant issues of concern were identified in the other key questions. We therefore did not inspect them, although we did follow up the breaches of regulations found at our last inspection. Ratings from previous comprehensive inspections for the key questions of Effective, Caring and Responsive were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

Enforcement
At this inspection we identified four continued breaches of regulations relating to the safety of service provision; care planning; monitoring service quality and compliance with the Mental Capacity Act (2005). We also identified a new breach of regulations regarding the notification of significant events.

In response to these breaches we have imposed additional conditions on the provider's registration, requiring the provider to take action to improve organisational governance. The action we have told the provider to take can be seen the end of this report.

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.

Follow up
We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

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

If the provider has not made enough improvement within this timeframe and there is still a rating of Inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

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.

Sandbeck House Residential Home

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 checked whether the registered 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak and to identify good practice we can share with other services.

Inspection team
Our inspection was conducted by one inspector.

Service and service type
Sandbeck House Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 CQC. Shortly before our inspection, the provider had appointed the deputy manager as the new manager of the home and she was in the process of applying to become the registered manager. Registered managers 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
The inspection was unannounced.

What we did before the inspection

In planning our inspection, we reviewed information we had received about the service. This included information shared with us by other organisations including the local authority contract monitoring and adult safeguarding teams.

During the inspection
During our inspection we spoke with the manager; three members of the care staff team and five service users and relatives. We also spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of written records including six people's care file, two staff recruitment files and information relating to the auditing and monitoring of service provision.

After the inspection
We reviewed further information we had requested from the provider, including data relating to staff training and Deprivation of Liberty Safeguarding (DoLS).

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 now deteriorated to Inadequate.

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

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

At our last inspection the provider had failed to effectively assess and mitigate a range of risks to people's safety and welfare. 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.

• We identified numerous safety hazards in the building which placed people at increased risk of harm. We found an unlocked fire door which was clearly marked 'must be kept locked' as a requirement of the provider's fire safety plan. Testing of electrical equipment was out-of-date and a broken portable electrical radiator was still in use in one person's room.
• A wall-mounted radiator in another person's room was faulty. There was no other source of heating and the temperature in the room was only 17.5 degrees centigrade. The person was sitting wrapped in a blanket and told us they were cold.
• Hazardous chemicals, one of which was marked, 'harmful if swallowed' were stored in an open cupboard in the laundry. At times, the laundry was unlocked and unattended and could have been accessed by people living with dementia, some of whom walked unsupervised around the home. Stair gates had been fitted at the top of two steep flights of stairs. But the gates were too low and would not have prevented someone falling down the stairs. A heavy fire extinguisher was hanging precariously on a small hook and could have caused serious injury had it been dislodged.
• Despite a significant outbreak of COVID-19 in the home, the provider had failed to take adequate steps to control and prevent the spread of infection. Staff coming on shift had to walk through communal areas to access the changing room, increasing the risk of the transmission of infection. The provider had recognised this risk and purchased a portacabin to enable staff to change outside the building, but this was not in use. Staff were not temperature checked when coming on shift and were observed carrying uncovered plates of food through communal areas.
• During our inspection we observed some staff were not wearing gloves and facemasks in contravention of the provider's directions on the wearing of personal protective equipment (PPE). Used PPE was found in open wastepaper bins, rather than in the covered clinical waste bins provided for this purpose. One person had been tested as COVID-positive and was being cared for in insolation. However, the door to their room

was open during most of the first day of our inspection, despite being marked to indicate it must be kept closed.
• In the kitchen, freestanding containers for dishwasher salt and rinse aid were thick with grease and dirt. These items were not listed on the kitchen cleaning schedules and had clearly not been cleaned for some time. Lino floors in some communal and ensuite toilets were cracked or unsealed at the edges, creating a trap for dirt and infection. The carpet in the downstairs hall was stained and dirty and there were cobwebs in some communal areas. One member of the housekeeping team told us, "[There's not enough [housekeeping] staff. We can't work wonders."
• In the laundry, clothing and bedding that was wet of urine was stored in uncovered buckets pending washing. Water-soluble bags containing soiled clothing and bedding were piled in a courtyard outside the laundry. Some had split and others had started to disintegrate in the rain. Both poor practices increased the risk of cross-contamination and infection.
• We identified significant shortfalls in the care planning system which meant individual risks to people's safety had not been properly assessed and reviewed. For example, one person had been admitted to the home on 27 September 2020 but no care plans or individual risk assessments had been completed. For another person assessed as being at high risk of skin damage, the required monthly review of risk assessments and care plans had not been completed since August 2020.
• Poor care practices also put people at risk of harm. For example, several people had been assessed as being at high risk of developing skin damage and needed support to reposition at two hourly intervals. However, when we reviewed recent repositioning charts, we found intervals of up to almost four hours between repositioning. On the morning of the first day of our inspection, we observed one person sitting in the lounge with only one footplate on their wheelchair. Staff acknowledged that they had transported this person through the home without the footplate, increasing the risk of a serious injury.
• We also identified significant shortfalls in the management of people's medicines. Shortly before our inspection, one person had returned to the home from hospital with a discharge note indicating staff needed to obtain antibiotics to treat an infection. However, due to poor communication between staff, the person went without antibiotics for three days, increasing risks to their health.
• There was not always a senior care assistant with medicines training rostered on the night shift. This meant there were occasions during the night when people were unable to receive 'as required' pain or anxiety relieving medicines, if these were required.
• When we reviewed people's medicine administration records (MARs), we found gaps in recording, indicating some people may have not received their medicines as prescribed. These errors had gone undetected by staff until highlighted by our inspector. There were also extensive gaps in the recording of temperature checks of the medicines room and fridge, increasing the risk of medicines not being stored safely.
• The provider had failed to take effective action in response to significant incidents, increasing the risk that something similar might happen again. For example, a month before our inspection, the local authority safeguarding team had upheld an allegation of abuse against the provider, following a serious injury caused to a person living in the home due to unsafe moving and handling by staff. In response to this incident, the provider had identified a need to immediately provide additional moving and handling training to some staff. However, on the first day of inspection this important training had still not been delivered.

The provider's failure to assess and manage a wide range of risks to people's safety placed people at risk of avoidable harm and 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
• Care staffing levels were generally sufficient to meet people's needs. However, as described above, action was required to ensure a medicines-trained staff member was rostered on every night shift.

• Additionally, the provider had failed to take steps to cover staff absences in the house-keeping team, resulting in the some of the shortfalls in infection prevention and control practice described above.
• More positively, we reviewed recent recruitment decisions and saw that the necessary checks had been carried out to ensure that the staff employed were suitable to work with the people who used the service.

Systems and processes to safeguard people from the risk of abuse
• The provider had a range of measures in place to help safeguard people from the risk of abuse. For example, staff had received training in adult safeguarding procedures.

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 deteriorated to Inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection, we found the provider had failed to maintain effective systems to monitor and improve the quality of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In response, the provider told us they would take action to ensure compliance with this regulation by June 2019.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

• Following the departure of the registered manager in November 2020, the provider had failed to make adequate alternative arrangements to ensure the safe and effective management of the service. The deputy manager had been appointed as manager and had started the process of applying to become the new registered manager. However, the provider had not backfilled the deputy manager position and there was no administrator employed in the home. This meant the manager was expected to cover the role of both manager and deputy, without dedicated administrative support. Describing the situation, the manager told us, "My job as deputy was to do the audits [and] oversee the carers. But [now] I am [also] having to do what the manager would do. It's over-whelming … trying to catch up on everything."
• The provider had a quality assurance system to monitor the quality of the service, including a range of regular audits. However, reflecting the inadequate management arrangements described above, many of these audits had not been completed for several months. For example, the monthly infection control and housekeeping audits had not been completed since September 2020 and the quarterly medicines audit had not been completed since July 2020.
• Reflecting these shortfalls in the quality assurance system, the provider had failed to assess, monitor and mitigate a wide range of risks to people's safety in areas including premises and equipment; infection prevention and control and medicines. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we also found the provider had failed to maintain an effective care planning system to meet people's needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014. In response, the provider told us they would take action to ensure compliance with this regulation by July 2019.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 9.

• As detailed in the Safe section of the report, there were still significant shortfalls in the care planning system, creating additional risks to people's safety and welfare. For example, one person had been living in the home for over two months without any care plan or individual risk assessments having been completed. For other people, the required monthly reviews of their care plans and individual risk assessments had not been completed for several months. Reflecting the shortfalls in governance described above, these issues had not been picked up through the provider's quality assurance system.

This was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found the provider had failed to uphold people's rights under the Mental Capacity Act (2005). This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In response, the provider told us they would take action to ensure compliance with this regulation by July 2019.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 11.

• Since our last inspection the provider's best interests decision-making processes had been revised and improved. Where decisions had been taken on behalf of people who lacked the capacity, these were documented in their care records. However, when we reviewed Deprivation of Liberty Safeguards (DoLS) applications and authorisations for people living in the home, we found that two people had been deprived of their liberty, without the necessary legal authority having been obtained. Again, reflecting the shortfalls in organisational governance, these issues had not been picked up through the provider's quality assurance system.

This was a continued breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• When preparing for our inspection, we reviewed notifications submitted by the provider to CQC. Notifications are events which happened in the home which the provider is required to tell us about. In the six months preceding our inspection, the local authority safeguarding team had investigated six allegations of abuse of people who lived in the hone. The provider had failed to notify us of any of these allegations, as required in law. The provider had also failed to notify us of at least seven DoLS authorisations.

The provider's failure to submit notifications was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

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; 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; Working in partnership with others
• The provider's internal and external communication systems were not consistently effective. For example,

as described in the Safe section of this report, one person had been without important medicine for three days due to poor internal handover arrangements between staff. The manager acknowledged, "We have quite a few issues with handover." Additionally, the provider had failed to inform some relatives that there had been a significant COVID-19 outbreak in the home. One relative told us, "I am not happy. I would have liked to know [and] am surprised not to have been informed."

• Throughout our inspection, the manager displayed an admirably positive and candid approach. Describing her management style, she told us, "I don't expect my staff to do something I wouldn't do myself. I've got an open-door policy [and] staff can come and talk to me." Describing the manager, a relative commented, "[Name] has a very nice manner."

• Despite the short period of time she had been in post, the manager had won the loyalty and respect of her staff. For example, one long-serving staff member told us, "[The manager] is fantastic. I absolutely think she can turn it around." Describing the atmosphere in the staff team, another member of staff said, "We've got a good team at the moment and morale is quite good. We are stronger because of what we have been through [with COVID]."

• The nominated individual maintained a regular presence in the home. The manager told us, "I get on well with [the nominated individual]. He comes two or three times a week [and] spends time with residents and staff." During and after the inspection, the nominated individual responded positively to our feedback and took immediate action to address many of the issues of concern we identified. For example, on the second day of our inspection, we found action had already been taken to rectify many of the health and safety hazards identified on the first day of the inspection.

• The people and relatives we spoke with were generally satisfied with the service provided. For example, one relative told us, "The staff seem very nice and have been very good with me."

• Staff maintained contact with a range of other professionals including GP's and community nurses. The manager told us she also found the local care providers' association was a good source of advice and support to her and her team, particularly during the COVID19 pandemic.

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 18 Registration Regulations 2009 Notifications of other incidents The provider's had failed to submit notifications about significant events.

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 9 HSCA RA Regulations 2014 Person-centred care The provider was still failing to maintain an effective care planning system to meet people's needs.

The enforcement action we took:

We imposed additional conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was still failing to uphold people's rights under the Mental Capacity Act (2005).

The enforcement action we took:

We imposed additional conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was still failing to effectively assess and mitigate a wide range of risks to people's safety and welfare.

The enforcement action we took:

We imposed additional conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was still failing to maintain effective systems to monitor and improve the quality of the service.

The enforcement action we took:

We imposed an additional conditions on the provider's registration.