Sanctuary Care (South West) Limited

Lake and Orchard Residential and Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Lake and Orchard Residential and Nursing Home is a residential care home providing personal and nursing care to 45 people aged 65 and over at the time of the inspection. The service can support up to 90 people.

There are two separate units within the home divided into nursing care and residential care. At the time of our inspection, the provider was not using one of the units.

People's experience of using this service and what we found
People remained at significant risk of unsafe care. The provider had failed to make changes following previous inspections. There was limited or no action to improve the safety of people. People did not always receive adequate nutrition and hydration, putting their health at risk. Pressure area management was not effective to prevent people's skin integrity breaking down. The provider had failed to learn from people's previous experiences of care and safeguarding concerns to prevent reoccurrences.

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 and update
The last overall rating for this service was inadequate (report published 19 August 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
We undertook this targeted inspection to check on specific concerns we had about people's eating and drinking, skin integrity, infection control and staffing. The overall rating for the service has not changed following this targeted inspection and remains inadequate.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to

hold providers to account where it is necessary for us to do so.

After our inspection of 22 July 2020 we took action to prevent new admissions without the express written approval of the CQC.

We have identified breaches in relation to safe care and treatment, safeguarding, premises and equipment 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?

Inspected but not rated

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

Lake and Orchard Residential and Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection was carried out by two inspectors, a specialist tissue viability and older people's nurse and a local authority social care professional.

Service and service type
Lake and Orchard Residential and Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the CQC. For services with a registered manager, this means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was announced one hour before our arrival at the service.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We reviewed feedback from the local authority and professionals who work with the service at daily briefing meetings about 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 judgements in this report. We used all of this information to plan our inspection.

During the inspection
This inspection was carried out by conducting a site visit and reviewing a range of records remotely. We spoke with two people about their experience of the care provided. We spoke with six members of staff including two representatives from the provider, the deputy manager and two agency care workers.

We reviewed a range of records. This included five people's care records and four medicine records. A selection of records relating to the management of the service, including staffing information was also reviewed.

After the inspection
We wrote to the provider to seek a response to immediate concerns about safety and quality at the service.

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check specific concerns. We will assess all of the key questions at the next comprehensive inspection of the service.

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.

● People were at risk of dehydration and malnutrition. Opportunities to promote people's food and fluid intake were missed. One person was identified as needing a fortified diet and assistance with eating and drinking. They had not had breakfast or snacks for three days running.
● When people's target fluid intake was not met, it was unclear what action was taken to prevent them becoming dehydrated.
● People were at risk as their specialist dietary requirements were not always followed or understood consistently by staff. One person was identified as being risk of choking and required thickened fluids to reduce this risk. We observed the person with a jug of juice that had not been modified to a consistency they could tolerate without putting them at risk of harm.
● Risks linked to people, including risks linked to skin integrity and pressure damage were not well understood and well managed. One person had a significant pressure sore that had not healed due to inadequate pressure care.
● People were put at risk of falls and injury due to inappropriate moving and handling techniques.
● Equipment was not properly maintained or safe for use to provide care and treatment for people. One person had a suction machine in place in the event of them choking. The machine was dirty and clogged up. This put the person at risk as it may mean the equipment would not work if needed.

We found some evidence that people had been harmed. Systems were not in place to demonstrate safety was managed effectively. This placed people at ongoing 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.

● Following our inspection, the provider told us the suction machine had not been used and had since been

removed.
● The provider told us they had taken action to reduce the risk of the person choking and to support people with their eating and drinking.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

At our last inspection the provider had failed to safeguard against abuse and improper treatment. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment).

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

● People had experienced and were at risk of experiencing significant harm. This included pressure sores and poor management of their nutrition and hydration.
● Health and social care professionals continued to raise concerns about people's care at the service which had not been acted on.
● We could not be assured effective and established systems were in place to investigate any allegation of abuse or learn lessons to prevent future occurrences.

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 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

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

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

● Agency staff had not always received an appropriate induction and were not familiar with people's care needs. Two agency staff we spoke with did not have access to people's care plans to help them provide people with appropriate care.
● It was not always clear there were sufficient numbers of staff. The provider's dependency tool had not been completed in full to show how staffing decisions had been made.

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

Using medicines safely

At our last inspection the provider had failed to have robust systems in place 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.

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

● Medicines management systems continued to be ineffective. One person missed three doses of medicines as it had not been ordered in time.
● It was not clear people received their medicines on time or as prescribed. Improvements had not been made from previous inspections. Medicine administration records (MARS) referred to 'M', 'N', 'T' and 'B' with no times given.
● It was not clear there were sufficient gaps between medicine doses to keep people safe.

We found no evidence that people had been harmed. However, systems continued to not be 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.

● Following our inspection the provider told us they were working with their pharmacy to make improvements to their MAR charts.

Preventing and controlling infection

At our last inspection the provider 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.

● Call bells were not always working or available in people's bedrooms should people or staff require assistance in the event of an emergency. Four out of the five bedrooms we went into did not have a call bell available or in working order.
● Areas of the home continued to be unclean and not appropriately maintained. Issues identified as part of an infection prevention control audit by a nurse specialist on 04 August 2020 had not been actioned.
● Appropriate bins were not in place for the safe disposal of waste. One person was sat in their bedroom with a waste paper bin containing a soiled incontinence pad near them.
● Staff did not always wash their hands before or after supporting people.

Failure to ensure premises were clean, properly maintained and suitable for their intended use was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was in the process of arranging for a new call bell system to be fitted. Following our inspection, they advised call bells had been made available in the bedrooms we identified concerns with.

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 12 HSCA RA Regulations 2014 Safe care and treatment 12 (1)(2)(a)(b)(e)(g)(h) The provider had failed to assess the risks to service user's health and safety and do all that is reasonably practicable to mitigate these risks. Medicines were not managed properly and safely. The risk of, prevention, detecting and control of infection was poorly managed.

The enforcement action we took:

Notice of proposal to vary the provider's registration 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 13(1)(2) The provider had failed to ensure service users were protected from abuse and improper treatment. Systems and processes were not effective to prevent this.

The enforcement action we took:

Notice of proposal to vary the provider's registration 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 15(1)(a)(c)(e) The provider had failed to ensure premises were clean, suitable for their intended use and properly maintained.

The enforcement action we took:

Notice of proposal to vary the provider's registration to remove the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing 18(1)(2)(a) The provider had failed to ensure there

Treatment of disease, disorder or injury	were sufficient numbers of suitably competent staff and that staff received appropriate support to enable them to carry out their duties.

The enforcement action we took:

Notice of proposal to vary the provider's registration to remove the location.