Amberbrook Management Limited

Sandridge House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**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 34 people living in the home and one person in hospital. Sandridge House is located in an older style building 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. The last registered manager left their position in April 2015. 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. A home manager commenced in post in April 2015 and had applied to become the registered person.

Our inspection was brought forward from the scheduled date because of increasing concerns from a number of external agencies. We received information from other organisations telling us that people had been harmed or were at risk of harm. We had already been in liaison with police and local authorities to ensure protection of people who lived at Sandridge House.

The last inspection was conducted on 7 October 2014 under the 2010 Regulations. At the last inspection, we checked that the provider had completed actions to make improvements to obtaining people's consent, cleanliness of the premises, reducing risks from the building and quality assurance. The provider demonstrated that they had achieved compliance with the regulations. The current inspection was unannounced and occurred over two days on 2 December and 3 December 2015.

People we spoke with told us they felt safe living at Sandridge House. People were not always safeguarded from abuse and neglect at Sandridge House though. When we questioned staff, they demonstrated good knowledge of what to do if they suspected someone had been inappropriately treated. However, not all staff had received regular safeguarding training to ensure their knowledge was current. When the provider had investigations carried out by the local authority following reported allegations of abuse or neglect, they did not take satisfactory steps to prevent recurrence or learn from the experience. The provider did not notify safeguarding events to the CQC as required by law.

A number of professionals who visited the care home or were involved because of people's care arrangements expressed their concerns regarding the standard and quality of care at Sandridge House. They also told us they were concerned about the lack of leadership, the use of agency staff and the absence of a large number of quality monitoring processes. Other agencies had increased their monitoring of the service and required the service to keep in regular contact so that people's safety was not further compromised.

Staff handling medications had not received satisfactory training or competency assessment to support them with this role. Appropriate protocols were not in place for the administration of 'as required' medicines. The location had ordered and overstocked too many medications, leading to wastage. Some documentation was not undertaken in line with standard practice.

Some staff had not received important training in topics like fire safety, chemical safety and health and safety. This meant people were at risk of receiving care from staff that did not have the required knowledge of how to provide assistance. Staff had also not participated in regular reviews of their performance with supervisors. Areas for staff improvement had not been discussed with individual team members.

People's privacy was maintained and they were treated with dignity. There was evidence that some staff provided genuine compassion and kindness, especially the activities coordinators. On the whole however, people were not afforded the opportunity to regularly participate in the running of the service. Although there were 'residents' meetings held, people had little or no input into the management of the care home. They felt that when they did get to have a say, their opinion was not taken into account by the provider.

People's care plans and risk assessments required significant improvement to provide the best care for them. We found examples where the construction of the care documentation was not followed through to ensure gaps had not developed in the planning. Some people and relatives told us they had been involved in the creation of their care plans, and other people said they did not know about them. The staff had commenced rewriting care plans and the content after revision was improved.

We found people's care was task-focussed and not person centred. We observed people taken to communal lounge or dining room fell asleep without staff present. Some people's care was ignored when they were not present in communal environments. For example, we saw people sitting by themselves and in their bedrooms where less attention by staff was paid. At meal times, people were taken to the dining room and had sufficient to eat and drink, but it was not a sociable environment.

Staff were concerned about the leadership and management of Sandridge House. They appreciated the home manager assisting with people's care. However, staff told us they were not satisfied with the standard of leadership from the home manager. We found that there was not a strong system in place for monitoring, auditing and driving improvements in the quality of care. Some audits and action plans were completed, but the risks were not properly assessed, reviewed, recorded or acted upon by the provider.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their

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 inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 appropriately safeguarded against potential or actual abuse.

Risks from the premises and environment were not reduced to ensure people's safety.

Infection control practices at the home meant people were at risk from cross-infection.

Is the service effective?

Inadequate

The service was not effective.

There was insufficient appropriate training and supervision for registered nurses and care assistants to ensure they had the knowledge and skill necessary to effectively care for people.

The location failed to follow the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People received adequate nutrition and hydration, although improvements were required with the service and delivery of meals and drinks to prevent malnutrition and dehydration.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People had access to in-house and external activities that made them feel part of the community.

People's feedback was not sufficiently sought and acted upon.

People's privacy and dignity was respected by staff.

Is the service responsive?

Inadequate

The service was not responsive.

Risk assessments and care plans were rewritten. However, risks for people were not always followed up by care plans or evaluated to ensure they were still valid.

Complaints were ineffectively investigated, managed and responded to. There was a lack of documentation associated with responsive complaints handling.

Is the service well-led?

Inadequate

The service was not well-led.

Statutory notifications, required by law, were not always sent to the CQC.

A robust system for detecting areas for improvement was not in place. Trends and themes in items like incidents and accidents were not used as learning tools to improve the care people received.

The provider allowed staff to have a say in how the service was run.

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 inspection took place on 2 December and 3 December 2015 and was unannounced.

The inspection team comprised an inspector, a pharmacist manager, a specialist advisor in care home management, a specialist advisor in premises and infection control and a specialist advisor in the Mental Capacity Act 2005.

Before the inspection we reviewed all the information we held about the service. This included notifications regarding safeguarding, accidents and incidents and changes which the provider had informed us about. Prior to the time of the inspection a Provider Information Return (PIR) had been requested, and one was submitted by the provider on 22 July 2015. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

In order to gain further information about the service, we spoke eight people who used the service and a number of relatives or visitors. We also spoke with the provider's nominated individual, the home manager, the compliance manager, the maintenance person, and 12 other staff. Outside of the home we contacted two local authorities, the Clinical Commissioning Group (CCG), the ambulance service, the fire authority and the Health and Safety Executive (HSE).

We observed care practices and people's interactions with staff during the inspection. We reviewed 11 people's care records and the care they received. We looked at people's medication administration records, (MAR). We reviewed records relating to the running of the service such as five personnel files, staffing information, documents associated with the equipment and premises and quality monitoring audits.

We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who use the service that could not communicate with us.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Sandridge House. However, there was a high incident and accident rate for people that the provider had not attempted to reduce. We checked the accident and incident report records from September to November 2015 and found 22 falls and 8 wounds recorded. Given the very high number of injuries in such a short period, we looked at the provider's accident rate for a longer period. From August 2014 to August 2015, there were 38 falls and some wounds related to the falls. There was no evidence from the service's own tracking form that any analysis of injuries had been completed since 16 February 2015. During our inspection we prevented a person from falling over. The provider was not aware of the number of incidents or near misses. They had also failed to reduce the risk of incidents reoccurring. This placed people at continued risk from falls.

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

The provider had a whistleblowing policy dated April 2014. Whilst the policy stated that concerns could be raised with a staff member's line manager, home manager, home owner or other authorities like CQC, threats of disciplinary action were made in the policy. These detailed that if the staff member did not follow the "appropriate route", it would be considered an "offence" or the staff member could be subject to "criminal investigation". The policy also did not mention the protection afforded to staff members from the Public Interest Disclosure Act 1998 (PIDA). This did not encourage staff members to report matters confidentially if they considered that harm to people may have, or was occurring.

Staff we spoke to knew what whistleblowing meant and told us they would not hold back in reporting matters. Staff that we spoke to were also able to adequately describe what they would do in the event of neglect or abuse and mostly stated they would report to managers. However, staff were not always aware they may have to notify other authorities like the safeguarding team, police or CQC.

We looked at the provider's policy for adult protection last revised September 2015. This was satisfactory and explained what staff and managers must do in the event that abuse or neglect of people is alleged or evident. There were some areas that still required accurate information inserted, like the telephone number for police and the forms used to notify CQC of abuse allegations. Our pre-inspection intelligence analysis showed that in the 12 months prior to the inspection, there had been no reported abuse or allegations of abuse from the service. We asked the home manager about this. They told us there were safeguarding allegations that had previously occurred and current cases that were under investigation. For example, there were matters being investigated by police and local authorities about alleged restraint and financial abuse. Our database showed that the provider had not reported these to CQC in line with mandatory notification requirements. When we asked why this was, the provider stated they assumed this was notified to CQC by the other agencies.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The local ambulance service confirmed they had reported safeguarding allegations to the local authority in

the three months leading up to the inspection. We obtained details and saw there were three reports of concerns related to 999 calls the care home had made. The ambulance service was concerned about the nature of the call and what staff reaction there was when they arrived at the building. The local authority had investigated and found that on two occasions, the ambulance's allegations were substantiated. We asked the home manager whether they were aware of these safeguarding incidents and upon checking their diary, they told us they knew about them. We asked the provider for further evidence that they safeguarded people from abuse. However, when we looked at the provider's folder containing documents associated with safeguarding, we noted that information was non-existent, missing, that thorough investigations had not been undertaken or recorded. Analysis of themes and contributing factors in cases was also not considered. This meant people were at risk of harm because the provider's protection mechanisms against abuse were not robust.

This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There were serious risks to people, staff and members of the public posed by the premises. The fire risk assessment dated 14 October 2014 was insufficient, inadequate and deficient in a number of areas. For example, it made no detailed reference of how less able or disabled persons would be managed safely in an event, if there was a full evacuation to a point of safety. The home manager advised that up to 15 people were considered to be wholly dependent on wheelchair use and therefore entirely dependent and reliant on care and nursing staff. Almost all people's bedrooms and all en-suites accessible to them had no emergency lighting. Additionally, we saw en-suites had no fire detection installed. Some people's rooms had fire detection while some did not, but the fire risk assessment did not mitigate the risk associated with this.

A number of installed emergency lights during inspection did not work or were very dimly lit when tested. This meant there were poor levels of light and a risk to people with visual impairments or dementia. We found there was also no comprehensive clearly marked fire action or evacuation floor plans in accordance with guidance from fire authorities. A fire escape route on the ground floor towards the rear of the premises was actually through a person's bedroom. Once outside from this fire exit, there was no external emergency lighting nor any external fire signage present. Furthermore, a wooden gate was padlocked and contravened fire safety legislation. This serious breach had been brought to their attention at our last visit to this premises in June 2014. For people's safety at this inspection, we requested this be removed immediately. The compliance manager ensured this occurred before the end of the inspection. As the legal responsibility for fire safety fell upon the nominated individual, there was no clear effective management processes in place to reduce fire risks. Our concerns have been shared with the local fire authority.

In June 2014, we found the provider did not have sufficient controls in place to ensure people were protected against Legionella. We shared our findings with the Health and Safety Executive (HSE) and they subsequently issued contravention notices to the provider. Prior to this inspection we again contacted the HSE to check on progress of the provider to comply with Legionella legislation. The inspector advised that the HSE awaited the findings of a recent water sample before they would consider the provider compliant. At this inspection, we found there was still no specific policy for Sandridge House about Legionella prevention and control. Upon review of maintenance procedures and records, we again found poor management and operation of ensuring that hot water delivered out of taps and outlets achieved the required 41 degrees Celsius. Many shower heads were observed to be full of lime scale, which provided an appropriate situation for Legionella to grow. Information we reviewed identified quarterly reviews of the premises for Legionella prevention carried out by an external contractor. However, some preventative measures were meant to carried out by the provider. This included weekly checks to thermostatic mixing valves and flushing of seldom used outlets. Our concerns have been shared with the Health and Safety Executive

We asked the provider to demonstrate their continued compliance with asbestos safety. Despite our request, there was no evidence of an asbestos policy, especially for the maintenance person or contractors to review and follow in their roles. We reviewed the asbestos survey register dated 2006. However, we considered this was out of date as a number of internal alterations had been carried out. These were explained when we spoke with the maintenance person. For example, the treatment room was recently introduced in the main building. No amendments had been made by the 'responsible person' to ensure the information about asbestos was up to date and that all contractors had access to it in the event they carried out work within the premises. There was a lack of safe management and operation of the premises to ensure risks were effectively managed or mitigated for people in relation to the control of asbestos exposure.

This was a breach of Regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at five personnel files to check how new staff applicants were recruited and what documents were checked and recorded. This included the home manager's personnel file. None of the five files contained all of the documents required by the regulation. Staff personnel files were stored in the home manager's office on the first floor of the building. The lack of a consistent administrator at the care home meant that personnel files lacked some of the documents and checks required by law. We saw that inadequate assessment processes had been followed at the interview stage of candidates to ensure fit and proper persons were employed. Personnel files did not contain notes of interviews undertaken and therefore the provider had not rated candidate responses. Instead the provider offered roles regardless of knowledge, skills, experience or competence to work in the roles. In addition, some personnel files had gaps in required documents. We saw some new starters did not have previous relevant qualifications copied, had gaps in their provided previous employment history and did not have their reasons for leaving other similar roles noted. For one staff member, a single check of previous conduct in prior employment was on file whilst another had not received a full Disclosure and Barring Service (DBS) criminal record check and should have been working under constant direct supervision. The provider employed staff from other European countries and had copied documents which were not in English. These had not been translated and so the provider was not able to determine what the document stated.

People were at risk because the provider did not demonstrate safe recruitment and selection processes. The provider had a recruitment and employment policy last dated February 2014 accompanied by guidelines dated August 2013. The policy detailed procedures for recruitment dated before the latest set of regulations commenced on 1 April 2015 and did not capture the enhanced legislative requirement to ensure fit and proper persons were employed every time.

This was a breach of Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The service had no robust method for determining safe staffing deployment. The care home had an ongoing registered nurse recruitment and employment problem which left vacancies for a deputy manager, one full-time registered nurse and some bank registered nurses. This resulted in the service using agency registered nurses on an ongoing basis. The compliance manager and home manager explained that sometimes agency nurses were contracted for longer periods of time, for example two months, to ensure some continuity. When we asked what system the care home used to derive safe staffing numbers, the provider could not demonstrate any method of determining appropriate allocation of workers to people's needs. We asked whether any dependency tools were used in calculating staffing levels, but the provider did not utilise them for planning staffing. In people's care records, there was however an assessment tool of how dependent each person's needs were, and therefore some indication of how long each day they needed assistance for.

We looked at staff deployed for the months of October and November 2015 using the rotas provided. We saw that the service had two registered nurses on a day shift and one on a night shift. In the morning, there were seven support workers and in the afternoon there were six support workers on the rota. At night there were just two support workers. This was confirmed by the compliance manager. However we saw there were often variations on this staffing level and it was not consistent. On both days of the inspection, in the mornings, we saw the home manager assisted with personal care of people. The front door bell and telephone rang multiple times during the morning and this meant nurses and support workers were required to deviate from personal care to attend to this. During the same period of the day, we observed that people's call bells were sometimes left unanswered for more than five minutes when they had pressed them. People we spoke with confirmed that they had to wait in the morning as staff were busy attending to other people's needs. The number of staff deployed at night was not safe. The building is spread out on multiple levels and if a hoist is used, two staff are required. This meant one staff member was responsible for 34 other people in their bedrooms over two floors. The nominated individual told us they had considered a fourth staff member was required.

This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People's medicines were not managed safely. There was a system for ordering, receipt and disposal of medicines in place. However the records were not always completed of medicines that had been received into the service. Medicines were not stored safely. There were large quantities of a supplemental feed that were stored on the floor and the stock had not been rotated so that the most recent items were stacked on top of previous supplies. The temperature where medicines were stored was recorded daily and was within the recommended range. There was a separate refrigerator for medicines needing cold storage. Records were available to show that the temperature range was being recorded daily. However, the maximum temperature recorded had exceeded the recommended range since September 2015. There were suitable arrangements for the storage and recording of controlled drugs, but when people left the service the records were not always updated.

The pharmacy provided printed medicines administration record (MAR) charts for staff to complete when they had given people their medicines. We looked at the MAR charts in use at the time during the inspection for 28 residents and those that were available from the previous month. There were no gaps in the records and they were completed appropriately. We found two examples of a handwritten chart where there was only one signature of the person who had completed the chart, so we could not determine if it these had been checked. Creams and other external items were recorded on topical MAR charts. Only two out of 18 records had completed body maps to instruct staff where to apply the preparation and 7 out of 18 records were not signed by the person who had copied the medicine instructions from the pre-printed MAR chart. These records were not consistently completed to demonstrate that the medicines had been applied in accordance with the printed MAR chart.

The opening dates of liquid medicines and eye drops were recorded to ensure that these were discarded within the required time range. There were non-prescription medicines kept in the home, for occasional use, these had been approved by the GP for use within the care home and were recorded when used. For six out of seven people who were prescribed 'when required' medicines, there was no information with either their MAR sheets or within their care records about how or when these medicines were to be given.

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

Infection prevention and control was unsafe. The local authority had previously reported that during visits on 13 November and 20 November 2015 they were concerned about cleanliness and odours in the building.

During our inspection, we found most areas of the care home, for example the lounge and dining areas were clean. We saw cleaners involved in their work and that they used trollies with chemicals, some of them corrosive, on top. The trollies were not secured and often left outside bedrooms while the staff member attended to the cleaning. People were at risk of harm if they took one of the cleaning agents and spilt it or accidentally consumed it.

We also observed both cleaners and staff members hold and carry waste bags with bare hands or on other occasions wearing disposable gloves and touching multiple surfaces, without handwashing. There was a risk to people because this could cause cross-contamination of other surfaces. Although cleaners were employed, several areas of the building were not kept satisfactorily clean. These included communal bathrooms and toilets, and people's bedrooms. Documentation regarding cleaning that had occurred was not adequate enough to show the exact locations each day, the frequency for each task and not stored in a place convenient to the cleaning. The laundry facility was located in an out building. However it had no cleaners' area or room, therefore the service could not ensure satisfactory standards for cleanliness and hygiene in the area where on-site laundry was undertaken.

The infection control management and operational control for the service was overseen by a registered nurse. We found there were no formal process in place by the infection prevention and control (IPC) lead to maintain a clinical assurance and framework for infection prevention and control. We saw there had been four infection control meetings up to the point of the inspection. These demonstrated that people's feedback had been considered and basic information like carpet cleaning, had been discussed. However, issues such as storage, equipment cleaning, flooring, and adequate clean and dirty utility provision had not been considered or addressed. There was no clear defined infection control risk assessment provided by the IPC lead and no evidence of advice from external support. The provider's 'Policy of General Precautions for Infection Control' dated June 2014 was unsatisfactory and did not take into account the specific guidelines from the Department of Health, which had been updated in 2015.

There were problems with infection prevention and control arising from the 'treatment' and dirty utility rooms. The treatment room where drugs and lotions were stored and prepared and clean and sterile supplies were held was not to the standard required to prevent cross infection. The service could not ensure cross infection was not occurring from the storage, surfaces and staff practices in the room itself. Clinical hand-hygiene facilities were also not present, so adequate hand hygiene by staff was not able to be practised. We found a satisfactory sluice room was also not present. The room we viewed had walls that appeared stained and we found the floor covering was dirty with grime clearly visible. The service did not have a room that facilitated cleaning of items of equipment, testing of urine and the disposal of body fluids including water contaminated with body fluids. The service could not adequately perform decontamination of commodes, there was no racking for holding supplies like urinals and no clinical wash hand basin or separate dirty sink. This increased the risk of items being dirty and contributing to cross contamination.

At the inspection we found there was no compliant cleaners' room available in accordance with relevant codes of practice. Instead what we found outside of the premises was an open facility with two taps and a hose facility. This area was profoundly unhygienic, with visible algae and green slime on a wall where dirty contaminated water was discharged out in the open. Furthermore, a wooden shed had been set up externally where used wet mops were left in buckets. There was no IPC lead intervention, management or control of setting up a compliant domestic cleaners' room, therefore the delivery of effective day-to-day cleaning services for people and the location was compromised.

During the inspection, a number of issues and concerns were raised and brought to the attention of the head chef, compliance manager and maintenance person regarding cleanliness of the kitchen. In

accordance and requirements to the Food Safety Act 1990 and the Food Hygiene (England) Regulations 2006, the service had poor cleaning and hygiene standards. We saw dirt and grime clearly on the floor coverings under floor mounted units, surfaces and on top fridges and freezers. The light fittings at ceiling height were covered with a film of grease and the fittings were full of dead insects. There was no access to a domestic cleaners' room for the kitchen, which meant access to cleaning equipment was not readily closely available.

This was a breach of Regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Inappropriate induction methods were used for new staff members. One staff member told us their induction involved working with another staff member for two days and then having a checklist signed off. We looked at the induction checklists for four support workers. We saw these included the new worker being given a copy of numerous policies to read, but the topic was not explored further and the staff member's understanding was not recorded. Practical training for some subjects, like moving and handling of people, was not completed at the same time as the induction and therefore the staff member performed the task without the competency. The provider's induction for new staff was not in line with Skills for Care's former 'Common Induction Standards' or the newly developed 'Care Certificate'. When we spoke with the compliance manager they informed us that the service was attempting to recruit a new staff member to act as the care home's trainer. However, the role had not been filled and the service relied on training provided by external companies. The home manager had commenced in post in April 2015. However, when we looked at the induction record, we saw many topics remained uncompleted and none of the completed ones had a date recorded. On one of the rota records, we saw a staff member who was 'on induction' had been counted within the established numbers for the shift, instead of being supernumerary.

We found people were at risk of being supported by staff without appropriate knowledge and skills to carry out their roles and responsibilities because not all staff were up to date with their training. The provider's staff training policy was dated August 2012 and had not been updated to reflect changes in practice and legislation. When we spoke to various staff on the days of the inspection, all of them could tell us that they had completed various training in the preceding year. We looked at the provider's training master record provided after the inspection and dated 8 December 2015. There were obvious training topics where an inadequate number of staff had a recorded attendance such as fire awareness, and control of substances hazardous to health (COSHH). In other topics like diabetes awareness, end of life care or management of artificial feeding we noted staff had attended or renewed their training. This put people at risk because staff did not have current knowledge of important safety topics. The provider did not assess staff knowledge after training and could not be assured staff had understood the training and were confident and competent to carry out their roles effectively.

The provider had inadequate systems in place to support staff development through the use of supervision or staff appraisal. There was little evidence of staff supervision or annual appraisals in staff member's files and staff confirmed they could not remember participation in any. This meant the provider failed to ensure staff worked to an appropriate standard or were safe to perform the role they were employed for. The home manager told us staff received regular supervision meetings with their supervisor and regular appraisals. Despite repeated requests at the inspection to look at staff supervision dates for 2015, the provider was able to supply only November's completed supervision list. We saw 10 staff had been ticked off as having participated in a supervision meeting in November. There was no assurance that staff were involved in supervisions over a longer term. Evidence of annual objective setting and performance appraisal with staff was also lacking.

This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We saw staff did not always seek consent from people before they commenced tasks or provided care. Some staff did not speak to people at all during a task, and therefore the person did not have the ability to say 'no' or refuse whatever the staff member was about to do. We observed other staff members who did speak with people simply tell people what they were doing, without providing the opportunity for the person to not have or do the required action. For example, we saw one support worker bring a person their lunch and state that the person had to commence eating. This meant consent to care and treatment was not always sought in line with legislation or 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. The application procedures for this in care homes and hospitals are 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 were being met.

We spoke to the home manager at the commencement of the inspection about DoLS authorisations. They told us that 13 people were subject to a standard DoLS and 16 applications had either been made or were in the process of being made. This did not tally with the pre-inspection information provided to us from two local authorities who had approved DoLS for people in the service. After looking through care records and seeking further information from the home manager we could see that there were actually authorisations for 8 people. There was one person for whom we could not find the appropriate authorisation on file. We looked at five people's DoLS authorisations and the provider's management of them in more detail.

Of the five we looked at, only two had the appropriate paperwork on the person's file to show that they were authorised to have deprivation of their liberty. We had to ask the home manager to find documents elsewhere in the care home to provide sufficient evidence that the people were actually subject to DoLS authorisations. In one person's file we saw a MCA assessment on the case record. The assessment had been undertaken in respect of the person's capacity "to make decisions about personal care". The assessment conformed to the MCA Code of Practice in so far as there was evidence of a two stage process. However, the focus of the assessment (decisions about personal care) was too broad. Staff had failed to consider whether there were any aspects of the person's personal care that they did have capacity to decide upon. This person also had a 'do not attempt cardiopulmonary resuscitation' (DNACPR) form dated 26 September 2014 completed. We saw the service used a 'Thinking Ahead – Advance Care Planning Document". The form was on this person's care record and although it was completed, it was not signed.

We saw another person had two MCA assessments on file. One was completed on 11 November 2015 and the other on 24th November 2014. The latter had been completed more fully than the former. The former assessment contained no information on the person's ability to understand, retain or weigh up information. The MCA had been completed in respect on the person's " ability to weigh up decisions regarding general aspects of her life". This was not decision specific. The assessment did not document whether there were some aspects of the person's life, however small and limited, where they could exercise a degree of choice. A 'Thinking Ahead – Advance Care Planning Document" was also found in this person's care record. However it had been partially completed and not signed.

We were informed by the home manager that another person was subject to an application for standard authorisation. On this occasion there was a letter dated 29 May 2015 from the local authority which

confirmed that a standard authorisation had been granted. We saw this authorisation had one condition that the care home should offer the person "at least one trip out once a month". We could not see any evidence on the activities record sheet in the case record that this condition was complied with. We spoke with the activities supervisor and activities assistant about the condition of the person's DoLS. Neither of them were aware of this condition nor of the importance of ensuring that a proper record was being kept of the service's efforts to comply. However, the activities supervisor was aware of the importance of offering this person trips out and told us that this was done on a regular basis. The person had most recently agreed to go on a trip in May 2015. The person's DoLS authorisation was further reviewed on 27 July 2015 and we saw a copy of the review letter from the local authority on the case record. The local authority had made a further condition to the authorisation that the service "explore the possibility of the resident speaking to a befriender who can speak to the resident in German". There was no record of this in the most recent review of the communication care clan dated 27 October 2015.

Another person had a DoLS authorisation with a condition that the service should have ensured that the resident "has a psychiatric and social care review within 4 weeks". There was no evidence on the case record that this was complied with. For another person, the home manager stated that this resident was subject to a standard authorisation and we found a document on the case record. However, this authorisation was in respect of another care home in Bracknell and so the provided document was not valid for Sandridge House. We spoke to the home manager about this and they confirmed that this resident had transferred from another care home and that a new application for a DoLS authorisation was made in August 2015.

This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

It is the responsibility of the provider to send statutory notifications to the CQC when DoLS authorisations have been approved, rejected or withdrawn. We checked our records and found that no notifications had been submitted for Sandridge House.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There were healthy meals and snacks offered, and we observed that in the dining room the menu was written up on a board each day. When we asked staff what the meals were for the day, they had to refer to the board and they did not know what was going to be served. People were offered a choice of two alternate meals plus soups and puddings, although some people who had difficulty communicating were simply given a meal without choice. Service of meals was tasked based, with staff lining up at a serving hatch and then distributing the food around the dining room and carrying it off to bedrooms for other people. We observed one support worker feeding one person who got up five times to attend to another person that wandered around the dining room. Another person we observed sat at the dining table and was served last. They were required to watch everyone else be served, gain assistance with their meal and finish it before a staff member commenced helping them. Some staff we observed did not communicate with people at all during the meal, instead assisted them to eat and then cleared away their plate.

People were at risk of dehydration at the service and we found this was in line with information that local authority social workers had shared with the CQC in their recent prior visits. When we observed people sitting in groups in communal lounge areas or dining rooms, we saw that fluids were offered and left for most people, but not everyone. For some people the fluids were not within their easy reach, which meant they may not have been able to take the drink when staff were absent from the room. We also observed other people who were in other areas on the ground floor by themselves. This was their choice, but staff often ignored the person's need for fluids and the person's medical condition meant they did not ask of their own accord. For one person, we observed that fluids were not offered throughout a whole morning, until

lunch time, and our inspectors asked staff to provide the person with fluids. At lunch time, we saw another person sit at the table for the complete dining period without a drink offered or given.

We looked at eight people's fluid intake charts at 11am on one day of the inspection. We saw that none of the documents contained entries for people received fluids since 6.50am the same morning. Later in the day, we found the documents had been completed. This meant retrospective charting of fluids occurred, and that accuracy of what people had actually consumed could not be confirmed by the provider. On one person's intake chart we saw staff had recorded 'asleep' between 11am and 5pm, with no recorded attempt to wake the person for an offer of fluids. On another person's intake chart, we saw for a 12 hour night period from 9pm to 9am the next day, just 200mLs of fluid consumed was recorded for the person. When we toured bedrooms and checked on people who did not leave their room, we found they did not always get drinks. We found jugs were sometimes out of reach, and that some jugs of fluid had unused cups sitting on top of them. The provider could not show they had a robust system for ensuring that people in their rooms had regular offers of fluid and that all attempts of fluid intake were recorded.

When we visited the main kitchen, we spoke with a chef and kitchen assistant. They showed they did not know most people's preferences for meals and snacks. They also had no knowledge of any intolerances and allergies that specific people or whether they could prepare meals that took this into account. We saw menus were rotated and changed for the season. We asked about how people's input was sought in preparation of new menus, but were told no input from people who used the service was taken into account in menu design.

Some people complained to inspectors that their food was often served cold. When we checked food temperatures with the kitchen staff we found that some meals were warm and not piping hot at the time of service. Some people's bedrooms were a further distance away from the serving hatch, so their meals did cool off more as staff transported the plated food to the bedrooms.

This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There was good support to the home from health professionals in the community. The local GP surgery provided visits to people each week and ensured that minor illnesses were detected and managed, where possible, without transfer elsewhere. There was evidence of other professionals attending to people's needs at the service. For example, we saw for one person who had a wound the service had referred to the tissue viability nurse (TVN) and they visited the person to assess their wound and provide advice. This was recorded in the person's notes. The person's care file showed a diagnosis of dementia and a risk of falls. However, we noted that this person had returned from hospital with a 'pressure sore' on the outer aspect of their foot and under the arch of the foot. The records showed the wounds were assessed by the service on 10 November 2015 and were documented as a "blackened necrotic area". It was six days later on 16 November 2015 that this was referred to the TVN. There appeared to be a delay in referral which could have resulted in further tissue damage for the person concerned.

Requires Improvement

Is the service caring?

Our findings

We spoke to some people in their bedrooms and asked their opinion of care. We saw one person in their room had their call bell within easy reach and they told us sometimes that it took a long time for the bell to be answered. They told us they spent their days in the quiet room on the ground floor where they liked to complete their puzzles. They told us they considered that they were now 'looked after', as when they lived at their own house they looked after themselves. The person said they didn't have any problems with the attitudes or manner of care from staff. They wanted to tell us the food could be better, but if necessary they would speak to the chef.

We saw activity coordinators were busy on the two days of the inspection putting up Christmas decorations. Both of them informed us of the trips out of the home, particularly of a recent visit to the Natural History museum. They told us that five people went with staff and they enjoyed their day. Both staff said that they enjoyed working at the care home with people and had been in posts for several years. We saw promotional material throughout the service of what activities were planned. People we observed that interacted with the activity workers were content, and the activities staff showed genuine concern for and compassion towards people.

One person wanted to complain to us after we introduced ourselves. They said they had told the staff many times that the light bulbs outside their room shined in their eyes and the staff had failed to respond. They told us their medical condition did not allow them to leave their bed much, and they faced the light fitting directly whilst they watched television. We noted the staff had pegged the person's bedroom door back using a chair, which was an obstruction and also a fire safety hazard. When we told the provider about the person's concern, they said the light bulbs could not be replaced. On the second day of the inspection the light fitting was not turned on and made it darker in the area for other people who sat there or walked past. However, by the end of the inspection, the light was turned on again and shining in the person's eyes. This showed that although people were listened to, their views were not always acted on.

Another person told us their opinion of the care provided to them. They said: "My husband died recently. He was a resident here and when my health got worse I moved in here two months ago. I'm contented although there is too much food, I've not had a bad meal. I can go out when I like and the nurses are good. One night when I wasn't feeling well the nurse sat and held my hand". This showed that staff listened to people and provided kindness to them in times of need. The person also told us: "They have pets in to the home. One time a donkey came in [to the grounds]". They liked that the activities workers tried to keep people actively involved in the local community and keep asking them what they wanted to do in upcoming months.

A third person we spoke with told us: "I've been here for three or four years; no complaints at all". Another person told us they hadn't been at Sandridge House very long but both she and her daughter were "very happy". A person's relative told us their mother's admission was four years ago and initially they were at risk of absconding from the building. They told us they were happy with the care and that they visit three times a week. They said: "I can now sleep at night".

We met and spoke with the care home's hairdresser. They told us: "Everyone tries their best here". They told us they had bought some equipment in and they do the hairdressing at the sink in the quiet room, as there was no hairdressing salon. When we spoke with two people who had their hair styled on the day, they smiled and were content with feeling and looking good.

There was some ability for people to be involved in the running of the service, although this had been limited in 2015. There was evidence of only two 'residents and relatives' meetings held in March and October 2015, where people talked about Christmas, dining, outings and activities. It was clear that despite having two chances to tell the provider how they felt, people were not encouraged to attend. Offers to take agenda items to the meetings on behalf of people were not provided or recorded, especially for people who did not leave their room and therefore attend the meeting.

There were no other methods in the home for people or relatives to provide feedback, for example a suggestion box. There was no clear plan for establishing feedback from people and relatives or visitors. Although we asked managers for evidence that surveys, questionnaires or other methods of seeking people's feedback about the service were in place, only three questionnaires were provided. We viewed three 'quality assurance questionnaires' dated November 2015. One had been completed by a relative and the other two had been completed by a staff member in discussion with the person who used the service. One had just the front page completed. People could rate from one to five on the survey form, where one was considered 'very poor' and five was 'very good'. Overall, the ratings were between four and five for topics like how were the staff, what was the daily care like, comfort rating and amount of social activities. There were some constructive comments recorded. For example, one included that incontinence pads were too small for one person and that they leaked. The managers could not show an action plan or a list of steps they took when people provided any type of feedback.

This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People's privacy and dignity was maintained. We saw that doors were closed by staff when personal care took place and other staff that came to the room knocked and sought consent before entering. People were neatly presented and suitably dressed in communal areas. The outside of people's rooms was not personalised so they could easily recognise the door along long corridors. However we saw that inside some people's bedrooms they were decorated with their possessions including photos and pictures.

Inadequate

Is the service responsive?

Our findings

Visitors we spoke with told us that they were consulted about their relatives' care and were kept informed when anything changed. Some people and also staff, told us that they felt unsure about who they could raise concerns with. They were not sure that they would be listened to and that their issues would be addressed. They linked this to not really knowing who was in charge and to poor lines of communication. Some people we spoke with confirmed that they felt that they had been consulted about their ongoing care but not attended meetings when relatives or other health professionals were involved. Evidence of good practice we saw was that people's 'life story' was completed for some people by the activities workers, which gave a holistic picture of the individuals.

We found that the care file folders for people were too small for the contents and as a result, on a number of occasions the contents had come out of the folder. This meant that information needed for the responsive care of people was stored inappropriately, missing or taken away to archive somewhere else in the service too early in the process. Two local authorities had visited the service on 13 November and 20 November 2015 to check people's welfare. In their visits they found that risk assessments and care plans were outdated, inaccurate or in some cases non-existent. We noted that some care files had been updated on or after 27 November 2015. However, in some of the care files, we found some of the risk assessments had not been reviewed for over a year. As a result this did not take into account any health changes for people that could happen during that the year. Many of the risk assessments and care plans were not signed by people who use the service, or notes were absent to say why they had not been involved in the care planning.

Of the 11 care files we audited, the risk management form had basic information and in some instances new care plans were in situ with no evidence of the old information which had been archived. During the inspection, this led to it becoming more difficult to audit care quality processes. When we asked to review the requested care information it was eventually made available, but not in a timely fashion. While there was evidence of staff rewriting care plans, the lack of old reviews and evaluations made it very difficult to assess the quality of care planning in the files. This also might have proved difficult for other members of the multidisciplinary team to gain important information during their visits to the service.

People were placed at risk from care by the service which was not responsive to their needs. For example, in most people's files we looked at, weights were recorded on a monthly basis. However, there was no evidence of monitoring trends of the weight measurements. In one care file a malnutrition risk had not been evaluated since 16 August 2015. This meant that the provider wasn't assessing regularly for weight gains or losses to prevent malnutrition. In addition, people were not always protected from avoidable harm by the service. One person had a risk assessment that identified them as having a potential for eating toiletries, and that toiletries had to be locked away within a drawer in their room. When we checked, we discovered the person had a bottle of shampoo unsecured in their bathroom which could have been consumed. There was also evidence of toiletries at easy reach within other people's nearby bedrooms.

We discovered that food was served through a hatch in the kitchen and there was no hot trolley in the dining room. Meals were plated by the chef through to staff waiting the other side of the hatch and taken through

to the people sitting in the dining room; trays and plated meals were then taken to individuals in their rooms. The dining room had tables set ready for lunch, but we noted very little interaction when people were served their meal. Instead the staff queued to get the meals and we did not see any evidence of a choice being offered to people.

People's care was not always individualised so that their care needs were assessed, reviewed or recorded. We had concerns with two individual people in particular during the inspection. One person sat in the reception and another sat in the dining room for most of the day. The person in the reception appeared to be restrained with the use of a bed table in front of them all day long. Upon further investigation it was moveable, however the individual might have felt trapped with the furniture blocking them in. We found that the person had behaviour that challenged the service and the person did not stay seated if the table was taken away from them. The care provided to this person was not person-centred. This was because the person's challenging behaviour had been dealt with appropriately by first assessing all of the potential strategies available.

In another instance, the person spent the majority of their day alone in a communal dining room. When we asked staff, they told us that the person liked it there and that's why they stayed there. The person had limited communication ability and we were unable to determine if this was correct. Staff, when questioned, also told us the person could mobilise without assistance and gather drinks for themselves. On one day, we observed the person sit continuously at a dining table without fluids, and play with a wooden puzzle. They did not get up to walk around, there was no interaction by staff (except inspectors) and no fluids were offered or obtained. A social worker from the local authority sat in the dining room for part of the day reviewing files. The social worker raised a safeguarding alert about the person's care when they left the service, on the basis that the person was left alone for long periods without staff oversight. On the second day of the inspection, the person was in the dining room again with no one else present. This time we observed a cleaner had mopped the whole floor, and the person was standing up using a chair as a mobility aid. The cleaner simply mopped around them and kept going. This put the person at risk or slipping on the wet floor. Again, the person did not have fluids offered to them or get drinks by themselves.

Bed rails were fitted to some people's beds to prevent falls out of bed. However, 'bumpers' had not been installed to ensure that people could not become trapped between the rails. Risk assessments about bed rails were present in people's files. However, for some of the people staff did not realise that bed rails were a form of restraint and that if the person could not consent to them, a best interest decision should have been recorded. In addition, some people that stayed mainly in their beds were at risk of developing pressure ulcers. Although there were pressure relieving air mattresses placed on their beds, people's planning and receipt of care related to this was inadequate. People's files did not state what the setting for the mattress should have been, meaning staff did not know whether the correct pressure was in operation. On one day of the inspection, we observed five mattresses had the audible alarms silenced. This meant if the mattress deflated or there was low pressure, staff would not be alerted that the person was at risk from continual pressure to one part of their body. Turning regimes, although sometimes documented by staff, were not clear about what sides people were turned to, the frequency of turns or people's skin integrity.

This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We asked Sandridge House to show their complaints records to us as part of the inspection. Instead, the home manager showed us a small lined book which had "comments book" typed on the front cover, and "complaints" written underneath the title. When we looked inside the small book, there were some handwritten notes about what people and relatives felt regarding the location, and that they were satisfied

with their room and care. However, there were no complaints written in the book.

The location had a complaints procedure dated April 2014 which we viewed. This contained a written acknowledgement letter within seven days of reporting the matter, and 28 days to the final response letter. We asked the home manager to show examples of acknowledgement letters and final response letters that have been sent to people in the last 12 months. We also asked the home manager where complaints and concerns were recorded. They were unable to present this to us during the inspection. This meant complaint investigations, documentation like witness statements and care records and other important information about people's feelings was not recorded and stored for a decided outcome. The failure to record concerns and complaints from people and relatives meant the provider was not able to make a tally on a monthly or yearly basis, and therefore use the information to help educate staff to prevent recurrence of such matters. There was also no evidence that if people provided verbal feedback of concerns to staff and action was taken, it was not recorded for future review by management.

People and relatives did not have a good view of information about how to raise concerns or complaints. There were few or nil posters or signs fixed around the building that told people how they would raise their concerns or complaints. In most people's bedrooms, the 'service user guide' was not available or suitable, and therefore information about how to raise problems was not easily able to be read.

This was a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Some involvement of staff was evident in the overall management of Sandridge House. When we asked staff their opinion about the home manager, the response was divided. Some staff members liked the fact that the manager would work on the floor beside them to support people with personal care. However, when we asked about leadership and vision for the service, the staff consistently did not feel that enough managerial oversight was undertaken by the home manager. We saw the home manager demonstrated patience with staff and listened to what they had to say. The home manager was also willing to assist, even during the inspection, when other registered nurses stated they had a clinical problem they needed help with.

A number of staff meetings were held in 2015 at the service. These were predominately with support workers and registered nurses, although we saw one meeting was held with the kitchen staff in May. When we viewed the meeting minutes, we saw a range of topics were discussed, such as the use of mobile phones whilst on shift, uniforms, pay, sickness absence and staff training. Infection control was a constant theme of the meetings. The minutes indicated that discussions were primarily focussed on advising staff correction of poor technique or procedures that were not in line with best practice guidance. There were limited instances where the meetings had focussed on care for people, although some examples showed discussion of unknown bruising for people and better communication. No action plans or follow up of the points raised were documented or planned for review.

We found a robust system of quality assurance was not in place at Sandridge House to ensure the service was well-led. We asked to see evidence of quality audits and any associated action plans that the provider used to improve care and drive up standards. Before the date of the inspection, there were limited examples of how quality had been assessed or used in the operation of the service. At the inspection, on both days, the home manager and compliance manager were asked on more than one occasion for audit information, action plans and ways the service had improved. We asked for different examples of assessments that they used to check the safety and effectiveness of the care. However there was a reluctance to provide the CQC with more detailed internal checks that the provider did have on file. In fact, access to one audit was provided at the end of the inspection day.

The provider had a policy titled 'Visits by Registered Provider' dated August 2014. This detailed that the frequency of visits by the provider was "likely to be no less than once per month" and the purpose was to form an opinion on the quality of care, treatment and support to people. We asked to see all of the provider visit records for 2015 and were provided with documents for September and October 2015. These contained checks on staff, service delivery, care practice, improvement activity and health and safety. Brief notes were detailed of tasks that were completed and new or outstanding actions that needed undertaking. In the September 2015 under improvement activities undertaken, the report stated the home manager advised that due to the time needed to spend on the floor, it was "very hard to get time in the office". This meant some tasks critical of the home manager fell behind or ended up being overlooked altogether. In the same visit report, it was noted that the 'service improvement plan' had been updated to take in account of the findings from the internal audit.

We reviewed the provider's service improvement plan which was created on 7 October 2015 and last updated on 23 October 2015. The detailed plan listed a number of risks that the provider was made aware of by various methods, for example prior CQC inspection visits and quarterly home manager audits. The action plan detailed the steps needed to reduce the risks for people who use the service, as well as the responsible person and the predicted due date. We asked the compliance manager to point out which of the actions had been completed since the inception of the service improvement plan. Whist a small number had been signed off as completed, the majority were outstanding. Some of the actions had not been commenced. These were actions that could affect the safety and care of people who use the service. For example, items that were not commenced included yearly updates of medication safety for registered nurses and commencement of the Care Certificate for newly employed support workers.

We saw the provider contracted an external compliance company to provide site visits on 10 March 2015 and 17 August 2015. The purpose was to check whether the service met the regulations that commenced on 1 April 2015 and provide an independent opinion about the standard of care provided to people. We looked at both reports that were provided to the managers of the service. The company had used our five key questions in the assessment of care, and recorded positive feedback and constructive criticism. For example, both reports stated that the home delivered warm care and had a positive atmosphere. The reports however noted that multiple items required improvement for people's safety and for the service to obtain a 'positive rating'. Items listed spanned one and a half pages of bullet point suggestions including cleanliness, recruitment, staff induction and training and care planning as well as record keeping. Despite having one of the reports since March 2015, the second visit by the contractor found almost exactly the same issues required improvement. The provider demonstrated no actions which had rated the risks to people, reduced the risk to prevent harm, or demonstrated that corrective action had been undertaken to resolve the issues detailed in the first report.

Some other audits were undertaken by the service. These included medication audits and we saw evidence of results from September to November 2015. Some issues were detected and recorded on the audits, for example paracetamol tablets that had expired. However, there was no documentation that accompanied the audit to show what action had been taken by the care home to resolve the issue. There were also quarterly audits completed by the home manager and we saw these were completed twice in 2015. Again, the audits using a pre-existing template pointed out areas that required improvements, such as updating the business continuity plan and holding 'residents and relatives' meetings. These items were listed in the service improvement plan and had been completed. Care plan auditing was last completed in January 2015. However, there was no evidence of any further checks of the content quality since this date. We saw a health and safety checklist was completed monthly from August to October 2015. Although issues were detected, such as a lack of health and safety training for staff, no resultant action had been taken up to the point of our inspection. The check also indicated that although risk assessments had been carried out for hazardous chemicals, for three months in a row staff had not been trained how to safely deal with the substances.

There was an unacceptable delay between registrations of managers at Sandridge House in 2015. It is a condition of registration that the provider has a registered manager at all times for the location. A registered manager is one of the people legally responsible for the care of people in the service. From our records, we saw the last registered manager deregistered with the CQC on 24 May 2015. At the inspection we found the provider had appointed a new home manager and they commenced in post on April 2015. However, the person had not commenced the application process to become a registered person until 13 July 2015. The application was rejected due to a mistake in the form submitted. The home manager finally made a successful application to CQC for registration on 30 October 2015. This application is currently under consideration by our registration assessors.

We spoke with local authority commissioners of care at the service and they were disappointed with the current standard of care and the deterioration the home had experienced in 2015. On 27 November 2015, one local authority placed the care home into their 'serious concerns' framework and the location agreed not to take any further admissions until further notice. Commissioners then required a series of meetings with the home on a weekly basis to address standards of care that placed people who use the service at risk. Commissioners were also still aware of ongoing areas of improvement the home had to address, for example, staff training and cleanliness. The provider had constructed a six-week action plan commencing 17 October 2015 with key priorities and areas to focus on. The action plan included care plans, staff support, staff learning and development and recruitment. We also noted that a flyer had been distributed after week one of the action plan which detailed successes and areas for continued effort.

This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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 18 Registration Regulations 2009 Notifications of other incidents The registered person did not notify the Commission without delay of incidents which occurred whilst services were being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of the regulated activity.

The enforcement action we took:

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users were not appropriate, did not meet their needs or reflect their preferences.

The enforcement action we took:

We issued a Notice of Decision to cancel 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 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 the proper and safe management of medicines. The registered person did not assess the risk of or prevent, detect and control the spread of infections.

The enforcement action we took:

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment in accordance with the regulation. Service users were deprived of their liberty for the purpose of receiving care and treatment without lawful authority.

The enforcement action we took:

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment All premises and equipment used by the service provider were not clean, suitable for the purpose for which they were being used, properly used or properly maintained.

The enforcement action we took:

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints received were not investigated and necessary and proportionate action was not taken in response to any failure identified by the complaint or investigation.

The enforcement action we took:

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not established and operated to ensure compliance with the regulation. The registered person did not assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services. The registered person did not assess, monitor and mitigate the risks to the health,

safety and welfare of service users who were at risk.

The enforcement action we took:

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Persons employed for the purposes of carrying on a regulated activity did not have the qualifications, skills and experience which were necessary for the work performed by them. Recruitment procedures were not established and operated effectively to ensure that person employed were fit and proper.

The enforcement action we took:

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed. Persons employed by the service provider in the provision of the regulated activity did not receive such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry our the duties they were employed to perform.

The enforcement action we took:

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