# Thornlea Nursing Home
# Care Home Service

21 Hawthorn Gardens
Loanhead
EH20 9EQ

Telephone: 01314 400 904

**Type of inspection:**
Unannounced

**Completed on:**
14 December 2020

**Service provided by:**
Thornlea Nursing Homes Limited

**Service provider number:**
SP2003002476

**Service no:**
CS2003010673

## About the service

Thornlea Nursing Home is located in Loanhead, Midlothian and is registered to provide care and support for up to 33 older people.

The service was operated by Thornlea Nursing Homes Limited.

This was a focused inspection to evaluate how well people were being supported during the COVID-19 pandemic. We evaluated the service based on key areas that are vital to the support and wellbeing of people experiencing care during the pandemic.

This inspection was carried out by inspectors from the Care Inspectorate and Healthcare Improvement Scotland.

## What people told us

At the time of the inspection 27 people were using the service.

Almost every person who used the service was being supported to isolate in their own room and many of them were very unwell. This made it difficult to have detailed discussions with them at the time of the inspection.

## From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

| | |
|---|---|
| How good is our care and support during the COVID-19 pandemic? | 1 - Unsatisfactory |

Further details on the particular areas inspected are provided at the end of this report.

## How good is our care and support during the COVID-19 pandemic? 1 - Unsatisfactory

**7.1 People's health and wellbeing are supported and safeguarded during the COVID-19 pandemic.**

People's health and welfare was not being appropriately supported or safeguarded. People's nursing care needs were not being met and carers were not supported by nurses to deliver care and support appropriate to people's needs. We were very concerned that people who were unwell and nearing the end of their life were not being given appropriate palliative care. The nurses had not ensured that end of life medication to help people stay comfortable was available.

People were not being checked for signs of changing needs that would then help other professionals such as a GP to be called quickly. There was a lack of observations including temperature checks, pulse rates and

oxygen saturation checks. The failure to undertake these essential observations and respond appropriately meant people who were ill were not experiencing the care and treatment they needed. This included medication not being reviewed, the need for end-of-life care not being recognised and people's experiences of care at the end of their life may have been compromised as a result.

People's oral health care was not monitored, this is essential so that people are comfortable when eating and drinking. People were frail and unwell, and care staff were unsure how best to care and support them. Associated risks such as monitoring good skin care was not undertaken to an acceptable standard and the potential for people's skin to become sore and damaged was high.

We concluded that people were at significant risk of harm due to the failure of staff to manage care and support appropriately.

As a result of the serious concerns identified at this inspection, the Care Inspectorate made an application to the sheriff at Edinburgh Sheriff Court seeking cancellation of the care service's registration under Section 65 of the Public Services Reform (Scotland) Act 2010. The application was based on the Care Inspectorate's belief that in the absence of an order there would be serious risk to the life, health or wellbeing of persons cared for by the service.

On 22 December 2020 and with the agreement of the provider, the Sheriff made an order temporarily suspending the registration of the service from 18 January 2021. The provider company subsequently went into liquidation and the care home permanently closed. As a result, we cancelled the registration using our power under section 64(4) of the Act on the basis that the provider had ceased providing the service, and the court case was dismissed.

**7.2 Infection control practices support a safe environment for both people experiencing care and staff.**

The home was not clean and there were not enough staff to ensure cleaning was carried out to the necessary standard to help prevent cross infection. This meant it was not a safe environment to live and work in.

We saw adequate supplies of the correct type of Personal Protective Equipment (PPE). However, PPE was incorrectly stored alongside cleaning equipment and products that were in use. PPE that was ready for use was on cluttered shelves among ornaments, and on a trolley with an open bag of clinical waste attached. This would result in contaminated PPE that would be likely to spread infection further.

We did not see staff performing hand hygiene at every opportunity following each episode of care or after removing PPE. This meant that people were not protected from cross infection.

Clinical waste was not managed according to guidelines. For example, we saw that clinical waste was not stored securely to prevent public access. We saw bags of clinical waste in over full waste bins that were not locked and bags of clinical waste on a path next to the main building.

We also saw clinical waste bags being stored in a bath, the room was not secure and did not have signage to indicate it was out of use as a communal bathroom. This meant that people could have entered the room and cross infection could occur. This showed a fundamental lack of knowledge and practice in the management of clinical waste and presented a serious risk to people's health.

People should experience an environment which is well looked after with a clean, tidy, and well-maintained premises, furnishings, and equipment. The lack of an effective cleaning regime and not using the right

cleaning products increased the risk of infection spreading. The service had not implemented the enhanced COVID-19 cleaning guidance and therefore the environment presented a serious risk to people.

As a result of the very serious concerns identified at this inspection, the Care Inspectorate made an application to the sheriff at Edinburgh Sheriff Court seeking cancellation of the care service's registration under Section 65 of the Public Services Reform (Scotland) Act 2010. The application was based on the Care Inspectorate's belief that in the absence of an order there would be serious risk to the life, health or wellbeing of persons cared for by the service.

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**7.3 Staffing arrangements are responsive to the changing needs of people experiencing care.**

We had significant concerns about the competency of the care home's nursing staff. This was because they failed to recognise when people were becoming unwell or were dying and did not react quickly enough to manage pain or people's symptoms as a result. For example, it was not until a local Health and Social Care Partnership (HSCP) Palliative Care nurse was on-site to provide support that sufficient anticipatory end of life medication was ordered. Anticipatory medication reduces the pain and suffering people experience at end of life and this should have been in place. We would expect registered nurses to be aware of the need to be prepared so they could provide the right care and support at the right time.

We found serious issues about staff knowledge and understanding about infection control practices and the correct use of PPE. We were told that training had been provided earlier in the pandemic by the HSCP Care Home Support Team. However, from what we saw and were told there was a real lack of awareness about where, when and what type of PPE should be worn. This meant infection prevention and control practices by staff in the home were not in line with the guidance. This was a failure by the provider to ensure staff followed best practice and meant that people were not being protected from the risk of infection adequately.

A number of staff were off work due to having to self-isolate after positive COVID-19 test results. When we spoke with those who were at work, they told us that some staff who had returned after self-isolating were struggling with fatigue. We were told that the service had attempted to source staff from agencies, but this had been unsuccessful. This showed that there was no staffing contingency plan in place to deal with an outbreak in the staff team. This meant we were not confident that enough staff would be available to meet the increasingly urgent medical needs of people.

Management support for the staff team was lacking with no clear direction being provided, apart from that given by HSCP nurses who were providing emergency assistance. This was having a very negative impact on people's care and support. During an emergency event, such as an outbreak of COVID-19, it is essential that care and support is provided in a planned and safe way. Extremely poor support and communication given to the staff team had resulted in care practices that did not always follow the relevant guidance and best practice. This had resulted in people experiencing unnecessary harm and suffering due to their health needs being neglected, including at the end of life.

The service had not engaged with the supportive functions available to them until the situation in the care home had deteriorated significantly. In response to this the local HSCP were providing some nursing cover on a temporary basis. In addition, there were delays in making the required notifications to the relevant bodies,

including the Care Inspectorate.

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## Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

## Detailed evaluations

| How good is our care and support during the COVID-19 pandemic? | 1 - Unsatisfactory |
|---|---|
| 7.1 People's health and well being are supported and safeguarded during the COVID-19 pandemic | 1 - Unsatisfactory |
| 7.2 Infection control practices support a safe environment for people experiencing care and staff | 1 - Unsatisfactory |
| 7.3 Staffing arrangements are responsive to the changing needs of people experiencing care | 1 - Unsatisfactory |

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