Prime Life Limited

Charnwood Oaks Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Charnwood Oaks Nursing Home is a residential care home providing personal and nursing care to 81older people aged 65 and over at the time of the inspection. The service can support up to 84 people.

The service accommodates people across four separate units, each of which has separate adapted facilities.

People's experience of using this service and what we found
People were not consistently kept safe. The relevant risk assessments to promote safe care and minimize the risk of catching and spreading infections were not in place. This meant staff did not have information on how to safely provide support to people.

The managers did not always have robust oversight to ensure all areas of safe care and infection prevention and control were monitored.

We have made a recommendation about oversight of safe care and risk assessments.

Staffing had improved at the service. The managers had taken action to address most concerns we found at our last inspection. At this inspection, we found further action was required to continue to improve the service.

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

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 15 September 2021) and there were two breaches of regulation. We served a warning notice and the provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made/sustained, and the provider was still in breach of regulations. This service has been rated requires improvement for the last three consecutive inspections.

Why we inspected

This was a planned inspection as part of CQC's response to the COVID-19 pandemic we are looking at how services manage infection control and visiting arrangements. During the inspection we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led to check whether the Warning Notice we previously served in relation to Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met / on a specific concern we had about governance and safe care and treatment. The overall rating for the service has not changed following this inspection and remains requires improvement.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Charnwood Oaks Nursing Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 monitor the service and 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.

We have identified continued breaches in relation to safe care at this inspection.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Charnwood Oaks 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.

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

Inspection team
This inspection was carried out by three inspectors.

Service and service type
Charnwood Oaks Nursing 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 had a manager who was in the process of registering with the Care Quality Commission. This means that they and the provider would be legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with 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 this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with two people who used the service about their experience of the care provided. We spoke with nine members of staff including the manager, regional manager, deputy manager, senior care worker, care workers and clinical staff. We observed the care people received in communal areas of the service.

We reviewed a range of records. This included seven people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Risk assessments were not always in place. Assessments for known risk to people's welfare were not always completed. For example, there were no risk assessments relating to COVID-19 or the pandemic in place for people except for people who have had COVID-19. This meant staff did not always have the information and guidance to mitigate risk and keep people safe.
- The service did not always follow their own admissions policy in line with the government guideline to ensure people would be safe from the risk of catching COVID-19 when a new person was admitted from hospital. Staff did not have risk assessments to guide them to support people who may have difficulty with following the isolation guidelines such as people living with dementia.
- Where people had refused to complete COVID-19 lateral flow tests, there were no protocols in place to mitigate risk to them and others. This was especially needed as the service had a COVID-19 outbreak at the time of our inspection.

These constitute a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the last inspection the provider had failed to ensure risks to people's health and safety had been assessed and done all that is practical to mitigate those risks. At this inspection, the provider had not made enough improvement and was still in breach of regulation.

Preventing and controlling infection
Due to the issues stated above, we were not assured that the provider was meeting shielding and social distancing rules. We were also not assured that the provider was admitting people safely to the service. We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

- We were assured that the provider was using PPE effectively and safely.

- We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Staffing and recruitment
● The provider had made improvements to staffing at the service. Staffing levels were increased to support safe care. The service used temporary staff to fill vacancies created as a result of the pandemic. They had plans in place to further improve staffing numbers, skills and deployment.
● The provider had a programme of training in progress to ensure staff had the skills and knowledge required to carry out their responsibilities and continue to improve the service.
● From our previous inspections we saw the provider followed safe recruitment practices. They completed relevant checks which assured them staff were suited to work with people who used the service.

Using medicines safely
● People received their medicines as prescribed by their doctor. Staff were competent in the safe management and administration of medicines. They consistently completed relevant records following good practice. This meant where people needed support with their medicines, the support they received was delivered safely.
● The provider has policies in place to guide and support staff with the management of medicines. We identified a minor issue where staff had not followed the provider's protocols in the storage of fluid thickeners. We brought this to the attention of the managers who told us they would address this with immediate effect.

Learning lessons when things go wrong
● The provider had taken actions to address the failings we found at our previous inspection of the service. There were systems in place to share learning and improvement within the staff team.
● The managers took action to address some concerns we raised during this inspection and made changes that further improved areas of the service.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At the last inspection the provider's systems and processes had not maintained oversight of the safety and quality of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Further improvement is still required, however the provider had made enough improvement at this inspection and was no longer in breach of regulation 17.

● The managers did not always maintain full oversight of areas of the service which could result to people being at risk of unsafe care. For example, areas such as relevant risk assessments and adherence to safe admissions, related isolation protocols and other areas relating to COVID-19 and the pandemic.
● The managers did not maintain oversight of lateral flow device tests for staff who used the service. This is to ensure robust compliance with government guidelines and minimise the risk of infection to people who used the service.
● Risks relating to managing some behaviours of people living with dementia had not been assessed. This meant staff did not have the guidance on how to support and mitigate risk.

We recommend the provider consider developing a robust system which prompts and support staff to risk assess, regularly review and mitigate risk relating to preventing and controlling the spread of COVID-19. This also includes other known risk to delivering safe care and ensure assessments are tailored to the needs of people who use this service. Action should be taken to update practice accordingly.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider had employed a new manager since our last inspection. Staff spoke highly of the support they received from their manager. They told us this has supported improvement since our last inspection. One staff member told us, "I am very pleased with the new manager, she is doing a real effort to get things to their best possible." Another said, "I can see a few changes with the new manager - trying to bring more staff in, trying to make changes and is more visible."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider demonstrated understanding of the duty of candour. We saw evidence of how they applied this when resolving complaints made to the service and sharing relevant information relating to COVID-19 with people's relatives and relevant professionals. Duty of candour is a requirement for providers to be open and honest with people when things may/could have gone wrong with the care they received.

Continuous learning and improving care; Working in partnership with others

● The service had worked to an action plan to address concerns from our last inspection of the service. The service had made improvements in relevant areas, however further actions are required to continue to improve the service.

● The service worked in partnership with relevant people and agencies. These included health and social professionals and people's relatives.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risks to people's safety including infection control risk had been assessed and done all that is practical to mitigate those risks.