Prime Life Limited

Charnwood Oaks Nursing Home

Inspection report

Sullington Road
Shepshed
Leicestershire
LE12 9JG

Tel: 01509600500
Website: www.prime-life.co.uk

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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 nursing home, it provides nursing and personal care for up to 84 older people living with dementia. At the time of inspection there were 79 people living there.

People's experience of using this service and what we found
People were not consistently protected from known risks. Not all risk assessments had been completed. We found some equipment was unsafe or not used correctly.

Injuries to people had not consistently been recorded appropriately or followed up. Unexplained injuries were not always investigated to identify a cause and to protect people from abuse.

People were at risk due to concerns with infection, prevention control. Not all staff completed COVID-19 testing regularly. PPE was not consistently worn in line with the providers policies and procedures.

Records of care tasks had not been completed consistently. We found concerns with the recording of repositioning checks to protect people from pressure damage and food charts for people who requires special diets.

Systems and processes required improvement. The provider lacked oversight. Audits completed did not identify the concerns we found with safety, records, equipment and safeguarding people.
The provider had not consistently sought feedback from people, relatives or staff. Trends and patterns had not always been identified to learn lessons and improve the service.

We could not be assured on the staffing levels. Staff and people told us they felt there were not enough staff on each shift. We found a number of unwitnessed falls had occurred.

People were supported by staff who knew them well and who had been recruited safety. Not all staff had received training in dementia, first aid or nutrition.

Medicines were managed well. Administration of medicines were recorded appropriately, and staff had their competencies checked to ensure they had the skills and knowledge to safely administer medicines.

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 26 November 2019) and there was one breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had not been made and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to falls management, environmental safety and nutrition. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has not changed from requires improvement. This is based on the findings at this inspection.

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.

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

We have identified breaches in relation to record keeping, risk assessment, safe care and oversight at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we 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 completed by three inspectors.

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

The service had a manager registered with the Care Quality Commission. However, they no longer worked for the service. This means that the provider is 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 and four relatives about their experience of the care provided. We spoke with eight of staff including the directors, nurses, care workers and a cook. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. 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, rotas 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 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; Preventing and controlling infection

- Risk assessments were not completed for all known risks. For example, there were no risk assessments in place for when a person was unable to use a call bell, or for one person who had communication needs. This meant staff did not have the strategies recorded to understand how to mitigate these risks.
- People were at risk from bedrails. We found two peoples bedrails were too low. This put people at risk of falling over them.
- Unexplained injuries had not consistently been investigated to find a cause. For example, one person who had a visible bruise, had no records that evidenced these bruises had been noticed by staff or if any follow up care was required. This put people at risk of abuse.
- Not all injuries had been recorded appropriately. We found some injuries had not been recorded and others did not have sufficient details recorded to ensure they could be followed up.
- We were not assured that the provider was using PPE effectively and safely or that the provider was making sure infection outbreaks can be effectively prevented or managed. Staff were not always wearing the correct PPE for specific tasks such as supporting a person with an aerosol generating procedure (AGP) in line with the providers policies and procedures. [An AGP is a medical procedure that can result in the release of airborne particles from a person's respiratory tract.]
- Risk assessments for when staff refused to be COVID-19 tested had not been completed. This put people at risk of COVID-19.
- People with specific dietary needs did not consistently have their nutritional needs met. For example, one person who required a low fibre, diabetic diet did not have foods offered that met this need.
- People were at risk of skin pressure damage. We found six people's pressure mattresses were set at the wrong weight for them and repositioning tasks had not been recorded within the specified time scales required to reduce this risk.

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. The provider had failed to ensure infection prevention and control had been managed effectively. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us they felt safe. One person said, "I have never felt unsafe." Another person told us, "I feel safe with the staff."
- We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● 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
● Staff levels required monitoring. The provider had a dependency tool in place to identify the required number of staff on each shift to keep people safe. However, staff told us that due to staffing levels they were unable to ensure staff were present in communal areas. One person told us, "There are not enough staff, I have to wait for personal care sometimes."
● Staff received training to ensure they had the correct skills to meet people's needs. However, the training matrix evidenced some staff still required training in dementia, first aid and nutrition. Staff told us they felt the training provided was "adequate" or "good."
● Staff were recruited safety. Safe recruitment practices were in place and the provider used references and the Disclosure and Barring service (DBS) to ensure no staff had any criminal convictions and were suitable to provide support for the people living at the service.

Learning lessons when things go wrong
● The provider analysed incidents and accidents to reduce risks. However, this did not always include trends and patterns such as if a fall was witnessed or unwitnessed, if incidents or falls related to the same person The provider put a new incident form into place to help identify any trends or patterns in the future.

Using medicines safely
● Medicines were administered safety. Staff had the training required to administer medicines. We found the medicine administration record (MAR) had been completed appropriately.
● People who had 'as required' (PRN) medicines prescribed were given these medicines correctly. Records were in place detailing the reasons to give the medicine.

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 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At the last inspection the providers 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. At this inspection, the provider had not made enough improvement and was still in breach of regulation.

● Systems and processes were not in place to ensure people received safe care and treatment. For example, the provider did not review the records of daily care tasks such as repositioning charts and food and fluid charts. We found limited recording in place to evidence these tasks had been completed. The provider had not identified the gaps and no actions had been put into place to mitigate associated risks.
● Audits completed on care plans and risk assessments did not identify the concerns we found with these documents. For example, one person who had suffered a choking incident did not have the specialist advise recorded within their care plan. Another person had conflicting information recorded regarding their pressure care. Not all known risks to people had been assessed and strategies implemented to reduce these risks. Staff did not have the information needed to provide safe care as care plans were not accurate.
● Systems and processes in place were ineffective in identifying risks to people. For example, the audits completed on pressure mattress settings and bedrail safety had not identified the concerns found on inspection.
● People and staff were not asked for their feedback on their care. Care plans did not contain people's involvement. The management team told us that feedback surveys had not been offered to staff or people. This meant the service could not improve based on people and staff's experience.
● Relatives we spoke to told us they had not been asked to feedback on their experiences or thoughts on the care provided to their loved ones. One relative said, "I have never been asked to feedback." Another relative told us, "They haven't asked me."
● Systems and process were not robust in gaining oversight and improving the service. For example, audits completed had not identified the concerns found with PPE use and people's dietary needs not being met.
● We found limited evidence of staff or resident meetings. When resident meetings had been completed there were no action plans to evidence improvements were made based on people's suggestions or

requests.

The provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Complaints had been recorded and responded to in line with the providers policies and procedures.
- The provider understood their responsibility to be open and transparent in line with their duty or candour responsibility. We saw evidence of duty of candour and outcome of complaints letters being completed.

Working in partnership with others

- Staff worked closely with external professionals. We saw referrals were made to speech and language therapists, falls team and dieticians. The GP worked with staff to support and meet people's health needs.
- Relatives told us they were kept up to date on their loved one. This included any changes in need or incidents that had occurred.