Prime Life Limited

Chamberlaine Court

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
Chamberlaine Court is a residential home providing accommodation and personal care for up to 38 people aged 65 and over, at the time of the inspection 35 people were living there, some people were living with dementia or a cognitive impairment.

People's experience of using this service and what we found
The provider's systems and processes did not always ensure risks to people were known and managed safely. Individual risks relating to health conditions were assessed, however, when changes had occurred, those risk assessments did not always reflect the person's current support needs. Inconsistencies in how people were cared for and how records were written, meant staff did not always have clear and current information to enable them to support people correctly.

Where people required monitoring of their foods and fluids, records were not descriptive enough to ensure the person got the help and support they needed. Actions identified during clinical checks and audits were not always implemented, which meant the provider failed to make identified improvements. We found people had fallen, yet care records, falls assessments, incident forms and falls analysis were incomplete. When we asked staff for some people's daily health records, we were told they were inaccessible. We found there was poor filing and storage of records we asked for. This meant the provider could not be assured they had accurate or up to date records, and there was a lack of oversight to ensure people's daily needs were being met in accordance with their care plans. There was no effective system to accurately record what had happened and the actions taken to seek the necessary health interventions.

The service was inspected during the COVID-19 pandemic. The provider's infection prevention and control measures were not always effective, so people were not consistently protected from the risks of cross infection. Clinical waste was not always disposed of, or stored, safely. Some personal protective equipment (PPE) had not been disposed of correctly into clinical bins. Clinical waste and general waste bins did not always have a foot pedal which meant staff and people had to use their hands to open the bins, which presented a risk of cross contamination. Cleaning schedules were in place but were not consistently effective because some areas of the home were not regularly cleaned. Overall cleanliness and limited managerial oversight meant current infection control and government guidelines were not followed.

Poor leadership and oversight of the service had impacted on the quality of care and treatment people received. The provider's systems to monitor the quality and safety of the service, were not always effective and had not always identified areas for improvement. The management had not identified the concerns that may arise through poor infection control, poor record keeping and a lack of consistency in recording and managing people's needs that changed over time.

Relatives felt staff did their best to help support people, yet communication with managers and staff was a barrier for them to understand their relative's current health and support needs, especially during the

COVID-19 pandemic. A relative was not told about the COVID-19 outbreak and was allowed entry to deliver a gift, against the provider's policy and government guidance.

We communicated our urgent concerns to the provider after our inspection visit. The provider responded to our concerns stating that they would work to improve the service within tight timescales through their own robust action planning and closer scrutiny of 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 good (published 09 August 2018).

Why we inspected
The inspection was prompted in part due to concerns received about risks related to moving and handling, food and fluid monitoring and people at risk of falling. We were also notified that the home had an outbreak of COVID-19. As part of CQC's response to care homes with outbreaks of coronavirus, we are conducting reviews to ensure that the Infection Prevention and Control (IPC) practice was safe and the service was compliant with IPC measures. We looked at the IPC practices the provider has in place.

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 coronavirus and other infection outbreaks effectively.

We reviewed the information we held about the service. No immediate 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.

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 Chamberlaine Court 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 COVID19 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 safe care and treatment and governance and management of the home.

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
At the time of this inspection, an investigation into a serious incident remained on-going. We will continue our investigation into the serious incident.

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.

Chamberlaine Court

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 could 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
The inspection was carried out by two inspectors who visited Chamberlaine Court on the 17 November 2020. Off site, two additional inspectors undertook telephone calls to staff, relatives and health professionals on 17, 18 and 19 November 2020.

Service and service type
Chamberlaine Court 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 doesn't currently have a registered manager, as the previous registered manager had deregistered on 26 June 2020. A manager was appointed on 27 March 2020 and this manager was in the process of registering with the Care Quality Commission. Following our inspection visit, the manager stepped down from this post. Interim management cover will be provided by the regional management team until a registered manager is appointed. Once registered, they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided

Notice of inspection
We gave a short notice period of the inspection because of the risks associated with COVID-19. This meant that we could discuss how to ensure everyone remained safe during the inspection.

What we did before inspection
We reviewed information we had regarding the service from family members who had contacted us. We sought feedback from the local authority and health professionals who work with the service and used any information the provider had sent us from their annual Provider Information Return. 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 used all this information to plan our inspection.

During the inspection
Because people were self-isolating, we were unable to speak with people living at the home. We spoke with five relatives about their experience of the care provided to their family members. We spoke with two members of care staff, a member of the housekeeping team, the manager and the regional manager. We asked to speak with more care staff but contact details were not provided for us to do so.

At our inspection visit we received information of concern regarding a serious incident that took place before our inspection visit. At the time of this inspection, the investigation into the serious incident remains on-going.

We reviewed a range of records. This included four people's care records and examples of medication records. We also looked at records that related to the management and quality assurance of the service, especially around managing risk and infection control.

After the inspection
We continued to seek clarification from the provider to validate the evidence found.

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 Good. At this inspection this key question has deteriorated to Requires Improvement. 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.

Preventing and controlling infection

- People were at risk because the provider failed to follow or meet national guidance in relation to infection control.
- Clinical waste was not always disposed of safely. For example, we saw a used apron was left hanging out of a clinical waste bin and a staff member had left their used face shield and a wipe in a laundry room without disposing of them safely and responsibly. Clinical bins were not all foot operated which increased the risk of cross infection.
- The environment was not clean and was unhygienic. Communal areas of the home were dirty. In one example, a window frame in a communal corridor was badly stained with grease and dried on brown matter. Regular cleaning practices went unsupervised. Some hand sanitisers and hand wash dispensers in areas where people needed to ensure good hand hygiene, were empty, even though a staff member had signed to confirm they had checked, 30 minutes earlier.
- Good food hygiene practice was not followed. In communal areas, we saw uncovered and undated food. Fridges were dirty and in one example, contained out of date food. One staff member said, "The stuff in the fridges and things like that are always out of date. The cleaners don't get enough time to keep on top of everything."
- Equipment associated with food and drinks was not clean. Drinks dispensers in communal areas were dirty and food and tea trollies were stained. A housekeeping trolley had a used wipe wrapped around a wheel which meant there was a risk of cross infection through the home.
- Staff did not always follow safe government guidelines to minimise risk of infection to people and each other. We saw a staff member speaking with a number of staff, not socially distancing and their face shield was upright, not covering their face as directed. Another staff member was seen to clean hand rails without wearing gloves but put on gloves and mask when they saw us. These actions put people at risk.
- After the inspection visit, we shared our urgent concerns with the provider and asked them to tell us, what improvements they would implement without delay to help minimise cross infection risks. The provider retrained staff in infection control practice, got an external cleaning contractor to improve cleanliness throughout the home and improved systems and processes to ensure improvements were sustained.

Assessing risk, safety monitoring and management, learning lessons when things go wrong, systems and processes to safeguard people from the risk of abuse

- A lack of effective management of risk, placed people at unnecessary harm. For example, people assessed of being at risk of falling, had assessments to minimise the risk. However, records of some incident and falls went unrecorded and unchecked. Where records had been maintained, they failed to accurately record the event, so a complete picture was not available as to the extent of the incident, injury and treatment.

● One person with underlying health conditions had fallen resulting in a hospital admission. Records showed they had fallen four times prior to their latest fall. These records indicated an increasing level of confusion, distress, agitation and tiredness. There was no evidence given to us that this was explored to minimise the risk of further falls or referred to the district nurse or GP.
● Risk management of escalating risks was not always completed, so actions could be taken at an earlier stage to rule out any changes in health contributing to the increased risks.
● We asked this person's relative if they knew what additional safety measures had been put in place to minimise risks. This relative said, "I don't recall any conversations with the home about what they were doing differently to manage the risk of (Person) falling."
● When concerns were identified or things went wrong, the approach to reviewing and investigating the cause to minimise the risk of it happening again, was ineffective. There was no evidence of learning from incidents. In two examples we looked at, we found there was no record of an incident or accident forms for any falls. We asked the manager why and they said, "I did not know about them, staff never told me."

These concerns were a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines management was an electronic system which helped support safe management. We looked at three medicines records and found no concerns with how those people received their medicines.

Staffing and recruitment
● There were enough staff to meet people's needs. Staffing levels were determined by the provider's own monthly dependency review. However, one staff member told us they felt there were not enough cleaning staff.
● During our visit we saw and staff told us, they worked across different floors, not keeping themselves separate from others to minimise risks of cross infection. Following our inspection, the provider increased the staffing numbers to support staff co-horting. This meant staff could work together on each floor to minimise the risk of cross infections. We were told increased staffing levels would continue until the provider had assurance people's safety risks were well managed. Additional staff hours were also allocated for additional cleaning tasks.
● We did not look at staff recruitment files during this inspection visit. Safe methods of staff recruitment were found at the previous inspection and no concerns were identified in planning for this visit.

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 Good. At this inspection this key question has deteriorated to Requires Improvement. 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; Continuous learning and improving care.

- Systems and processes were not used effectively to review and maintain oversight of the service. This lack of oversight impacted negatively on the quality of care and standards some people received.
- For example, falls management had failed to record each fall, and incident forms were not always completed in line with the provider's policies. The manager said their falls analysis was accurate during our conversations, but our evidence showed it was not. We found falls related to two people that resulted in hospitalisation were not recorded on incident forms or monthly falls analysis. Care plans were not always reviewed in response to escalating risk. Where incidents had occurred, there had been ineffective governance to review the incident and learn lessons. The poor review of incidents affected the provider's understanding of when things went wrong so that action had not been taken. We found several incidents resulting in serious injury, had not always been shared with family members.
- The provider's systems and process to maintain good infection control were not robust to minimise the risks of cross infection. The manager's actions failed to continuously monitor and improve cleaning regimes, or follow latest government guidance, in relation to the pandemic. Cleaning and environmental audits failed to identify and address the risks we found. For example, through our limited time observing staff, we saw one staff member go from room to room supporting people with meals and drinks, yet they did not change gloves. The regional manager said a glove change was an expectation. The provider had failed to ensure staff were following their own policies and procedures, and their own training in good infection control practice.
- One relative delivered a gift in person to the home which was against government advice and the provider's policies. During our visit, there was no signage advising visitors of the outbreak at the home or visiting restrictions. This put the visitor and others at the home at risk of cross infection.
- Important information regarding people's personal needs were not readily accessible. Records we asked for were not always made available to us in a timely way. This was because they either did not exist or the filing system made it extremely difficult to find them.
- The regional manager and manager acknowledged the shortfalls we found in the service. During our visit, they put plans in place to address some of the issues we found. Following our inspection visit, the provider implemented an action with short timescales to improve standards and practice at the home.

This was a 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;

● During the visit, we found examples where improvements were needed. For example, telling visitors and relatives about the visiting restrictions and when their family members had become unwell or who had fallen, what had been done and how they were.

● Limited responses to our questions from the manager during our inspection did not always give us confidence in the manager's understanding of what their responsibilities were to ensure good systems of governance and safe care were followed. The issues we identified during our visit that posed extreme risks had not been identified by the manager or their team.

● Following our visit, the provider was asked to send us an action plan to tell us how they would improve the service. Their detailed action plan with tight timescales and managerial oversight would ensure improvement actions were swiftly made.

● At the time of our visit there was no registered manager. A manager was in post and was applying to be registered with us. Following our inspection visit the manager chose to withdraw their application for registration and left their role at Chamberlaine Court. Interim management arrangements were put in place by the provider until a new manager could be appointed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Following our visit to the service we wrote to the provider with our serious concerns. The provider responded with an action plan to improve the service and provided staff with the guidance, resources and support needed to help deliver the level of service people expected.

● Assurance has now been provided to relatives regarding the current restrictions on visiting. The regional manager said it was important for families to stay connected to improve and support positive mental wellbeing and plans were being made to facilitate this at the right time.

Working in partnership with others;

● The regional manager said they had worked with the local authority to seek support and training. Links with other agencies such as the local authority and Public Health England were established.

● Internal communications continued to keep managers and staff updated on latest guidance and best practice, although our observations showed this was not always followed.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not adequately assess and protect people against risks by doing all that was practicable to mitigate any such risks. This included managing and preventing risks related to infection control and ensuring risks associated with people's care were accurate, reviewed and followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured robust quality systems or processes were fully effective to monitor the service appropriately, including people's safety and effective oversight of the environment.