Empowering U Healthcare Limited

Charnwood

Inspection report

7 Finchfield Road
Finchfield
Wolverhampton
West Midlands
WV3 9LS

Tel: 01902424579

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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 is a residential care home providing personal care to up to 19 people aged 65 and over. At the time of the inspection the service was supporting 16 people, some of whom where living with dementia.

People's experience of using this service and what we found
People were not always supported to have their needs met in a timely way by staff. People, staff and relatives advised staff did not always have time to engage with people in a meaningful and flexible way.

People were not consistently supported to receive their 'as required' medicines in a safe way.

People's care files did not consistently contain clear and up to date guidance to enable to staff to meet their needs. People's daily care notes did not always reflect how they should have been supported with their care needs. People had access to health professionals, however care records were not updated to reflect professional guidance was being followed.

People were not supported to reduce their risk of exposure to infection. The provider had failed to assess and mitigate risks in relation to infection control. People were not supported by staff who had knowledge of changes in government guidance around the spread of infection.

Quality assurance tools were not consistent or robust and had failed to identify and sustain areas of improvement required at the service to ensure people received safe and effective care and support.

People found the manager approachable. However, the provider did not have effective oversight at the service to ensure people's needs were consistently being met. The manager sought people and their relative's feedback about 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 14 May 2019). The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns following a targeted thematic inspection around infection control. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
We have found evidence that the provider needs to make improvements. Please see the Safe and Well Led sections of this report.

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

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.

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 monitor the service and 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 staffing, people's safe care and treatment and the governance of the service 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 meet with the provider and request an action plan 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

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 as part of our Thematic Review of infection control and prevention in care homes.

Inspection team
The inspection team consisted of two inspectors.

Service and service type
Charnwood is a 'care home'. People in care homes receive accommodation and 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 CQC, however the manager was on leave during our inspection and the service was being supported by a covering manager.

Notice of inspection
We gave the service notice of the inspection the day prior to our site visit. This was because the service is small and we wanted to be sure the manager would be at the home to speak with us.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We also 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 three people who used the service and one relative about their experience of the care provided. We spoke with five members of staff including the provider, manager, care workers, domestic staff and the chef.

We reviewed a range of records. This included six people's care records and multiple medicine records. We looked at a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who visit the service.

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.

Assessing risk, safety monitoring and management

● Risk assessments contained guidance for staff to follow however, were not consistently reviewed and updated. For example, one person's risk assessment did not contain up to date details of a person's dietary needs. Despite this, regular staff understood people's needs as they had worked at the service a long time, this reduced the risk of this person receiving an incorrect diet.

● Risks associated with choking were not always managed safely. For example, at lunchtime there was no staff present for long periods of time in the dining room despite people being at risk of choking. This placed people at increased risk. We discussed this with the manager who advised a senior carer would usually be in the dining area administering medicines, however due to staff absence this was not the case on the day of inspection.

● People were not always supported to reduce their risk of dehydration. For example, we saw staff were not following professional advice to offer fluids hourly to a person who was at high risk of dehydration. This placed the people at increased risk of dehydration.

● People were not always supported to reduce their risk of skin breakdown. For example, we could not be assured a person was being supported with pressure relief in line with their care plan by being turned two hourly as this support was not recorded on their daily records. Despite this, people had not developed pressure areas at the service, this meant people may have been receiving pressure care but staff may not have been recording this.

Preventing and controlling infection

● People were not always supported in a way which limited their risk of exposure to COVID-19. For example, we saw seven people had been admitted to the care home without being isolated as per government guidance. This placed other people within the home at higher risk of the potential spread of infection.

● Staff were not wearing appropriate personal protective equipment (PPE) in line with government guidance. For example, staff were not routinely wearing masks around the home. We raised this with the manager who was not aware of this being a requirement, however, acted during the inspection to ensure staff wore masks.

● The provider had failed to ensure staff had access to a suitable area for putting on and taking off their PPE as per government guidance.

● The provider had failed to ensure staff adhered to social distancing guidance where they were able. For example, staff were not socially distancing during handover periods.

● The provider had failed make changes to the environment to adhere to government guidance. For example, no changes had been made to the dining area to support people to socially distance at mealtimes.

● The provider had failed to ensure staff were aware of and following government guidance relating to COVID-19 on cleaning high touch areas twice daily. This means there was an increased risk of the spread of infection at the service.

Using medicines safely
● People did not always have protocols in place for as required medicines to ensure staff had an understanding of the circumstances these medicines should be given in.
● The provider had failed to ensure there was an effective system in place to regularly review people's medicines records. The manager told us they chose which records they reviewed by placing their hand in the folder at random.

Systems were either not in place or robust enough to demonstrate risks to people's safety were effectively maintained and managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager responded immediately during and after the inspection. We saw on the second day of inspection the manager had ensured all staff were adhering to government guidance on PPE and staff had access to designated areas to put on and take off their PPE. The manager also had plan in progress to address the other infection control concerns we had raised.

● Despite this, we saw people received their regular medicines by trained staff as they were prescribed.

Staffing and recruitment
● There were insufficient staff to ensure people were always supported in a timely way. One staff member told us, "If we are supporting a person who needs two staff, other people have to wait." Another staff member told us, "We just deal with each buzzer, residents may have to wait."
● We saw people had to wait for 40 minutes from being supported by staff to the dining table to receiving their lunch. We also saw people had to wait for support with their continence needs.
● Staff's time was task focused and there were insufficient staff to ensure they could engage with people in a meaningful way outside of care tasks. One person said, "Staff are always rushed. That is what its missing, what we are doing now, just having a chat, they haven't got time for that." One relative told us, "I do think that daily activities for the residents would help with both their mental and physical state."
● The provider had failed to ensure there was an effective tool in place to ensure there was sufficient staff available to meet people's needs. Following the inspection the manager sent us their dependency tool which helped them calculate how many staff are required to meet people's needs. However, this tool did not consider the time people may require to maintain their emotional wellbeing, only direct care tasks.

Whilst we found no evidence that people had been harmed, systems were either not in place or robust enough to demonstrate staffing was effectively managed to ensure people received their care in a timely way and had regular opportunities for meaningful interaction with staff. This placed people at risk of harm and a deterioration in their wellbeing. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were supported by staff who had been recruited safely in line with the provider's policies.

Learning lessons when things go wrong
● We could not be assured lessons were learned when things went wrong as whilst the manager had acted on the concerns we raised around infection control practices, the local authority had raised concerns about

this prior to our inspection and any improvements had not been sustained.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe. One person told us, "I feel protected here."
- Staff knew how to recognise the signs of potential abuse and how to report and record their concerns. One staff member told us, "If I see something that concerns me or notice something on a person I know to report it straight away."

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Systems were not in place to effectively monitor and assess the quality of the service, to drive and sustain improvements and to ensure compliance with the regulations. For example, there was no system in place to ensure all people would have their care and medicines records reviewed regularly. Whilst the management team acted following our inspection to implement improvements these were reactive to our visit and did not evidence a proactive commitment to quality monitoring.
- The provider's quality assurance tools had failed to identify where people's care plans had not been updated following professional advice. For example, one person's care plan had not been updated around professional advice for their fluid intake. This placed the person at risk of not receiving care in line with their changing needs.
- The provider's quality assurance tools had not identified where people's care plans contained out of date information about their needs. For example, one person's care plan stated they were mobile however they were nursed in bed.
- The provider's quality assurance tools had not identified medicines were not always managed safely. For example, two people did not have clear guidance for staff to follow around their 'as required' medicines.
- The provider's quality assurance tools had not identified where staff had not recorded people's required support in their daily care notes in line with their care needs. For example, one person required two hourly pressure relief however we saw staff had frequently recorded the person waited longer than two hours for this support. This placed the person at risk of skin damage.
- The provider had not assured there was a system in place to ensure staff were aware of government guidance around infection prevention and control and care was provided in line with this. For example, the provider had not completed risk assessments for people or staff to consider any increased risks around COVID-19 were considered and action was taken to mitigate risks. This placed people at increased risk of exposure to infection. During the inspection the manager was not aware people and staff required risk assessments or of changes in the government guidance around PPE.
- The provider had failed to ensure there was a tool in place to assess people's needs and adapt staffing levels to meet these. Feedback from people, relatives and staff along with our observations during the inspection confirmed people did not always receive support in a timely way and staff did not have time to interact with people outside of their care tasks.
- The provider had failed to ensure the manager was aware of when to send notifications to the Care Quality Commission (CQC) and relevant authorities as required.

Systems were either not in place or robust enough to identify and sustain improvements to the quality of care and documentation at the service. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had displayed their previous rating clearly on entrance to the service.

Working in partnership with others
● Feedback from professionals we spoke with was mixed in relation to how the management team followed guidance to promote people's safety during the pandemic. For example, we saw the provider had not sustained improvements required by the local authority from their last review of the service.
● Whilst the service engaged with professionals where people required additional support with their healthcare needs, we could not be assured staff always followed their guidance as people's care plans and daily notes did not reflect changes in people's care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff gave positive feedback about the manager and told us they were approachable. One staff member told us, "If I was worried about something I could go to her. I had a bad time not long and she sat me and talked to me about things. I felt much better."
● The management team worked with us during the inspection to address areas of immediate concern we raised in relation to infection prevention and control.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had sought feedback from people and their families during the pandemic. For example, the manager had set up a 'whatsapp' group for families to access support where they required this.

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 manager understood their responsibilities under the duty of candour and had been transparent with people's relatives where things had gone wrong.

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 People did not consistently received safe care in relation to their 'as required' medicines, pressure relief, nutrition and hydration. There were not sufficient staff at the service to support people in a timely and meaningful way which allowed for people to have time with staff outside of direct care tasks. Staff at the service were not fully aware of or compliant with government guidance around infection prevention and control. This placed people and staff at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient staff at the service to support people in a timely and meaningful way which allowed for people to have time with staff outside of direct care tasks.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure they were following government guidance around infection prevention and control to reduce people and staff's risk of expose to infection. The provider had failed to ensure there were effective quality assurance systems and tools in place at the service to ensure areas of improvement were identified, implemented and sustained. The provider had failed to ensure there was effective oversight at the service in the absence of the registered manager.

The enforcement action we took:

We have requested an action plan to explore the concerns we have raised as part of our inspection.