Four Seasons (Evedale) Limited

Charnwood

Inspection report

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16 July 2019

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Charnwood is a care home providing personal and nursing care to people. The service can support up to 88 people, at the time of the inspection 45 people were using the service. The service is split into two buildings 'Charnwood House' and 'Charnwood Court'. Both were considered at the inspection.

People's experience of using this service and what we found
Care records did not always provide sufficient detail to guide staff on how to look after people. Staff told us that they do not always have enough time to read care plan guidance. We found staff were not always aware of people's needs. This put people at high risk of their care needs not being met safely.

People were not protected in a safe environment. The environment was unclean, and staff did not always follow hygienic uniform policies. The fire evacuation plan was unclear, which would put people at risk in the event of a fire emergency.

While people felt safe at the service, incidents were not always appropriately recorded and referred to the local authority to investigate. This put people at risk of incidents and potential abuse re-occurring.

People told us that staffing levels still impacted on the quality of care. They told us that this was variable according to the needs at the service. We did not observe unnecessary delays at our inspection visit.

Some improvements had been made to the management of medicines, medicines were now safely given as prescribed. Some improvements were needed to ensure that routine checks were completed as per the provider's policy.

There had been some improvements since the last inspection, for example mattresses were now clean. However other concerns were raised on this inspection. The registered manager and provider had not ensured a consistently safe service.

Systems and processes designed to identify shortfalls, and to improve the quality of care were not always effective. While some improvements were noted since the last inspection, other concerns were raised on this inspection. This is the third time that this service will be rated inadequate, we are therefore concerned about the overall governance at 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 Inadequate (published 16 July 2019) and there were multiple breaches of regulation. This service has been rated inadequate for the last two consecutive inspections.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 30 April and 7 May 2019. Breaches of legal requirements were found in regulation 12 (safe care), regulation 17 (governance) and regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also identified that the provider had not notified us of events that had occurred at the service, this is a legal requirement so we can monitor the safety of a service. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We undertook this focused inspection to check they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led. This is where we had the highest level of concerns at our previous inspection. The ratings from the previous comprehensive inspection for those Key Questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service remains Inadequate. This is based on the findings at this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Charnwood on our website at www.cqc.org.uk.

Enforcement
We have found the provider remains in breach of Regulation 12 (Safe Care and Treatment) and Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They have also failed to notify the CQC of events that have happened at the service. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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.

Special Measures:
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This service has been in Special Measures since 12 February 2019.

This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe	**Inadequate**
Is the service well-led? The service was not well led	**Inadequate**

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.

Inspection team
The inspection team consisted of an inspector, an assistant inspector and a nurse (specialist advisor).

Service and service type
Charnwood is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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. This means that 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
This inspection was unannounced.

What we did before the inspection
The service has been rated Inadequate in 'Safe' and 'Well led' key questions for the last two consecutive inspections. We used our current understanding of risks at the service to focus our inspection planning. We also reviewed information we had received about the service since the last inspection.

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 six people who used the service about their experience of the care provided. We spoke with six members of care staff and 2 nurses. The registered manager was unavailable, so we spoke to the covering manager.

We reviewed records related to care and support for nine people. 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. We spoke with two professionals who regularly visit the service.

Inadequate

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 Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.
The previous inspection found that the service was in breach of regulation 12 (Safe care), and regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This inspection found ongoing breach of regulation 12 (Safe care.) This is the third inspection, where we have identified a breach of regulation 12. This has put people at ongoing risk of harm.

Assessing risk, safety monitoring and management
● An inspection eight months ago had highlighted that care plans needed improvement. We found that there was still insufficient guidance for staff. This has put people at prolonged risk of harm. For example, one person had fallen from their wheelchair four times, and there was no guidance to prevent this reoccurring.
● Staff told us that they had limited time to read care plans. This can affect their knowledge of people's care needs. For example, a staff member was not aware that a person needed more regular repositioning than was being provided. This could impact the person's skin health.
● Daily records showed that there were gaps in regular care. One person's fluid record had not been completed since 11am the day before our inspection, a visiting professional identified that they were dehydrated.
● People were not protected from the risk of fire. The evacuation procedure was inconsistent. The provider said they had changed this after our inspection.

Preventing and controlling infection
● The environment was still unclean. For example, we identified that rubbish had been stored on top of a bin. This put people at risk of ill health
● There was multiple areas of peeling paint and exposed wood work which can present as a surface for bacteria build up.
● Staff did not wear the correct uniform to ensure hygiene and reduce the risk of cross contamination.

The unsafe risk management and lack of cleanliness is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● When an incident had occurred, staff knew how to report potential abuse to senior managers. However, concerns had not always been referred to the local authority Safeguarding team to investigate.
● There was also poor record keeping in relation to incidents. For example, two people had an altercation, but staff could not locate records explaining what had occurred. This meant that the incident could not be analysed, and preventative measures put in place to keep these people safe from each other.
● People told us that they felt safe, but systems needed improving to ensure that potential abuse was

recognised and responded to appropriately.

Staffing and recruitment
● People and staff told us that staffing was not always sufficient to meet people's needs safely. This has been a recurrent concern from previous inspections.
● We did not see long delays for support. Staff told us the need for increased staff is variable according to daily needs at the service. One staff member said "It's just if they're [the residents] clashing together it can be difficult."
● Staff were safely recruited, for example staff had completed a Disclosure and Barring Service check (DBS), to ensure they were safe to support people.

Using medicines safely
● Some improvements had been made to the medicine's management since the last inspection. For example, medicines were now disposed of safely.
● We identified that some routine checks were not being completed as per the company policy. For example, some medical equipment was not regularly calibrated to ensure it was safe and effective.
● People received their medicine as prescribed and from trained staff. Medicine was stored appropriately

Learning lessons when things go wrong
● The last inspection identified concerns with; unclean mattresses, un-safe moving and handling and poor medicine storage. The provider had addressed these concerns.
● Despite some improvements, we noted other concerns at the service like not using bin bags and poor daily record keeping. There has been a prolonged risk to people's safety due to limited effective action.

Inadequate

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 Inadequate. At this inspection this key question has now remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality 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 designed to identify shortfalls and to improve the quality and safety of care were not effective and people were exposed to potential risks as a result. We identified shortfalls in record keeping, cleanliness, fire safety, and reporting safeguarding concerns to the local authority.
- Whilst we noted some improvements to the service (for example, cleaner mattresses and safer storage of medicines), this inspection has highlighted new concerns. The governance was not appropriate at sustaining a good quality service.
- Staff were not effective in their roles. They said they lacked time to read care plans, and we found staff did not always know people's care needs. This put people at risk of not being safely supported.
- Charnwood had a registered manager in post. Registered managers, along with registered providers have legal responsibility for how the service is run.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was a culture of poor care planning at the service. This did not promote good outcomes for people. Care plans did not always guide safe care and daily records showed care was not provided as required.

The systems and processes in place have not created or sustained improvements at the service. This has put people a prolonged risk of receiving poor quality care. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff knew people's likes, dislikes and preferred routines. They worked hard to meet their preferences. We observed positive interactions between staff and people.
- Staff told us, and records supported that they had received increased training since the last inspection.

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 had not always communicated promptly with the local authority or CQC when concerned about potential abuse.
- The provider was aware of the requirement to be open and honest around when things went wrong. The provider had contacted relatives if needed.
- The provider had displayed their previous CQC rating for visitors to see. This is a legal requirement.

●The provider has a legal duty to report incidents to the Care Quality Commission. This allows us to assess the safety of the service. We found we had not always been notified of incidents that had occurred at the service. This is an ongoing concern from the previous inspection.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Care plans had been developed to include equality characteristics. This would ensure people's individual needs and preferences were recognised.

● Residents, relatives and staff were engaged in regular meetings. People told us that they felt listened too.

Working in partnership with others

● We observed a health professional visiting the service. People told us that they could see health professionals as they required.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Guidance was not always in place, or followed by staff. This put people at risk of their needs not being met safely. The service was not always clean and this put people at risk of ill health.

The enforcement action we took:

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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems and processes designed to identify shortfalls and to improve the quality and safety of care were not effective and people were exposed to potential risks as a result. We identified shortfalls in record keeping, cleanliness, fire safety, and reporting safeguarding concerns to the Local Authority.

The enforcement action we took:

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.