

Tynefield Care Limited

Tynefield Care Limited

Inspection report

Egginton Road
Etwall
Derby
Derbyshire
DE65 6NQ

Tel: 01283732030
Website: www.tynefieldcare.com

Date of inspection visit:
30 November 2020

Date of publication:
14 January 2021

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

Tynefield Care Limited is a nursing home providing personal and nursing care for up to 45 people. There were 31 people living at the home at the time of our inspection. The service provides support to younger and older people with a range of support needs including complex health conditions, acquired brain injury, learning disability and dementia.

The service is a purpose-built home with all accommodation on the ground floor, split across three wings. It is situated on the edge of Etwall village with limited access to public transport and facilities.

People's experience of using this service and what we found

Infection control practices needed to be reviewed to ensure staff wore personal protective equipment correctly and suitable cleaning products were used. Quality monitoring systems were carried out in the home although further review was needed to ensure these were fully embedded and identify where all improvements were needed.

Staff were being supported to undertake additional training to enable them to have a specialism and have responsibility for carrying out audit in their specialist area.

People felt safe living at the service and risks to people's safety and well-being were assessed and mitigated as much as possible. There was sufficient staff working in the service, who had been safely recruited to work with people.

People's medicines were managed safely. The provider undertook assessments of staff practice to ensure that staff were competent 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

The last rating for this service was requires improvement (published 20 December 2019).

Why we inspected

We carried out an unannounced focused inspection of this service on 30 November. We reviewed the information we held about the service. 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.

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. 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 Tynefield Care Limited on our website at www.cqc.org.uk.

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?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was well-led.

Details are in our well-Led findings below.

Requires Improvement ●

Tynefield Care Limited

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

One inspector and an assistant inspector carried out this inspection.

Service and service type

Tynefield Care Limited 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 two managers who were preparing to register with the Care Quality Commission.

Notice of inspection

This inspection was unannounced.

What we did before the 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. We reviewed information sent to us and spoke with one social care professional and reviewed information from health care professionals who had links with this service. We used all of this information to plan our inspection.

During the inspection

We spoke with four people who used the service, a registered manager from another service managed by the same provider, two managers, one nurse, two care staff, head of house cleaning and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records including records relation to management of infection control, two staff recruitment files, care records and records relating to the management of the service.

After the inspection

The provider sent us information regarding additional cleaning products which had been ordered and information relating to further training for staff in infection control and use of Personal Protective Equipment (PPE). We spoke with two care professionals who regularly visited the service.

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 now 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

- We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed as PPE was not used effectively and safely. Throughout the inspection, without exception, staff were seen touching their masks and touching surfaces. Cleaning products used were not always suitable to ensure the control of COVID-19 which meant we were not assured that the provider was promoting safety through hygiene practices of the premises. However, following the inspection, the provider sent us information to demonstrate new cleaning products had been ordered and staff would access further training provided by the local clinical commissioning group to ensure practices were improved.
- 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 accessing testing for people using the service and staff.
- We were assured that the provider's infection prevention and control policy was up to date.

Systems and processes to safeguard people from the risk of abuse

- People felt safe and we saw them speak with staff and share experiences. One person told us they had time to speak with staff and share any concerns.
- Training had been provided for the staff team to give them the knowledge and understanding to safeguard people from potential abuse. Staff described how they would report any concerns to the local authority safeguarding team.
- Where concerns had been identified, the manager and staff had liaised with the safeguarding team to ensure this was investigated.

Assessing risk, safety monitoring and management

- Risks to people's safety and well-being were assessed and plans in place to mitigate risks and staff understood the support they needed.
- Where people needed support to eat and drink safely, information was available to ensure food was prepared safely.
- Where people were at risk of falls, necessary steps had been taken to reduce risks and monitor people's safety.

Staffing and recruitment

- The provider had recruited staff to cover vacancies and a core group of agency staff worked in the service

to cover where needed.

- Pre-employment checks were completed before new staff were employed. These included receipt of satisfactory references and criminal record checks.
- There was a process to ensure nurse registrations were up to date and their competencies were current.
- People felt there was sufficient staff, who were available to provide support in the home.
- Where people had been identified as having COVID-19, one member of staff provided all their care on each shift to reduce risk to other people.

Using medicines safely

- People's medicines were managed safely. New systems had been developed for receiving medicines into the service, administering and storing them. Medicine administration records (MAR) were completed to demonstrate people had received their medicines as prescribed.
- Staff had received training to support them to manage people's medicines safely. Assessments of staff practice in this area were being undertaken to confirm staff were competent to administer people's medicines safely.
- Daily stock checks took place and medicines audits were carried out to help ensure procedures were followed. Where we identified large amounts of medicines were stored, the provider agreed to review this.

Learning lessons when things go wrong

- Lessons were learned and shared across the team. We saw where medicine management systems had been reviewed safer practices were implemented and preventative measures introduced to reduce the risk of the errors.

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, to 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

- There had been management changes and the registered manager was no longer working in the service, however, two new managers had been recruited and were currently seeking to apply to become the registered managers within the service.
- The new managers were reviewing the monitoring and management systems to identify and resolve issues in the home, and we will continue to review this to ensure these are embedded in the service. Further development was needed with infection control monitoring to ensure this identified how the service operated and care standards maintained, to identify how current infection control practices could be improved.
- The provider was arranging further training to upskill some of the staff team for their personal development and where they may wish to take on further management duties.

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

- Throughout the COVID-19 pandemic the staff had shared information with relatives to ensure they understood expectations and risks and developed systems to ensure people could maintain contact with friends and family.
- People felt the staff had provided information they needed about the current COVID-19 pandemic and felt staff were managing the situation well. Meetings were held with people to discuss any concerns and provide further information to ensure people knew the impact in the home and the wider community including national and local restrictions.

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

- The staff spoke enthusiastically about the new managers and working together to develop the service to ensure people and their needs were a priority.
- Staff felt supported by the new managers and information about new developments had been shared with them.

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

- Where complaints had been received or accidents occurred, the staff had informed people's relatives of

any concerns.

- The provider had notified us of significant incidents as required, in order that we could continue to monitor the service.

Continuous learning and improving care; Working in partnership with others

- The managers worked with other managers from homes owned by the provider. They told us this support helped them to understand expectations and develop the service. This also provided additional support in the daily management of the home.
- The provided had shared information with us regarding their occupancy concerns and developments.