Prime Life Limited

Tanworth Court

Inspection report

Tanworth Court Nursing Home
Tanworth Lane, Shirley
Solihull
B90 4DD

Tel: 01213892266

Date of inspection visit:
03 March 2022

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28 April 2022

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

Tanworth Court is a residential care home providing personal and nursing care to up to 60 people. At the time of our inspection 49 people lived at the home and one person was in hospital. Some of those people lived with dementia.

People's experience of using this service and what we found
Risks associated with people's care were not always identified or responded to in a timely way. Quality assurance checks were not always effective, as they failed to identify the issues we found, such as the environment risks. Issues they did identify relating to poor record keeping, remained unresolved.

People felt safe living at Tanworth Court. Staff were recruited safely and felt supported by the management team.

A service improvement plan was under constant review and the provider took appropriate action to address the concerns we raised during the inspection. However, further time was needed to ensure improvements made were sustained.

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 good (published 14 July 2021).

Why we inspected
We received concerns in relation to the safety of people living at the home. As a result, we undertook a focused inspection to review the key questions safe and well led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report.

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

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 read the report from our last comprehensive inspection, by selecting the 'all reports' link for Tanworth 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 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 will take further action if needed.

We identified breaches in relation to people's safety, the safety of the environment and governance of the service.

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.

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.

Tanworth 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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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 carried out by three inspectors, a Specialist Nursing Advisor and an Expert by Experience who visited the home on the 3 March 2022. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Tanworth Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement dependent on their registration with us. Tanworth Court is a care home with nursing. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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 . The registered manager was unavailable during the inspection due to unplanned leave, an interim manager was providing cover.

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 who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers 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
We spoke with seven people who use the service and seven relatives about their experience of the care provided. We spoke with 11 staff including the regional director, manager, nurses, senior care workers, care workers and housekeepers. We carried out general observations of the way people were supported.

We reviewed a range of records including seven people's care records. We looked at three staff files in relation to recruitment and staff support and a range of records relating to how the service operated and was managed.

After the inspection
We looked at training data and the providers policies and procedures.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection

- Risks associated with people's care were not always managed safely. For example, one person was experiencing toothache. Records did not clearly show if their pain levels were being assessed or regularly monitored and an oral care plan had not been put into place to guide staff on how to manage this.
- One person was assessed at risk of choking and required a prescribed thickener to be added to their drinks to reduce their risk of choking. We found staff's knowledge of what the prescribed level of thickener was, differed from what the care plan had recorded, which was, as the speech and language therapist had prescribed. This posed a risk of them choking.
- Some people were at risk of dehydration and required their fluid intake to be monitored. Records were not always completed, to show how much fluid people had been offered or drank throughout the day. This increased the risk of complications to health due to dehydration.
- Environmental, health and safety checks were completed. However, during our visit some environmental risks had not been identified. On the first floor, the door leading to the laundry chute was unlocked, due to a faulty lock and the hatch was unprotected. This unlocked room also contained containers of cleaning liquids which could pose a risk of harm to people. The manager took action to fix the door before we left.
- Medicines were not always managed safely. Three people had their medicines prescribed covertly. This meant their medicines were disguised in food or fluid which would help them to maintain their health or manage their condition. This decision to administer medicines covertly must be agreed with the GP and pharmacist as altering the form of medicines can have adverse effects. Records contained no guidance to instruct staff about the safe way to administer these medicines. We brought this to the attention of the manager, who took action to address this during the inspection.
- Some people were prescribed medication 'as required'. We checked seven medication records and identified, one person had no protocol in place to advise staff when and how to administer these medications safely which increased the risk of this medicine being given inappropriately.
- We were not assured that the provider was using PPE effectively and safely. On numerous occasions we saw staff wearing their face masks below their noses. The manager acknowledged this and reminded staff, of the importance of wearing PPE appropriately.

We found no evidence people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This place 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.

● Other environmental risks were managed safely. For example, each person had a personal emergency evacuation plan (PEEP) which reflected the support they would need to evacuate the premises safely, in the event of an emergency.

● 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 was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● People were able to spend time with their family. People had visitors come to the home and there was a visiting policy in place to help keep everyone safe. This included the use of PPE, testing and a booking process.

Staffing and recruitment
● People and staff provided mixed feedback when we asked if there was always enough staff on duty. Comments included, "Staff are very good but focused on supporting me, they have limited time to spend with me, for a chat" and "It can be difficult, when we have agency staff, as they don't know people". The provider told us, that they are currently recruiting to fill their vacancies and book regular agency staff to help address this.
● Staff were available when people needed them during our visit and people's requests for assistance were responded to promptly.
● The number of staff required on each shift was determined by assessing people's individual needs. The manager reviewed these assessments regularly, to ensure staffing levels remained safe.
● Staff were recruited safely in line with the providers procedure.

Systems and processes to safeguard people from the risk of abuse
● People felt safe. One person told us, "I feel safe, the staff make it safe for me."
● Five relatives told us people were safe in the home. One said, "Yes, she's safe, the care is good, staff are kind and respectful."
● Staff had received safeguarding training and understood their responsibilities to report any concerns to managers. Staff were confident that their concerns would be followed up.
● The provider understood their responsibility to report concerns to the local authority and to us (CQC) to ensure any allegations or suspected abuse were investigated.

Learning lessons when things go wrong
● The provider acknowledged improvements were needed and had started to review people's care records and the training needs of staff. A trainer was working, alongside new staff to offer support and practical, training to demonstrate and embed good care practices.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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

- Although systems and processes were in place to drive improvements within the home, these failed to identify the concerns we found during our inspection. For example, care and environmental risks had not always been identified and records to support safe medicines practices were not always effective.
- Where governance systems had identified concerns, action taken did not always resolve the issues such as poor record keeping.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. 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.

- Relatives spoke positively about the staff. One relative told us, "The staff are good, I'm happy with them."
- Staff felt supported and received the guidance needed to fulfil their roles through individual and team meetings.

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

- People and relatives told us the management of the home had improved recently. One relative told us, "Staffing and communication has got better. The (interim) manager does listen to any concerns, I may have, I do feel that they are addressing the issues, it has improved."
- Staff spoke positively about the impact the management team have made and felt they could raise concerns at any time.
- The providers' policies and procedures promoted inclusion and diversity and reflected protected characteristics as defined by the Equalities Act 2010.

Continuous learning and improving care

- The management team were in the process of updating care plans to ensure they were person-centred and reflected people's needs.
- Training in record keeping for all staff has recently been put into place, including for all new staff.
- The regional director visits the service regularly and completed additional checks of the service to

continually improve care provided to people. Actions taken for example, are the recruitment of new staff and a trainer, to support their ongoing learning.

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; Working in partnership with others

- The provider understood the need to be open and honest when things went wrong in line with their responsibilities under the duty of candour.
- Throughout our inspection visit the manager was open and honest. They welcomed our inspection feedback and took action to address the issues identified.
- Records showed staff liaised with a range of health and social care professionals involved in people's care to support their physical health and wellbeing.

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	The provider did not ensure that risks relating to people and accurate records of their needs, medicines management and the environment were always completed and updated to keep people safe.

The enforcement action we took:

Warning Notice issued.

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	The provider did not ensure that systems in place to give oversight of the service were fully used to identify errors or make quality improvement.

The enforcement action we took:

Warning Notice issued.