Grov Limited

Talbot House Nursing Home

Inspection report

28-30 Talbot Street
Rugeley
Staffordshire
WS15 2EG

Tel: 01889570527

Date of inspection visit:
26 November 2020

Date of publication:
23 April 2021

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
Talbot House Nursing Home can accommodate up to 25 older people with nursing care needs. There were 14 people using the service at the time of our inspection. They accommodate people over three floors. One room is shared occupancy.

People's experience of using this service and what we found
People who lived at Talbot House did not receive a safe or well led service. The provider was unable to demonstrate the safe and effective running of the service.

People were not safeguarded from the risk of abuse because the provider could not demonstrate they had acted to protect people from harm and not investigated concerns appropriately. Their lack of action placed people at risk of actual harm.

Fire safety arrangements within the home were unsatisfactory and unsafe. We took immediate regulatory action to ensure changes were made to ensure people's ongoing safety.

Risks had not always been assessed or safely managed meaning people may receive unsafe care and treatment.

Infection control measures had not kept people safe during the pandemic and a high number of people and staff had been adversely affected. The provider was working with health protection agencies to improve practice.

There was a lack of sufficiently trained staff at a senior level in order to oversee the ongoing monitoring and auditing of the service to ensure its effectivity and safety. The provider did not regularly visit the home but remained in contact with the deputy manager via regular video calls. However, the provider had not established that audits and safety checks were not being carried out suggesting communication was not effective. This lack of oversight had led to issues being mismanaged and had impacted upon the safety of the service.

Although we appreciate the recent Covid 19 outbreak had impacted upon the service, some issues were historic.

Quality and safety had not been monitored or managed and this had led to poor and unsafe practice.

Rating at last inspection
The last rating for this service was good (published 6 March 2018).

Why we inspected

We had received information of a recent outbreak of Covid 19 within the home which had affected a high number of people who used the service and staff. This triggered an inspection where we looked at infection control practices as well as the safety and leadership within the home.

Enforcement
We have identified breaches in relation to safeguarding people from abuse, assessing and managing risks, safe care and treatment, staffing, and in 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
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. 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 six 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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Talbot House on our website at www.cqc.org.uk.

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**

Talbot House Nursing Home

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
This inspection was carried out by two inspectors.

Service and service type
Talbot House Nursing Home 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 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. The registered manager has since left the home and started the deregistration process with CQC.

Notice of inspection
This inspection site visit took place on 26 November 2020 and 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 and professionals who work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We had an email from Healthwatch to say they had no information about 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. We used all this information to plan our inspection.

During the inspection
We spoke with one person who used the service. We spoke with three members of staff (a senior care worker, a nurse and a kitchen assistant) and the deputy manager.

We reviewed a range of records. These included two people's care records and extracts from others.
We also looked at variety of records relating to the management of the service although some information requested was not available.

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

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 Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not safeguarded from the risk of abuse because the provider could not demonstrate they had acted to protect people from harm and not investigated concerns appropriately. Staff told us they did not know the current referral telephone number, or which paperwork to use to make safeguarding referrals.
- One senior staff member told us they were aware of signs of abuse although they had not referred a recent allegation of concern to the local authority (as per the service's policy and procedure) and they had not acted to safeguard others. The lack of action meant that the alleged abuser could continue to work with vulnerable people placing them at risk of harm or poor care.
- When we reviewed care plans and accident records, we also saw that other incidents that warranted a referral for investigation by the local authority safeguarding team had not been made. For example, one person left the home through an unlocked door and was found walking unsupported in the road. This placed them at risk of harm. Another person had unexplained bruising, and another had had unwitnessed falls. Incidents which could constitute abuse had not been shared or investigated appropriately and as a result people were vulnerable to harm or may have been harmed.

This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The person who spoke with us said that the staff team were always kind and respectful. They told us they had made them feel safe during the recent outbreak of coronavirus within the home.

Assessing risk, safety monitoring and management

- On the day of our inspection site visit we identified concerns about fire safety arrangements within the home. For example, there was no recent record that weekly fire safety checks had been carried out. This meant the provider could not demonstrate the fire safety equipment would work in the event of a fire.
- Fire doors were not closing properly meaning they would be ineffective in holding back smoke during a fire.
- Fire escapes and fire doors were obscured by objects including furniture and cardboard. An external fire escape had an old chair beneath the steps and combustible materials to the side. The boiler door was seen to be blocked and the loft hatch was open. This would impact on staff's ability to safely evacuate the home.
- Staff didn't know how to safely evacuate the home in the event of a fire or emergency. One staff member told us, "We used to evacuate but the policy changed and I'm not sure now." This lack of knowledge could place people at risk of harm or death.
- Last year's fire risk assessment dated 2019 identified the same issue relating to blocked fire doors, yet we saw a year later, the same door was still cluttered and obstructed.

This meant the provider had not acted to monitor improvements and requirements.

● When risks had been identified there was nothing documented to show how staff should mitigate these risks. For example, both people whose care and support we reviewed were assessed as being at high risk of falls. Risks had not been assessed to keep people safe and mitigate the risk. This meant people were more likely to fall and sustain injury.

● The deputy manager told us they 'did not know' if there had been any falls within the home. Representatives from the local authority had told us that unwitnessed falls had not been referred to the safeguarding authority to see if they could have been prevented. Our findings reflected these concerns. This meant people were not being protected from the risks associated with falls.

● On the day of the inspection we were told by the deputy manager that staff had not had their personal circumstances assessed as to their vulnerability to work with people who were Covid-19 positive. The deputy manager told us they had not had time to do this, however there had already been an outbreak in the home and appropriate risk assessments could of reduced people's risks of contracting the disease and so reduced the impact on the people who used the service. Following the inspection, the provider sent us evidence that telephone calls had taken place between the registered manager and individual staff members to assess their safety. This information was not known to the deputy manager who was assuming current management responsibilities.

● Assessments had not been appropriately completed or reviewed when at least two people were admitted to the home. The deputy manager told us they were not sure why policy was not followed about isolating people from hospital. They said, 'We should have done it.' This oversight meant that people, and staff, were placed at risk of harm.

● People living at Talbot House were required to have a personal evacuation plan in place so people can be moved to a place of safety in the event of a fire. We looked at one person's plan and found it to be totally inappropriate. We shared the detail with the deputy manager who also found it to be inappropriate. They told us, "It would break [the person's] back. I'm mortified."

● Following the inspection, the provider sent us updated evacuation plans for everyone who lived at the home, but they were not personalised to meet individual needs and still detailed unsafe practice. For example, one person was identified as having a fractured arm and they were to be moved the same as everyone else. This could cause pain, discomfort and harm. After sharing our ongoing concerns about these documents the provider sourced a new form which, if completed, will support a more personalised approach.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● We did not look at recruitment processes at the time of this inspection given the absence of the registered manager.

● Following a recent meeting with the local authority, the provider had been required to increase staffing levels to provide additional support while people were being nursed in bed as part of their care and recovery from coronavirus. The provider was aware that the registered manager was away from the home and the deputy manager was assuming management responsibilities. However there was a discrepancy as to whether they had sufficient hours to carry out this role effectively as the home was short of nursing staff.

● The deputy manager was assuming management responsibilities and continuing with their nursing shifts. They were unable to provide a management oversight at the home meaning a number of monitoring processes were not being done. Staff all told us how they were all 'working together' however there was no structure to enable the home to operate safely while promoting the wellbeing of the people who use the service and the staff team.

● On the day of the inspection the deputy manager had come to the home to support the nurse in charge in the absence of the administrator.
● The recent lack of staffing (due to staff sickness) had negatively impacted upon people who used the service. For example, the service had used agency nurses however the deputy manager told us there was no formal induction for such workers and this had impacted on people's wellbeing on at least one occasion over recent weeks. No follow up action had been taken by the provider to ensure a reoccurrence did not happen thus placing people at risk of harm or poor-quality care.

This was a breach of Regulation 18: Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were not assured that the provider had promoted safety through the layout and hygiene practices of the premises. The infection control team from the local authority had advised that cleaning staff record hourly, the cleaning of contact points to demonstrate compliance. This had not happened, and the deputy manager advised that staff knew that they had to do this. Throughout the inspection we saw staff touching face masks, dropping them below their noses to speak and complete tasks. This meant that the effectiveness of wearing a mask for protection was diminished.
● We were not assured that the provider's infection prevention and control policy was up to date and implemented effectively to prevent the spread of infection. We did not see an up to date policy as it was not readily available for review.
● We were not assured that the provider was admitting people safely to the service. The admission of two people had been linked to an outbreak within the home.
● We were not assured that the provider was using PPE effectively and safely because we saw staff moving masks from their noses to talk to others thus making them ineffective.
● We were not assured that staff training, practices and deployment show the service can prevent transmission of infection and/or manage outbreaks because we saw incidents of poor infection control practices.
● We were not assured that the provider had been meeting shielding and social distancing rules because feedback from health and social care professionals had identified that they had not. Poor isolation practices had been linked to the outbreak that affected the home.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were somewhat assured that the provider was preventing visitors from catching and spreading infections because they were now checking people upon arrival to the home and recording their details.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

Learning lessons when things go wrong
● We were not assured that lessons were learnt after things had gone wrong. For example, staff were not following all of the guidance of the infection control team. They therefore couldn't offer reassurance about a future spread of infection.
● The fire risk assessment dated 2019 identified issues that were again identified this year. For example, the requirement to clear clutter from fire doors. This meant that the provider could not demonstrate they had addressed improvements and improved practice to keep people safe.

Using medicines safely.

● The medicine cabinet containing people's medicines was seen to be open and unattended. This meant that medicines could be accessed by people not requiring them and causing possible harm. The deputy manager took immediate action to rectify this.

● One person told us that they received their medicines as and when required. They also maintained control of one medicine so they could administer it as and when required.

● People were currently being supported in bed, so we did not see any medicines being administered but the deputy manager was knowledgeable about what people received and when.

● Medication Administration Records for two people were seen to have been fully completed and this meant that staff could demonstrate they had administered the right medication, to the right person and at the right time.

● The deputy manager and the nurse on duty told us that medicines were only administered by staff who were trained and competent to do so, however in the absence of the registered manager, the deputy manager could not evidence that this was the practice of the home.

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 Good. At this inspection this key question has now deteriorated to Inadequate. 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

- The service was not well led or managed. The provide was unaware of issues of concern that we raised during this inspection.
- The deputy manager, who was assuming management responsibilities, was not carrying out monitoring and auditing tasks to ensure the safe running of the service. A review of records identified that records were incomplete or not accessible.
- The deputy manager told us they did not know if audits were taking place by the provider, or within the home to monitor the quality of the service to demonstrate processes were being followed.
- Fire safety checks and records were not up to date and the provider did not have up to date records to show that fire doors had last been checked. The home's policy stated in the absence of the person responsible for checks then another person should be delegated the responsibility.
- The deputy manager could not find records to show that checks to ensure the storage, administration and recording of medicines had been carried out safely. For example, medicines audits. Since the inspection the provider has shared with us the last audit of the medicine's arrangements that took place in July 2020. Given the additional pressures on staff and the higher use of agency staff this audit could not demonstrate that current arrangements were safe.
- Infection control records, as required by the local authority infection control team, had not been implemented meaning the provider could not demonstrate compliance, thus reassure themselves of safe working practices to keep people safe.
- Some records were seen to reflect care provided, however we saw where people were required to have their fluid intake monitored, records were available but totals had not been identified. This meant that the recording was meaningless.
- The environment was, in parts, unsafe. A door to a steep flight of cellar steps was left open and unattended, despite there being a sign stated the door was to be kept locked. There was a large gas pipe exposed in the communal lounge fire place. The deputy manager said it had been like it since the summer and that people used the room. We later saw a service user sitting in the room. These issues posed safety risks.
- The poor admissions practices within the home had impacted on the health and wellbeing of people living at the home and staff.
- The deputy manager told us that agency nurses do not have an induction to the home and they could not produce records to reflect they had.

● The lack of management oversight within the home meant that all of the issues above had impacted on the quality and the safety of the service and people had been at risk of harm, or harmed as a result.
● The provider was unaware of all of the day to day issues affecting the home.

Continuous learning and improving care
● We saw how some issues had been identified by external agencies and that the provider had not addressed them or made improvements to practice preventing a reoccurrence. For example, the fire officers' recommendations and those of the local infection control team.
● One visiting professional said that they had identified some improvement to practices, but it was at a 'slow pace'.

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 worked with agencies during investigations when things had gone wrong however they had not proactively shared information prior to incidents arising. This meant they had not acted with duty of candour.

This is a breach of Regulation 17(1) good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Care plans seen were generalised and not person centred. For example, the personal emergency evacuation plans did not account for people's individual needs and wishes. It had been recommended at the time of our last inspection of the service that improvement should be made in relation to providing and documenting person-centred care. Evidence reflected this had not happened and the outcome impacted on people's quality of life.

Working in partnership with others
● The provider had been working with outside agencies following our inspection to make urgent improvements required to keep people safe.
● Since receiving support from the local authority improvements have also been made in relation to joint working with community health providers. This had meant better access to medical assistance for people living at the home.
● Staff were currently working with outside agencies to review and improve infection control measures within the home although some practices had still not been embedded.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The person we spoke with felt well informed about the running of the home and that they were consulted about issues that were important to them.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Fire safety measures were inadequate to keep people safe in the event of a fire. Risks had not always been considered or assessed and this had resulted in harm to people who used the service. Infection control measures had been inadequate to prevent the spread of covid 19 within the home.

The enforcement action we took:

We issued a letter on intent to cancel registration unless urgent action was taken

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding policies and procedures were not being followed meaning vulnerable people were at risk of, or of actual. harm

The enforcement action we took:

We are imposing positive conditions to the provider's registration to address breaches identified

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The lack of provider and management oversight meant that controls were not in place to monitor the quality and safety of the service. This had impacted upon people's health and wellbeing.

The enforcement action we took:

We are imposing positive conditions to the providers registration to address breaches identified

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing arrangements at a senior levels were inadequate to support the safe and effective

Treatment of disease, disorder or injury	running of the service.

The enforcement action we took:

We are imposing positive conditions to the providers registration to address breaches identified