Grov Limited

Talbot House Nursing Home

Inspection report

28-30 Talbot Street
Rugeley
Staffordshire
WS15 2EG

Tel: 01889570527

Date of inspection visit:
10 November 2021
11 November 2021

Date of publication:
22 December 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Talbot House Nursing Home is a care home providing personal and nursing care to 24 people aged 65 and over at the time of the inspection. The service can support up to 25 people.

People's experience of using this service and what we found
The environment was not always safe. Environmental risks had not been appropriately managed to keep people safe from harm. Staff did not always have the information they needed to keep people safe. Medicines were not managed safely to ensure that people's rights were protected, and that people got the medicine they needed, when they needed it.

There was enough staff to meet people's needs. However, improvements were needed to the recruitment, induction and training processes.

Improvements had been made to infection prevention and control practices. However, improvements were still required to ensure safe admission processes were implemented.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The environment was not always suitable for people living with dementia and the mealtime experience needed improvement.

There was a new registered manager since the last inspection. However, good governance systems were still not in place to ensure to ensure that areas for improvement were identified and acted upon. This continued to leave people at risk of receiving unsafe or poor quality care.

Staff felt the registered manager was approachable and supportive.

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 23 April 2021) and there were four breaches of regulation. We imposed conditions on the providers registration and the provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made in all areas, and the provider was still in breach of two regulations, with one new breach identified.

Why we inspected

We received concerns about a lack of improvement since the last inspection. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. During the inspection we identified concerns about the effectiveness of the service, so we inspected the effective key question also.

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.
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.
The overall rating for the service has remained inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe, effective 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. 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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Talbot House Nursing Home 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 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 safe care, need for consent and governance at this inspection.

We have issued three warning notices to the provider, one for each of the breaches of regulation we found. We will inspect the service again to check whether these warning notices have been met.

Follow up
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.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains 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 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

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
The inspection was carried out by three 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.

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, professionals who work with the service, the fire 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 used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and one relative about their experience of the care provided. We spoke with twelve members of staff including the provider, registered manager, a nurse, senior care workers, care workers, the head cook, a kitchen assistant, an activities staff member and a member of the domestic team. We also spoke with two visiting professionals. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. 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 registered manager 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 inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people, including fire safety and falls risks. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Though improvements had been made in relation to fire safety and managing falls risks, enough improvement had not been made to ensure safe care was delivered and the provider was still in breach of regulation 12.

● The provider had failed to ensure people were protected from environmental risks. A legionella risk assessment was last completed in 2010. Legionella bacteria is commonly found in water and the provider has a duty to manage the risks associated with these bacteria, in order to keep people safe from harm. We found the provider had not followed all recommendations in the risk assessment, which left people at risk of harm. For example, weekly flushes of little used outlets were not being recorded and cold water temperature checks were not recorded. This left people at risk of contracting legionnaires disease.
● We found the door to the boiler room had been left unlocked and very hot pipes were exposed. Some people were living with dementia and were independently mobile. This meant there was a risk they could access this room unsupervised and cause themselves harm. We also saw this was an issue at our last inspection.
● Whilst improvements had been made to fire safety measures, we found that some actions given by the fire service had still not been completed. For example, additional emergency lighting had not yet been fitted and whilst torches were an acceptable temporary measure, we found one of the torches was missing. This meant people continued to be at risk in case of fire.
● The provider had failed to ensure that people's risks were safely managed. Care plans were not always up to date with specific information required to manage people's risks. For example, one person's nutrition care plan did not match their choking and aspiration risk assessment, completed by a Speech and Language Therapist (SALT). This meant staff may not have access to accurate and up to date information to manage people's risks.
● Care staff did not know which foods were suitable for people living with diabetes. This resulted in a person with diabetes receiving a desert option that was not intended for them due to their diabetes. This could have resulted in harm to the person.

The above evidence demonstrated that people were placed at continued risk of harm through ineffective risk management. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● The provider failed to ensure that medicines were safely managed. Covert medicine is medicine which is 'hidden', usually in food or drinks. One person was assessed as requiring covert medicine. We found that a pharmacist had not been asked for advice as to how the medicines should be hidden in food or drinks, to ensure the efficacy of the medicine was not affected for example by the temperature of the food or drink. This meant there was a risk the medicine may not have its desired effect.

● It was not clear to see when and how the prescriber had been involved in decisions to administer medicines covertly. Staff were unclear about whether the person required their medicines covertly or not which meant there was a risk of covert medicines being administered when not in the person's best interests.

● Prescribed topical creams were stored in people's bedrooms, not in a locked cupboard. This meant the creams were accessible to people who used the service, some of whom were living with dementia and were at risk of ingesting or accessing the topical medicines that were not prescribed for them. Similarly, Personal Protective Equipment (PPE) was stored in corridors and was accessible to people using the service.

● Some people were prescribed 'as required' (PRN) medicines. There was not always clear and personalised guidance for staff to follow when administering these medicines which meant there was a risk of over or under medication.

Systems were either not in place or robust enough to demonstrate medicines were safely 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.

Preventing and controlling infection

At our last inspection the provider had failed to ensure safe infection prevention and control practices were followed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12 in relation to infection prevention and control practices, though some improvement was still required.

● We were only somewhat assured that the provider was admitting people safely to the service. This was because the registered manager could not demonstrate an understanding of current government guidance in relation to care home admissions and the admissions policy was not up to date and reflective of the latest guidance. We have signposted the registered manager to resources to develop their approach.

● 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 using PPE effectively and safely.

● 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.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong
● Lessons were not always being learned when things went wrong. For example, there was no accident and incident analysis which meant the provider could not assure us they were taking action to prevent reoccurrences and learning lessons from accidents and incidents.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to safeguard people from the risk of abuse because they could not demonstrate they had acted to protect people from harm and had not investigated concerns appropriately. 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● Some staff told us they had not received training in safeguarding adults during their employment at Talbot House. Despite this, staff understood their responsibilities in recognising and reporting safeguarding concerns. A staff member said, "I've never had to report any concerns but most definitely I would if I needed to. [The registered manager] would listen but I would call safeguarding myself if not."
● Records showed that investigations had taken place when concerns about potential abuse or avoidable harm were raised. The registered manager had contacted the local safeguarding adults' team to make referrals or obtain advice when this was required.

Staffing and recruitment

At our last inspection the provider had failed to ensure that sufficient numbers of suitably skilled staff were deployed to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● There were enough staff to meet people's needs. We observed that people did not have to wait for the support they needed, though staff told us, and we saw they were busy.
● The registered manager completed a monthly review of people's needs to ensure they had the correct numbers of staff on duty to meet people's needs.
● When new staff were recruited, a criminal records check was completed to ensure they were suitable to work with people who used the service. However, recruitment processes needed to be more robust to

ensure a full employment history was obtained and complete records of applications and interviews were kept, to ensure staff were suitable for the role.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

The last time we inspected against this key question in January 2018, it was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- We found the service was not working in accordance with the MCA. Assessments of people's mental capacity had been completed but these did always follow the principles of the MCA because they made the decision people lacked capacity, before assessing this. This meant people's rights were not always upheld.
- DoLS applications had been made when required. However, we found these applications did not include all the restrictions being placed upon a person. For example, one person had a lap belt on their wheelchair and bed rails on their bed. There was no record of consent to these restrictions and no record of a best interest decision. It was not clear whether these were the least restrictive options for the person and the DoLS assessor had not been made aware of these restrictions.
- Some people had conditions on their DoLS authorisations. We found these had not always been complied with and the registered manager was not aware of all people's conditions so could not assure themselves of compliance. This meant there was a risk that people were being unnecessarily restricted, and their rights may not be upheld.

The above evidence demonstrated that people did not always give valid consent to their care and treatment and where people lacked capacity to do so, the MCA was not always complied with. This was a continued breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs and choices were assessed when they moved to the service. However, it was not always clear how people had been involved in these assessments and how they were enabled to participate and make choices about their own care and support.

● When people were unable to make their own choices, the right people were not always involved in discussions about their needs and decisions. For example, one person had appointed a Lasting Power of Attorney (LPA), but the LPA had not always been involved in best interests' discussions and it was not clear how they inputted into the person's care plan.

Staff support: induction, training, skills and experience

● Staff told us they felt supported in their roles. However, some staff told us they would benefit from training in how to support people when they are experiencing distress. A staff member said, "I don't always know if what I'm doing is the best way."

● There was no training matrix to keep track of staff training. The registered manager told us staff training was mostly up to date. However, some staff told us they had not completed online training, and some said annual training was overdue.

● A new member of activities staff had not received any induction or training. We saw they were responsible for supervising people in communal areas when care staff were busy, and this posed a risk to people as the provider could not be sure the staff member was competent to support people safely and effectively.

● Staff induction records were not fully completed so the provider could not be sure that staff were fully competent to support people effectively.

Supporting people to eat and drink enough to maintain a balanced diet

● People enjoyed the food on offer, and it looked and smelled appetising. However, the mealtime experience needed to be improved. We saw staff piled used plates in front of a person who was still eating their meal. One person was positioned in front of a cupboard to eat their meal. Staff needed to access to this cupboard throughout the mealtime, so the person was frequently disturbed and moved whilst eating their meal. Another person who used a specialist chair looked uncomfortable whilst eating and dropped their food down their front. These issues meant the mealtime experience was not a positive experience.

● Some people required their drinks to be monitored due to hydration risks. However, there was not always an individual daily fluid target recorded for these people. This meant it was not easy for staff to see when the fluid target was not being met and not easy to know when to escalate any concerns. There was a risk that people's hydration needs may not be met.

Adapting service, design, decoration to meet people's needs

● The dining room did not have enough tables and chairs to facilitate all people who used the service being able to sit at a table to eat their meal if they chose to. We discussed this with the registered manager who said some tables had been removed to allow for social distancing and they would consider bringing extra tables back into the dining room.

● The service supported people living with dementia. However, the environment was not dementia friendly. It was not easy for people to identify their own bedroom doors. We saw that one person's bedroom door had the wrong name on it which could cause confusion for them and others.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● We saw that people had referrals to professionals when required. For example, we saw referrals to a dietician had been completed when a person had lost weight.

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 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; 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

At our last inspection the provider had failed to ensure an effective governance system was in place to monitor and improve the quality and safety of care provided. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Though some improvements had been made, enough improvement had not been made to implement an effective governance system and the provider was still in breach of regulation 17.

● There was a new registered manager since the last inspection. However, the governance systems in place were still not effective to assess, monitor and improve the safety and quality of services provided. Audits were not always effective and did not always drive improvements, which meant people continued to be at risk of harm.
● We found that from May to October 2021, hot water taps were checked, and the temperature was recorded. The records showed consistently very hot water that presented a scalding risk to people. No action was taken to reduce this risk until visiting professionals identified the issue in October 2021 and instigated action. This meant systems to monitor and reduce risks to people were ineffective and this left people at risk of harm.
● A maintenance audit was last completed in September 2021. It did not identify the issues we found, for example with legionella risks and water temperature monitoring. The audit tool also did not cover all required elements. The registered manager agreed the audit tool was not good quality, however they told us they had not had time to address the issue of the quality of the audit tools which continued to leave people at risk of harm.
● There was a tracker in place to monitor Deprivation of Liberty Safeguards (DoLS) referrals and authorisations. There registered manager told us they had prioritised working on this. However, we found it was not up to date and did not include any conditions on DoLS authorisations. This meant it was not an effective tool to monitor DoLS compliance and meant people continued to be at risk of not having their rights upheld.
● Checks of daily charts including food and fluid monitoring had increased from monthly to every three days. However, we found they still did not effectively identify shortfalls. For example, some people had no fluid target, so it was not easy for staff to see when the daily target was not being reached and to act and

escalate concerns in order to manage the risks. The checks had not identified this issue which left people at risk of harm.

● Care plans were not always accurate and up to date. They did not contain all the information staff needed to safely and effectively manage risks to people. The care plan audits in place had not identified this, which meant they were ineffective in identifying areas for improvement and driving the required improvements, leaving people at risk of harm.

● Medicines audits were carried out but did not identify the issues we found with administration and storage of medicines which meant they were ineffective and left people at risk of harm.

Governance systems were chaotic and disorganised. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Residents meetings had taken place; however, these were sporadic, and it was not clear how people had been supported to be fully involved and engaged with the development of the service.

● There was a suggestions box in the foyer of the building, however, there was little engagement and involvement of relatives to keep them informed and gather their feedback in order to make improvements to the service.

● Staff told us the registered manager was approachable and supportive. Staff felt there was an open culture where they could raise any concerns and they felt action would be taken.

Continuous learning and improving care

● There was no training matrix, so it was not clear for the registered manager and provider have oversight of staff learning. Some staff felt additional training would be beneficial but there was no evidence the registered manager or provider had discussed this with staff or acted to provide additional learning in order to improve care.

Working in partnership with others

● We saw that referrals to external professionals were made when 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 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider failed to ensure that people gave valid consent to their care and treatment. Where people lacked the mental capacity to consent, the Mental Capacity Act (2005) was not always complied with.

The enforcement action we took:

We served a warning notice which advised the provider should be compliant within 12 weeks or we would take further 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 failed to ensure safe care treatment was delivered. They failed to appropriately assess and mitigate risks to people. They failed to ensure the safety of the premises. They failed to ensure the safe management of medicines.

The enforcement action we took:

We served a warning notice which advised the provider should be compliant within 12 weeks or we would take further enforcement action.

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 failed to operate good governance systems to assess, monitor and improve the quality and safety of the services provided.

The enforcement action we took:

We served a warning notice which advised the provider should be compliant within 12 weeks or we would take further enforcement action.