

Tilford Care Home Limited

# Tilford Care & Nursing Home

## Inspection report

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11 November 2021

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## 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

Tilford Care & Nursing Home is a care home providing personal and nursing care to 25 people aged 65 and over at the time of the inspection, some of whom were living with dementia. The service can support up to 50 people and is set across two floors.

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

We were not assured that staff were always following national guidelines on the use of personal protective equipment (PPE). We observed staff did not consistently wear face masks in accordance with national guidelines. There was a lack of oversight from the provider prior to our inspection to ensure staff were consistently following the UK Health Security Agency Guidance on the use of PPE: 'Personal protective equipment: resource for care workers working in care homes during sustained COVID-19 transmission in England'. The provider took action to address this following our findings.

We received mixed feedback about the support available for staff. Whilst some staff commented on the positive culture in the service, others told us they did not always feel they had the support to read care plans and risk assessments and did not feel they could always approach management about this as they felt they did not have the time.

We reviewed minutes of staff meetings and staff told us they were able to feedback using surveys, however we saw that action was not always taken in response to surveys. Staff told us they were aware of risks associated with people's care.

People and their relatives told us they felt safe and that staff were kind towards them. People's medicines were stored and administered safely. There were sufficient staff at the service to support people with their care needs. Care plans including the management of risks were in place. There were plans in place to evacuate people in the event of a fire.

People and relatives told us they felt management would address concerns and that they felt able to feed back if they had ideas to improve the care provided.

There were some systems in place to monitor the quality of care provided. Accidents and incidents had been reviewed to see if the risk of them happening again could be reduced.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

### Rating at last inspection

The last rating for this service was good (published 17 August 2020).

### Why we inspected

We received concerns from the local authority and healthcare organisations in relation to staffing levels and competence, lack of management oversight and poor infection prevention and control. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led detailed findings sections of this 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.

#### 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?

The service was not always safe.

Details are in our safe findings below.

**Requires Improvement** ●

### Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

**Requires Improvement** ●

# Tilford Care & 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 team consisted of two inspectors.

#### Service and service type

Tilford Care & 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. On the day of the inspection, the registered manager was on a period of leave.

#### 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 and professionals who work with the service. The local authority and local hospital made us aware of concerns they had in relation to the quality of care provided to people. We attended local authority provider support meetings with representatives from the service and healthcare professionals. 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 of this information to plan our inspection.

#### During the inspection

We spoke with four people who used the service about their experience of the care provided. We spoke with nine members of staff including the deputy manager, an operations consultant, nurses, care workers and the chef. We observed interactions between staff and people who used the service.

We reviewed a range of records. We looked at three staff files in relation to recruitment and staff supervision. We reviewed people's medication administration records (MARs). A variety of records relating to the management of the service, including policies and procedures were reviewed.

#### After the inspection

We spoke with six relatives about their experience of the care provided to their loved ones. We spoke with three members of staff. We continued to seek clarification from the provider to validate evidence found. This included five people's care records and multiple medication records. We looked at training data and quality assurance records. We received feedback from a healthcare professional and the local authority. We continued to attend the provider support meetings arranged by the local authority.

# 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 staff were always following national guidelines on the use of personal protective equipment (PPE). We observed staff failing to wear face masks in accordance with national guidance whilst in communal areas. Over a period of one hour, we observed eight occasions where staff were not wearing a mask or wearing a mask below their nose or mouth. This meant people using the service and staff were at increased risk of transmission of COVID-19. This was not in line with the UK Health Security Agency Guidance on the use of PPE: 'Personal protective equipment: resource for care workers working in care homes during sustained COVID-19 transmission in England'.
- We approached a member of staff, who was standing in the dining room where people using the service were sitting if there was a reason they were not wearing a mask. They told us that they were quickly going to the toilet. This was not in accordance with national guidance, as highlighted above, and increased the risk of spreading COVID-19. We approached the deputy manager about this. Despite this, there were further occasions where we observed staff not wearing their face masks correctly. The provider sent us an action plan following the inspection and highlighted the actions they were taking in response to our findings.
- During visits prior to our inspection, the local authority had identified that some PPE was stored in a bathroom which could increase the risk of cross-contamination. During our inspection, we found PPE was still being stored in a bathroom. We made the operations consultant aware who immediately took action to identify an alternative area to store the PPE. Since the inspection, the registered manager has returned to the service and has engaged with the local authority and local clinical commissioning group to schedule training in relation to infection prevention and control.

Failure to consistently adhere to national guidance in relation to the use and storage of personal protective equipment placed people at increased risk of contracting COVID-19. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They confirmed they had put further measures in place to ensure staff were following national guidelines on the use of PPE. We will review this at the next inspection.

- 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.

- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
- We were assured that the provider had systems in place to monitor vaccination and COVID-19 status of current employees, prospective employees and visiting professionals entering the care home.

#### Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe with staff. A person told us, "Feel safe with staff, they understand what I need." Another person told us, "I do feel safe. The staff are nice." A relative told us, "I know he's safe and well-looked after." Another relative told us, "I do feel that she's safe."
- Staff understood what constituted abuse and the actions they would take if they suspected abuse. One member of staff told us, "It (abuse) could be hitting someone. I would go to the police, safeguarding or CQC." Another member of staff told us, "[Abuse is to] hit someone or mentally abuse them or verbally abuse them by cursing them. I would go to head office or whistleblow."
- The training records we reviewed showed staff had received training for safeguarding. One member of staff told us, "I've done safeguarding and whistleblowing training." Another member of staff commented, "We did safeguarding training online."

#### Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Care records were in place to identify and manage risks. Risks had been assessed and there was clear guidance for staff to follow. For example, where a person required a hoist for transfers, there were instructions on which hoist and slings to use and how to best reassure the person.
- Where people were at risk of developing pressure areas, there were measures in place to reduce the risk of these occurring. This included for the person to be weighed regularly and for the air-flow mattress to be adjusted accordingly; as well as regularly assisting the person to reposition themselves in bed. A person using the service told us, "They know what to do with the mattress. The mattress helps. I don't have any pressure sores now."
- Staff told us they knew what to do to reduce known risks. One member of staff told us, "[Person using the service] was on normal fluids before but then got put on thickener. I would tell the nurses [if I had concerns]." Another member of staff told us, "[Person has] got a [pressure] sore on his back. It's clearing up though. He doesn't like coming out of bed. I explain everything to him."
- When we highlighted a potential concern to the registered manager following the inspection, they immediately took steps to ensure lessons could be learnt. This included increasing the number of 'spot checks' of people being assisted by staff with their mobility needs; ensuring staff were completing relevant training; and planning a staff meeting to discuss the concerns and look at further lessons that may be learnt.
- The Management team had undertaken a regular analysis of accidents and incidents to see if there were lessons that could be learnt and to look for trends. In one instance, a further member of staff was deployed to the lounge to supervise people to reduce the risk of falls.
- The provider had an emergency evacuation plan and people had personal emergency evacuation plans (PEEPs) in place. PEEPs included information on mobility and the person's ability to recognise dangers.

#### Staffing and recruitment

- Staff files showed that the provider had undertaken appropriate checks prior to commencing employment. The checks included requesting and receiving references from previous employers and with the disclosure and barring service (DBS). A DBS check is a record of a prospective employee's criminal convictions and cautions. Where appropriate, evidence of up to date registration with the Nursing and Midwifery Council (NMC) was included.
- People and relatives told us there were sufficient staff to meet people's needs. One person told us, "They



(staff) come reasonably quickly." A relative told us, "When we've been there, there's always been enough staff. There's always someone around." Another relative told us, "There's lots of staff always on hand."

- Prior to the inspection, visiting healthcare professionals had raised concerns around staffing levels when they had visited the service. However, when we inspected the service, there were fewer people living in the service and staffing levels were appropriate to meet people's needs.
- The provider had assessed staffing levels and adjusted this according to people's needs. One member of staff told us, "I think there's enough staff here now. We were always on the go to get things done." Another member of staff told us, "We always have enough staff to do all the personal care."

#### Using medicines safely

- People's medicines were managed in a safe way. People's medicines were recorded in Medication Administration Records (MARs) with a photograph of the person, allergies, protocols for 'when required' (PRN) medicines and how the person liked to take their medicines.
- Staff had completed regular training and competency checks to ensure they had the relevant skills to administer medicines.
- Prior to the inspection, the local authority made us aware of a concern in relation to a delay in booking in and administering medication. During our inspection, we saw appropriate checks were in place to ensure medicines were signed in by two members of staff when they were delivered to the service.
- Where people were prescribed anticoagulant medicines (anticoagulants are medicines that help prevent blood clots), there were systems in place to ensure people had regular blood checks and that the dose administered was current.

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

- On the day of the inspection, the registered manager had been on a period of leave. During their absence, there was a lack of robust management oversight as staff continued not to wear masks consistently and in accordance with national guidance. This was despite having been raised as a concern to management by visiting healthcare professionals and the local authority prior to our visit. The provider sent us assurances in response to our findings and immediately increased their presence within the service to ensure there was robust oversight.
- Audits undertaken by the provider had failed to identify the issues identified the local authority in relation to personal protective equipment (PPE) storage and ensuring staff had access to a ventilated and sufficiently spacious staff room. For example, a provider audit undertaken in July 2021 failed to identify the storage and staff room issues and did not review mask compliance as only aprons and gloves were mentioned as the PPE available in the home.
- Prior to the inspection, we received concerns from visiting healthcare professionals that staff did not know people's needs well enough to ensure they were providing the appropriate care. Staff were able to tell us about the risks associated with people's care. However, they told us they had not read care plans and risk assessments and did not always feel supported to do so. A member of staff told us, "I don't get a chance to read care plans. I don't know if [management] would give me the time." Another member of staff told us, "We haven't got really enough time to read the care plans." A third member of staff told us in relation to reading care plans and risk assessments, "It is difficult here because you can't always ask if you have questions [due to time constraints]." This meant there was a risk staff may not always have been fully aware of people's up-to-date health, social and care needs where this was recorded in care plans.
- We received mixed feedback from staff about the management of the service and the support available. Comments from staff included: "There's team work here. There's a lot of different cultures here.", "I think [management] would listen but sometimes they don't like sending us home [when staff have said they are not feeling well].", "I think there is a little bit of a problem with management regarding if people (staff) are off sick." and, "I could definitely speak to [management] if I didn't feel well or need help."
- Where we highlighted areas of concern during the inspection, the operations consultant provided us with regular updates as to the action they took. In one instance, the local authority and our inspection had

highlighted that staff did not have access to an adequately spacious and ventilated staff room. The operations consultant ensured an alternative room was identified and converted to become the new staff room which enabled staff to distance and had windows for ventilation. Whilst action was taken on the day of the inspection, this had been highlighted in a staff survey in May 2021. A member of staff told us on the day of the inspection, "We need a staff room. At the moment, there is only space for my bag and coat."

Failure to ensure there were effective governance systems in place to assess and monitor the quality of the service meant that shortfalls were not always identified and acted on. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and relatives were complimentary about the management of the service. One person using the service told us, "[Registered manager] sometimes comes in and can be very nice and ask for feedback." Another person told us, "They are friendly here." A relative told us, "Everyone - staff and the managers are willing to help with any problem of any description."
- Daily handover meetings took place to update staff and discuss changes in people's needs. A member of staff told us, "In the mornings, we have handovers. The nurses go through each person how they were in the night and if anybody is hospitalised or what can be done differently."

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

- Services providing health and social care to people are required to inform the Care Quality Commission (CQC) of important events that have happened in the service. The provider had informed the CQC of significant events. Following the inspection, where the registered manager had been unsure as to whether to notify CQC of an incident, they sought appropriate guidance to ensure this was reported.
- Relatives told us they were informed of accidents, incidents and changes to people's healthcare needs. One relative told us, "They let me know of incidents. They got on the phone with me straightaway." Another relative told us, "They keep me informed."

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

- People using the service and relatives had the opportunity to attend meetings and feedback on the service via surveys. One relative told us, "It's (the meeting) going to be on Zoom. I'll be going." Another relative told us, "There's a relatives' meeting on [date of meeting] face to face but they've decided to make it on zoom because of the new [COVID-19] variant."
- Where the registered manager identified that an individual's relative had not always been involved in their care, they took steps to ensure this would happen without delay which resulted in the relative feeding back to us that they felt reassured about their loved one's care and the steps the registered manager was taking.

Working in partnership with others; Continuous learning and improving care

- People and their relatives told us they felt management would take action if they had an idea on how to improve care at the service. One relative told us, "If it was something serious or if I think they should do something differently, I would seek out [registered manager]."
- We saw from people's care records that healthcare professionals had been involved in their care. One healthcare professional commented, "I was impressed with the staff's knowledge of the resident's swallowing, and their understanding of the importance of her view and opinions in decision making."
- Following the inspection, the provider engaged with the local authority and healthcare organisations, such as the local clinical commissioning group (CCG) to work together in order to admit people safely to the service.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

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	Regulation 12 (2) (h) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014  The provider had failed to ensure staff were consistently taking adequate measures to prevent the spread of infections.

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	Regulation 17 (2) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014  The provider had failed to effectively monitor and improve the quality and safety of the services provided.