HC-One Limited

Tower Bridge Care Centre

Inspection report

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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
Tower Bridge Care Centre is a residential care home providing personal care to up to 128 people. The service provides support to people aged 65 and over, including people living with dementia. There were 112 people living in the home at the time of the inspection.

People's experience of using this service and what we found
The provider was still not consistently mitigating risks to people's health and safety. People had personalised risk assessments in place for different areas of risk, but nutritional care plans did not always contain information about people's needs and there were no dementia care plans for people to ensure their dementia needs were fully met.

The provider was not always managing people's medicines safely. People were usually getting their medicines as required and the provider usually kept accurate records of administration. However, we identified one example where a medicated cream was signed for as given when it was not and staff reported internet connectivity issues which delayed their recording of medicines administration.

The provider conducted a range of audits, but these did not identify some of the issues we found at the inspection.

The provider ensured there were enough staff on duty to support people and they had conducted appropriate pre-employment checks before hiring new staff. The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA).

The provider followed good infection prevention and control practises. Notifications of significant events were sent to the CQC as required. The provider ensured lessons were learned when things went wrong. Staff gave good feedback about their experiences of working for the service and people and their relatives gave mostly positive feedback about the service overall.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (27 October 2022).

This service has been in Special Measures since October 2022. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

At this inspection, we found although the provider had made some improvements, they remained in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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 improved to requires improvement. This is based on the findings at this inspection.

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

Enforcement and recommendations
We have found breaches in relation to safe care and treatment and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.	**Requires Improvement**
Is the service well-led? The service was not always well-led.	**Requires Improvement**

Tower Bridge Care Centre

Detailed findings

Background to this inspection

Inspection team
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 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, a specialist advisor and pharmacy inspector. The specialist advisor was a nurse with experience of older people's care.

Service and service type
Tower Bridge Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and we looked at both during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post

Notice of inspection
This inspection was unannounced, but we announced the second day.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included any significant incidents that occurred at 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 reviewed the previous inspection report and actions plans submitted after that inspection. We contacted the local authority commissioning team to obtain feedback. We used all of this information to plan our inspection.

During the inspection
Inspection activity started on 31 March 2023 and ended on 9 May 2023. We visited the service location on 31 March 2023 and 4 April 2023. 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 spoke with the registered manager, the regional manager, 6 nurses and 5 care workers and other members of the senior management team. We also spoke with 6 people using the service and 4 of their relatives. We also contacted all relatives via email after our inspection and received feedback from 8 of them.

We reviewed a range of records, both on and off site. This included 15 people's care records, numerous medicines records and 10 staff files in relation to recruitment. We also reviewed records related to the management of the service, which included incident reports, quality assurance records and minutes of staff meetings.

We carried out observations throughout the day in relation to infection prevention and control procedures and staff awareness of best practice.

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 inadequate. The rating for this key question has improved to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety.

At our last inspection, we found the provider had failed to ensure the safe management of people's medicines and failed to fully assess and mitigate risks to people's health and safety. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found although the provider had made improvements, they remained in breach of regulations.

Assessing risk, safety monitoring and management

● At our last inspection, we found there were issues with people's turning charts as these were not filled in contemporaneously. At this inspection, although we found improvements had been made in the completion of people's turning charts, there were other issues in people's risk assessments. We identified two examples where people's nutritional care plans did not contain up to date information about their care needs. We also found people did not have dementia care plans in place, thereby creating a risk of their dementia care needs not being fully met.

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

● People's care records contained a variety of risk assessments in areas such as falls and skin integrity. Specific risk assessments were also completed in areas of individual risk to people, for example one person had a specific risk assessment in place for 'frequent bruising and skin tears. We found their risk assessment and care plan contained clear advice for staff in how to manage their specific skin integrity issues.

● Care workers demonstrated a good understanding about the risks to people's care. For example, one care worker demonstrated a detailed understanding of the moving and handling needs of people on the unit in which they worked, and care worker person gave us examples of how they provided care to a person with skin integrity issues.

Using medicines safely

● The provider was not always managing people's medicines safely. At our last inspection, we found the provider failed to ensure the safe management of people's medicines and best practice was not always followed. At this inspection, we found although the provider had made significant improvements in the management of people's medicines, they were still not fully managing people's medicines safely.

● At our last inspection we found the provider was using an electronic recording system for people's medicines. We noted that staff administering people's medicines were signing the electronic MAR (Medication Administration Record) charts in batches due to connectivity issues. At this inspection we found

although staff were signing MAR charts contemporaneously, they reported that Wifi connectivity issues remained and caused delays in their signing of the electronic MAR charts.
● At our last inspection we found there were significant and widespread issues with the records of administration as records were not reliably accounting for the medicines people had been given. At this inspection we found although records were more reliable and usually tallied with the physical stock of medicines available, there was one example of a medicated cream that staff had signed for as administered, which in fact, had not been administered. We spoke with the provider about this and they took immediate action to question those involved. They also implemented an immediate check of all medicated creams to ensure this incident would not be repeated.

The above issue constitutes a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had made significant improvements in other areas of medicines management in association with a new pharmacy. Previous issues in relation to medicines deliveries had been rectified through the new provider.
● Records of controlled drugs (CDs) were accurate and we found the amount recorded was the amount available in stock. CD's were being disposed of appropriately in line with legal requirements. A CD is a prescription medicine that is subject to strict legal controls. These controls are to prevent it from being misused, being obtained illegally or causing harm.
● CDs that were no longer required were destroyed on site. Records of medicines disposals were being kept and were accurate. Medicines were stored safely. Staff were recording temperatures of medicines storage areas and fridge temperatures were checked, as required. Staff were appropriately trained and demonstrated a good understanding of their responsibilities in relation to medicines management.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● At our previous inspection, we found the provider was not meeting the requirements of the MCA. Where people had fluctuating capacity and required their medicines to be given to them covertly, we found decision specific mental capacity assessments were not in place and the appropriate processes were not followed to ensure decisions to give medicines covertly were made in people's best interest. For people who were given their medicines covertly, we found their DoLS did not include details of this.
● At this inspection we found the provider had made sufficient improvement in this area and were no longer in breach of regulations. Where people were given their medicines covertly, we found the provider was now completing decision- specific mental capacity assessments and decisions were made in people's best

interest.

● The provider was also completing decision- specific mental capacity assessments for other decisions and where people required their liberty to be restricted for their own safety, applications had been made to the local authority as required. Although some of these had not yet been decided, we saw evidence the provider had followed up applications requesting an update.
● Care staff demonstrated a good level of understanding about their responsibilities to provide care in accordance with people's valid consent. One care worker told us "Some people struggle to decide, so we help them by presenting them with choices. We help them to make a decision, but they are making the decision and we will do what they want."

Staffing and recruitment
● At our previous inspection we found there were not enough staff to meet people's needs. Although the provider scheduled enough staff to provide people with support, they did not take timely action to ensure enough staff were in place when people called in sick. At this inspection we found the provider ensured there were enough staff to support people safely and were no longer in breach of regulations.
● People, their relatives and staff told us there were enough staff on duty to provide support. One care worker told us "Every day is usually fine- scheduling is fine, but the only problem is if somebody calls in sick. They try to sort this out quickly though."
● We observed there were enough staff on duty throughout our inspection. We reviewed staffing rotas and these showed there were enough staff scheduled to attend the service to support people. We also observed staff responding to people's needs quickly.
● The provider conducted appropriate pre- employment checks before hiring new staff. We reviewed 10 staff files and found they contained evidence of checks including staff employment history, two references, passport checks and Disclosure and Barring Service (DBS) checks. These provided information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection including the cleanliness of premises
● 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 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.

Visiting arrangements were safe for people using the service. The provider imposed no restrictions on visitors and had masks available for people in the reception area, should they require this.

Systems and processes to safeguard people from the risk from abuse
● People told us they felt safe using the service. Care staff confirmed and records indicated they received annual training in safeguarding vulnerable adults from abuse. Care staff demonstrated a good understanding about their responsibilities in this area as well as the signs of abuse to look out for. One care worker told us, "If I suspected anything it would just break my heart- I'd have to report it straight away and

make sure it was taken seriously."
● The provider had a clear safeguarding policy and procedure in place and reported concerns to the local authority for investigation as well as the CQC as required.

Learning lessons when things go wrong
● The provider responded appropriately in the event of an accident or incident. We saw that staff had completed an incident report where people had an accident or incident and people's risk assessments were updated to reflect any changes to the risks relating to their care as a result. Any lessons learned were communicated to staff through handover meetings as well as monthly staff meetings and minutes reflected this.
● The provider conducted quarterly accident and incident analyses in order to identify trends in accidents and incidents and implemented any changes required. This information was also shared with the local authority. One care worker told us "We don't have many accidents and incidents, but if anything happened, we would discuss this- we'd get information in handovers and meetings, we'd talk to each other to make sure we know what we're doing."

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 inadequate. The rating for this key question has improved 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.

At our last inspection, we found the provider did not effectively operate systems and processes to assess, monitor and improve the quality and safety of the services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the provider was no longer in breach of regulations.

Continuous learning and improving care

● At our previous inspection, we found systems of audit were in place but had not identified the issues we found. At this inspection, we found although the provider's audits were identifying some issues and had improved, they had not identified the issues we found. The provider was conducting audits of care records, and these did identify some issues in some care records. However, because the provider was conducting an audit on only 10% of records each month, these had not identified the issues we found.

● We also saw the provider was conducting medicines audits, however, these had not identified the issue we found with unadministered cream. The provider immediately checked all medicated creams within the home following our feedback and had implemented an additional, check of all medicated creams.

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

● The provider promoted a positive culture that achieved good outcomes for people. Staff gave positive feedback about the service, the management team as well as their colleagues. One care worker told us, "They are supportive. I had a lot of personal issues, and they really helped me through this." Another care worker described the management team as "our boss[es], our friends, our colleagues. Everything."

● People and their relatives gave mostly good feedback about the service as well as positive feedback about the managers and staff. Their comments included, "We have no issues with Management, we always find them approachable and professional" and "I'm happy the service and I feel my [relative] is safe and communication with management is good".

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 understood their obligation to be open and honest and to report notifiable incidents to the CQC where needed. The registered manager ensured notifications were sent to the CQC as required.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully

considering their equality characteristics

● Although the registered manager and other staff were clear about their roles and responsibilities, senior management were not always clear about risks as they were not clear about the risks associated with not having dementia care plans in place. Although the risks associated with people's conditions were detailed in other care plans, such as those relating to behaviours that may challenge staff, the provider was not fully clear about the need to have these care plans in place.

● Nursing and care staff understood their responsibilities in managing risks and the registered manager had a good understanding of their role in relation to regulatory requirements.

● The provider engaged people in the running of the service. Residents and relatives meetings were held on a monthly basis and minutes were kept of these. The provider conducted a range of staff meetings as well as meetings with external multi- disciplinary professionals. Staff confirmed they found these meetings useful and were well- informed. One care worker told us, "They are useful- we get good information. If I'm not here, we get told what happened."

Working in partnership with others

● The provider worked in partnership with other multi- disciplinary professionals. The provider was working closely with the local authority and Integrated Care System (ICS) to implement improvements within the home. We spoke with one member of the ICS who was present during our inspection, and they spoke positively about the joint work they were conducting with the provider.

● The provider had implemented changes to the professionals they were working with since our previous inspection as some of the issues had emanated because of poor working relationships. The provider reported they were now working well with their new GP and pharmacy, resulting in more seamless access to services.

● People's care records also showed evidence of joint working with other professionals such as social workers and people's GP. Where advice was given by the professional, we saw this was recorded and the details were followed.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always assess the risks to the health and safety of service users receiving care and do all that is reasonably practicable to mitigate any such risks. The provider did not always ensure the proper and safe management of medicines. Regulation 12 (1) (2) (a), (b) and (g).