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Towerhouse Residential Home

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
Towerhouse Residential Home is a care home providing care and support to people aged 65 and over. The home can accommodate up to eight people in one adapted building. When we inspected seven people were living at the home.

People's experience of using this service and what we found
People's prescribed medicines were safely stored. However, during this inspection we saw people's medicines had been dispensed into pots and placed by their breakfast table settings and not administered individually to people directly from the packet which is good practice for medicines administration. We noted a gap in a person's medicines record where a medicine was not recorded as having been taken.

We were not assured that the provider was ensuring people's safety in relation to the risk of infection. A bathroom had cracked tiles and exposed grouting which presented an infection risk to people using it. There were no records of the twice-daily temperature checks which the provider said had taken place for people and staff. Infection control audits had not been updated to include information about COVID-19 and the relevant risk assessments had not been undertaken for people. The home's COViD-19 policy and procedure had not been updated since March 2020 and did not include more recent guidance for care homes. The home had sufficient supplies of personal protective equipment (PPE) and the provider and care staff were observed wearing masks and other PPE at all times. However, we observed a visitor entering the home and walking through communal areas without wearing a mask. Suitable cleaning materials were used. Although these were generally stored securely, we found a room containing laundry fluids had been left unlocked.

People and staff, including agency staff had been tested regularly for symptoms of COVID-19. People and permanent staff had been vaccinated. Staff had received training in infection prevention and control.

The provider had not fully ensured people were not placed at risk in the event of a fire evacuation. A fire exit was partially blocked by a chair and a fire exit sign was not placed correctly. A gate leading to the fire assembly point was locked by a padlock meaning the assembly point could not be readily accessed from the garden in case of fire. The provider said an independent fire risk assessment had been carried out the week prior to our inspection and the issues with signage and the padlocked gate had been pointed out by the assessor, but these had not yet been addressed.

The home's quality assurance systems had failed to ensure that risks associated with infection control, fire safety and external building works that were taken place during our inspection had been identified and addressed. Regular audits of safety and systems had taken place. However, weekly tests of, for example, the fire alarm system had not been carried out for two weeks prior to our inspection. The provider told us the deputy manager who usually carried out the checks was away from work and acknowledged that no arrangements were in place to undertake checks and audits in their absence.

Staff were safely recruited and checks of their suitability had been carried out before appointment to their roles. The provider had sought evidence of appropriate checks having taken place for agency staff working at the home.

Staff had received training in safeguarding adults and understood their responsibilities in ensuring people were safe from harm or abuse. There had been no safeguarding concerns about the home during the past year.

People and family members told us they were satisfied with the care and support provided at the home. A staff member said they felt well supported by the provider and received the information they required to do their work effectively. People and staff were asked for their views about the home at regular meetings.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 12 November 2019).

Why we inspected
We received concerns in relation to environmental safety and infection prevention and control. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 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 sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Towerhouse Residential 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 monitor the service.

We have identified breaches in relation to people's safety at the home and the provider's quality assurance and monitoring systems 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
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Towerhouse Residential 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
Towerhouse Residential 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 home is managed by the registered provider who is 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 inspection
We reviewed information we had received about the home since the last inspection. We sought feedback

from the local authority. The provider told us they were 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 two people who lived at the home about their experience of the care provided. We spoke with the provider, a care worker and an agency care worker.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two 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 provider to validate evidence found. We looked at care records and quality assurance records. We spoke with two relatives of people who live at the home.

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 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.

Using medicines safely

● We observed that people's morning medicines were placed in pots next to their table settings to take with their breakfast. We asked the provider about this. She told us this was not usual practice, but since she was the only person qualified to administer medicines when we arrived at the home, she did this to enable her to give time to the inspection. This meant that people were potentially put at risk since their medicines were not directly administered from the prescribed container, nor observed by a suitably trained staff member.

● We reviewed people's medicines administration records (MARs). We saw the medicines placed in pots for people on the morning of the inspection had been signed for, despite not being administered directly by a trained staff member. A person's MAR showed a gap where a medicine due to be administered during the afternoon of the inspection had not been signed as being taken by them. The provider said that the medicine had been administered. However, she acknowledged that the staff member should have signed the person's MAR at the time. This meant we could not be sure that administration of medicines was always safe and appropriately recorded.

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

● People's medicines were safely stored in a locked clinical room. Although no-one at the home was prescribed controlled or refrigerated medicines at the time of the inspection, we saw that suitable storage facilities for these were in place if required.

Preventing and controlling infection

● We were not assured that the provider was preventing visitors from catching and spreading infections. During our inspection a person entered the home to undertake a domestic task. They entered through a communal area and did not wear a mask and the provider did not ask them to do so. Anti-bacterial hand gel and masks were provided at the entrance to the home, but these were not offered to the person. The provider did not ask inspectors about their COVID-19 status and they were not offered temperature checks on entry. The provider said that generally visitors were asked to wear PPE and have their temperature checked. However, when prompted by the inspection team, it took five minutes for the provider to find a thermometer.

● We were not assured that the provider's infection prevention and control policy was up to date. The provider had not up-dated their infection control and COVID-19 policies and procedures since March 2020 to include up-to date guidance on reducing risk.

● We were not assured that the provider was meeting shielding and social distancing rules. The seating in

the lounge area was arranged to support social distancing. However, although there was space to arrange tables and seating in the dining room to ensure social distancing, we saw that two people were sitting close to each other and staff had not encouraged them to socially distance. The provider said that she would rearrange the dining room tables to reduce any risk in future. A person who went out from the home accompanied by staff to go to a bank and shops did not have a risk assessment associated with this. The provider said the person used a mask and carried hand gel and gloves when they went into the community, but there was no record of these arrangements in the person's care plan or personal risk assessment. We did not see the person leaving the home during the inspection so we could not be assured that they used a mask when going out.

● We were somewhat assured that the provider was admitting people safely to the service. A person who had recently been admitted to the home had tested negative for COVID-19. The provider said the person had been tested on admission and isolated for two weeks prior to receiving further negative test. However, there was no record of this in the person's care notes. The home's COVID-19 policy had not been updated since March 2020 and no up-to-date guidance on admissions in relation to current guidance was available.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Although the home appeared clean, we found a shared 'wet room' had exposed grouting to the water outlet and water had not fully drained away. Tile were also unevenly placed with grouting exposed. This presented an infection risk to people using the 'wet room'. Appropriate cleaning products were used. However, at this inspection we found that some cleaning products had not been stored securely, meaning people living at the home may have had access to these.

● We were assured that the provider was using PPE effectively and safely.

● We were somewhat assured that the provider was accessing testing for people using the service and staff. The provider told us people and staff were tested regularly in accordance with government guidance. We saw some records that showed testing had taken place. However, the provider's policies and procedures on COVID-19 had not been updated since March 2020 and did not set out the home's current arrangements for testing of people and staff.

● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. There had been no outbreaks of COVID-19 at the home. However, the provider's policy and procedures were dated March 2020 and did not include up-to-date guidance on managing the risk of COVID-19. People's care records did not include personal risk assessments in relation to risk of infection. The provider told us people and staff had twice-daily temperature checks. However, there was no record that these had taken place. The provider also said that visitors to the home were provided with PPE, and that COVID-19 lateral flow tests had taken place. Again, there was no record, and we observed a person coming into the home without being provided with these.

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

● We spoke with the provider about this. They told us they would take immediate action to address these failures.

Assessing risk, safety monitoring and management

● Although the home's records showed people's personal risk assessments had been regularly reviewed, there were no assessments in relation to risk of COVID-19 or other infection to people. For example, there was no risk assessment for a person who regularly went to shops or banks in the community.

● Risk assessments and audits maintained by the home did not include any infection control assessment or audit in relation to COVID-19.

● We found there were risks in relation to fire. A fire door was partially blocked by a chair. A fire exit from the

back garden to the home's fire assembly point was locked by a padlock rather than an easy to open system. Fire exit signs did not always point people to the appropriate fire exit. This meant people were at risk should there be a fire at the home. The provider said that an independent fire risk assessment had been carried out before the inspection. They had been made aware of risks associated with the back garden exit and fire signs but had not yet addressed these.
● The provider had commissioned a building contactor to undertake improvements to the home. However, they had not carried out a risk assessment in relation to these works. We saw, for example, trip hazards in the back garden that was accessed by two people living at the home during our inspection.

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

Systems and processes to safeguard people from the risk of abuse.
● The home's systems an d procedures for ensuring people were safe from the risk of abuse were up to date and reflected good practice.
● We reviewed the home's safeguarding records. No safeguarding concerns had arisen since our last inspection.
● Staff working at the home had received safeguarding training. A staff member we spoke with described her role in ensuring people were safe from abuse or harm.

Staffing and recruitment
● Staff were safely recruited. Checks had been carried out to ensure that they were suitable for their roles. These included references and criminal records checks.
● At the time of our inspection, some staff working at the home were provided by an agency. The provider had ensured the agency provided information about checks they had undertaken for their staff.
● Agency staff worked at the home regularly to ensure consistency of care to people. The provider told us agency staff working at the home were not working elsewhere
● We looked at the home's staffing rotas. The rota for the day of our inspection was consistent with the staff we observed working at the home. We noted people did not have to wait for support then they required it.

Learning lessons when things go wrong
● The records that we viewed did not provide information regarding changes or improvements to the service to ensure that lessons were learnt following any incidents or concerns.
● The provider assured us that improvements were made following incidents or concerns. However, the records we viewed did not show how improvements had been made.
● The provider told us they would make improvements to the forms used by the home so they showed clearly what actions had been taken in response to incidents and concerns.

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 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

- The provider's policies and procedures in relation to managing infection prevention and control during the COVID-19 pandemic had not been updated since March 2020. More recent government and CQC guidance was not included in the policies and procedures. The home's infection control audits had not been updated to ensure that issues in relation to the risk of COVID-19 were addressed.
- The provider did not maintain records showing that staff had been regularly provided with up-to-date information in relation to infection prevention and control and safe care during the COVID-19 pandemic.
- We saw that people may have been placed at risk should there need to be a fire evacuation of the home. Details are contained within the Safe section of this report. The provider acknowledged concerns had been raised during a fire risk assessment during the week before our inspection. However, no immediate action had been taken to address these.
- The provider had failed to carry out a risk assessment in relation to building works being carried out at the home before and during our inspection.
- A range of regular monitoring and quality checks had been carried out at the home. These had been carried out by the deputy manager who had been away from work for the two weeks prior to our inspection. We saw that weekly quality monitoring had not taken place during the period that the deputy manager had been absent. The provider acknowledged that no arrangements were in place to ensure that regular quality assurance monitoring was covered when the deputy manager was away.

The above is evidence of a breach of Regulation 17 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

- Staff members understood the needs of the people they supported and spoke positively about their roles in delivering quality person-centred care.
- People and their family members told us that staff were responsive in meeting their needs. A family member said. "I think it is a good home for [relative]. She is able to do the things she wants and seems very happy there."

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 notified CQC of incidents and concerns required in relation to the home's registration.
● The provider described the importance of ensuring that people, family members and other key professionals were always informed when there were any issues or concerns.
● The home's records showed that issues or concerns were immediately reported to the local authority or other key professionals.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Regular monthly meetings had taken place for people living at the home. The records of these meetings showed that people were asked for their views about, for example, changes at the home, activities and meals. Staff had discussed COVID-19 testing and vaccination with people at these meetings.
● Details about people's information and communication needs were included in their care plans. Staff understood how to provide people with the information they required. For example, a person with a visual impairment received information verbally and on tape. A person said, "I can choose what I want to do. Staff explain things to me."
● Staff team meetings had also taken place regularly. The records of these showed that staff were provided with opportunities to discuss people's care and support needs and preferences. Information about COVID-19 testing and vaccination was also provided to staff at these meetings.
● A family member told us, "The staff keep us up to date on [relative] and we are happy with the information we get. We have been asked about our views and I appreciate that."

Continuous learning and improving care
● The provider and staff had participated in learning opportunities provided by the local authority throughout the COVID-19 pandemic, including training in relation to infection prevention and control. A staff member told us the training she had received was helpful in improving her practice.
● However, the provider had not acted to ensure the home's procedures were updated in relation to recent local authority learning.

Working in partnership with others
● The home's records showed that staff had liaised with other professionals to ensure people's healthcare needs were met. People had been supported to attend regular appointments and health professionals had visited the home where required.
● The provider told us she had regular contact with the local authority and had attended on-line meetings set up for care home providers.