Mr & Mrs C Thomlinson

Tweedmouth House

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
Tweedmouth House is a care home providing accommodation and nursing care for up to 55 older people. Accommodation was divided into three smaller areas. People who had general nursing and personal care needs lived in 'Royal' and 'Tweedmouth.' Those who had a dementia related condition lived in 'Orchard House.' There were 47 people living at the home at the time of the inspection.

People's experience of using this service and what we found
An effective system was not fully in place to monitor the safety of the home. We identified shortfalls with safeguarding people from the risk of abuse, the assessment of risk, fire safety and the maintenance of records relating to infection control and accidents and incidents. In addition, an effective system to ensure notifiable events at the home were reported to CQC was not fully in place. This meant there had been no overview by CQC of certain events at the home to check the correct action was taken.

There were enough staff deployed to meet people's needs. Safe recruitment procedures were followed. Medicines were generally managed safely. We identified several minor shortfalls relating to the recording of medicines which the registered manager told us would be addressed.

Staff explained they had worked as a team to help promote people's wellbeing throughout the pandemic. We observed positive interactions between staff and people. One person told us, "It's the best place for me." Health and social care professionals also spoke positively about the home and staff. One health and social care professional told us, "They seem to have the best interests of those they care for at heart."

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 good (published 30 October 2018).

Why we inspected
We undertook this targeted inspection to look at infection control processes at the home. We look 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 coronavirus and other infection outbreaks effectively.

When we inspected, we identified shortfalls relating to safeguarding people from the risk of abuse, the assessment of risk, fire safety, the maintenance of records and the provider's governance system, so we widened the scope of the inspection to become a focused inspection which includes the key questions of safe and well-led.

The overall rating for the service has changed from good 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 Tweedmouth House 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 identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment, safeguarding people from abuse and improper treatment and good governance. We also identified a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (notification of other incidents).

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

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.

Tweedmouth House

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.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Tweedmouth House 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 had two managers 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
The 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. We used all of this information to plan our inspection. We did not request a 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.

During the inspection
We spoke with three people who used the service and 10 members of staff including the registered manager, deputy manager, nurses, care staff and housekeeping staff.

We reviewed a range of records. This included people's care records, medicines records and information relating to staff recruitment. A variety of records relating to health and safety and the management of the service, including policies and procedures were also examined.

After the inspection
We spoke with two relatives. We were also contacted by a third relative whose family member had lived at the home. We passed our findings to the local authority contracts and safeguarding teams and Northumberland Fire and Rescue Service.

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 previous inspection, this key question was rated good. At this inspection this key question has 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.

Systems and processes to safeguard people from the risk of abuse
- An effective safeguarding system was not fully in place.
- Not all safeguarding incidents had been reported to the appropriate agencies including CQC. This meant there had been no overview by external agencies to check whether suitable action had been taken and people were safe and protected from the risk of abuse.

The failure to have an effective safeguarding system in place was breach of Regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us they felt safe living at the home. Staff raised no concerns about staff practices at Tweedmouth House.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong;
- An effective system to monitor and manage risk was not fully in place. Risks relating to pressure relieving mattresses and one person's bed rails had not been fully assessed to ensure people's health and safety.
- Shortfalls were identified with fire safety. We referred these to the local authority fire safety team who carried out two visits to the home. They identified further shortfalls and issued the provider with a schedule of works which needed to be completed as soon as possible to ensure the safety of people, staff and visitors.

- An effective system was not fully in place to analyse accidents and incidents. Not all accidents and incidents were recorded in the home's accident book.

The failure to have an effective system to assess, monitor and manage risk was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The failure to ensure accurate records were maintained in relation to accidents and incidents was also a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our visits, the registered manager wrote to us and stated that the fire safety shortfalls had/were being addressed.

Using medicines safely

● Medicines were generally managed safely. We identified several minor shortfalls relating to the recording of medicines which the registered manager told us would be addressed

Preventing and controlling infection
● Infection control records did not fully evidence that best practice was followed to ensure people, staff and visitors were protected from the risk of infection. There were shortfalls and inconsistencies with infection control records relating to the admission procedure, the assessment of risk and testing for visitors. The provider's governance system had not identified these shortfalls.

The failure to ensure accurate and contemporaneous infection control records were maintained was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Staffing and recruitment
● There were enough staff deployed to meet people's needs.
● Safe recruitment procedures were followed.

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 previous inspections this key question was rated good. At this inspection, this key question has 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; Continuous learning and improving care

- An effective system was not fully in place to monitor the safety of the service. We identified shortfalls with safeguarding people from the risk of abuse, the assessment of risk, fire safety, the maintenance of records relating to infection control and accidents and incidents. These had not been highlighted by the provider's governance system.

The failure to have an effective system in place to monitor the safety of the home was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- An effective system to ensure notifiable events at the home were reported to CQC was not fully in place. We had not been notified of a police incident and safeguarding allegations.

This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009. We are dealing with this matter outside of the inspection process.

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

- There had been no incidents which required the provider to act on this duty.

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; Working in partnership with others

- Staff explained they had worked as a team to help promote people's wellbeing throughout the pandemic. We observed positive interactions between staff and people. One person told us, "It's very nice – I can't fault it in any way. The staff are all nice and look at this beautiful home – look at those views."
- Processes were in place to involve people, relatives and staff in the running of the home. Most relatives spoke positively about the home and the care and support provided. Comments included, "We are very happy, the staff that deal with my mum are exceptional" and "It's 100% all round." One relative whose family member had lived at the home contacted us with several concerns which we passed to the registered manager to investigate.
- Staff liaised with health and social care professionals to make sure people received care which met their

needs. Health and social care professionals spoke positively about the home and the care and treatment provided. One health professional said, "I find that the nursing staff and manager work well with me and refer residents to me for input and advice when they recognise the need and the advice/management plan that I offer is 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 An effective system to assess, monitor and manage risk was not fully in place. Regulation 12 (1)(2)(a)(b)(d)(e)(h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment An effective safeguarding system was not fully in place to help ensure people were protected from the risk of abuse. Regulation 13 (1)(2)(3)(6)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance An effective system to monitor the quality and safety of the service was not fully in place. In addition, there were shortfalls and inconsistencies with the maintenance of records. Regulation 17 (1)(2)(a)(b)(c)(d)(ii)(f).

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 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	Notifications relating to safeguarding allegations and a police incident had not been reported to CQC in line with legal requirements. Regulation 18 (1)(e)(f)

The enforcement action we took:

We issued a fixed penalty notice which the provider accepted and paid this in full.