HC-One Limited

Tower Bridge Care Centre

Inspection report

1 Tower Bridge Road, London, SE1 4TR
Tel: 020 7394 6840
Website: www.hc-one.co.uk

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate

Overall summary

We carried out an unannounced comprehensive inspection of this service on 16 and 17 June 2015. Breaches of five legal requirements were found and we issued warning notices for two of the breaches in relation to safe care and treatment and meeting people's nutrition and hydration needs.

We undertook this focused inspection on 12 August 2015 to check that they had complied with the warning notices. This report only covers our findings in relation to those two requirements. 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. The provider was not meeting the requirements of the warning notices and we are considering what further action we need to take. We will check on the outstanding breaches at our next comprehensive inspection on the service.

At the time of this inspection 84 people were using the service. A new permanent manager had been recruited and was in the process of registering with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our previous inspection we found that safe care and treatment was not provided as there was not proper and safe management of medicines. We found that medicines were not stored appropriately, adequate stocks were not maintained and medicines were not administered as prescribed. At this inspection we saw that appropriate supplies of medicines were delivered to the service. Medicines were stored securely and on three out of the four floors people received their medicines as prescribed. However, on first floor we saw that people did not always receive their medicines as prescribed and the stocks of medicines did not tally with the numbers recorded as administered on people's medicine administration records. People's opened insulin pens were not stored

Summary of findings

appropriately. People were potentially left in pain, discomfort and anxious as they did not receive their medicines as prescribed. The service continued to be in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

At our previous inspection we found that some people were not supported to have sufficient to eat and drink. We found that some people requiring their fluid intake to be monitored however, fluid charts were not completed correctly. We saw there were delays in people receiving drinks and some people's specific dietary requirements were not shared with the kitchen staff. At this inspection people's nutrition and hydration needs were met. People were supported to eat and drink sufficient amounts to meet their needs. Staff were aware of people's dietary requirements and liaised with other health care professionals when needed to obtain further advice and guidance about how to support people safely at mealtimes.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Appropriate stocks of medicines were at the service and medicines were stored securely. We saw on three of the floors that people received their medicines as prescribed and medicines administered were correctly recorded on a medicines administration record (MAR). However, on the first floor we identified that people did not always received their medicines as prescribed. The stocks of medicines at the service did not tally with the numbers recorded as administered on people's MAR. We saw that people's opened insulin pens were not stored appropriately. People were possibly left in pain, discomfort and anxious due to not receiving their required medicines.

The service continued to be in breach of the regulation inspected and therefore the rating awarded at our comprehensive inspection on 16 and 17 June 2015 was not amended.

Is the service effective?

Inadequate

Staff were aware of people's nutrition and hydration needs. We saw that people's dietary requirements and food preferences were catered for. People who were at risk of dehydration had their fluid intake monitored, and we saw for the majority of people that they received the amount of fluid appropriate for their needs. Staff liaised with other health care professionals when necessary to obtain further advice and guidance about how to support people with their nutrition and hydration needs, and ensure people's safety at mealtimes.

We could not improve the rating for effective from inadequate because to do so requires consistent good practice over time and compliance with the outstanding breaches identified at our comprehensive inspection on 16 and 17 June 2015. We will carry out further inspections to review the outstanding breaches.

Tower Bridge Care Centre

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Tower Bridge Care Centre. This inspection was carried out to check whether improvements to meet legal requirements planned by the provider after our inspection on 16 and 17 June 2015 had been made. The team inspected the service against two of the five questions we ask about services: is the safe? Is the service effective?

Three inspectors undertook this inspection on 12 August 2015.

During this inspection we spoke with five people and two relatives. We spoke with 11 staff including the new permanent manager, a member of the interim management team and the chef. We reviewed 13 people's care records and reviewed 23 people's medicines.

Inadequate

Is the service safe?

Our findings

At our previous inspection on 16 and 17 June 2015 we found that people's medicines were not managed safely. Medicines were not stored appropriately, adequate stocks were not maintained and medicines were not administered as prescribed. We found that one person received half the prescribed dose for one of their medicines, another person received three times their prescribed dose and one person received six doses of a medicine that had previously been stopped by a GP. We found that for six medicines the amount recorded as administered on people's medicine administration records did not tally with the stocks of medicine kept at the service. We found there were higher levels of medicines at the service than expected which meant people had not received their medicines as prescribed. We found that protocols were not available to instruct staff about when people should receive their 'when required' medicine. We also saw that insulin pens had been opened but were not labelled with the person's name or date of opening.

At this inspection we found that the service had liaised with the GP and the pharmacy to address the previous concerns regarding ordering and supply of medicines. We saw that appropriate stocks of medicines were supplied and held at the service. Medicines were stored securely.

We checked eight controlled drugs at the service and saw these were administered as prescribed and stock levels were as expected. We saw on three of the four floors people received their medicines as prescribed. Across the three floors we checked 17 people's medicines. We saw people's medicine administration records (MAR) were completed accurately and it was recorded when people received their medicines. Accurate stocks of medicines were stored and for the majority a daily stock balance was recorded to ensure people received their medicines and safe medicines management was maintained. On one floor there had been one medicine error and this was identified and addressed during spot checks undertaken by the management team.

People told us they received their medicines. However, on the first floor we checked six people's medicines and for four people they had not received their medicines as prescribed. This related to six medicines. We saw for five medicines there was additional stock indicating that a person's MAR had been signed that the person received their medicines when they had not. For one medicine there was less stock than expected meaning the person had received their medicine but it had not been recorded on their MAR. This meant people were left either in pain, discomfort or feeling anxious because they did not receive their medicines to manage their health needs.

We also identified on the same floor that three people required insulin to manage their diabetes. Their insulin pens were labelled and had the date of opening however, they were kept in the fridge. Administering insulin straight from the fridge would be painful to the people receiving it.

The management team told us the nurses undertook daily checks on medicine administration and the management team undertook daily spot checks on medicines management, however, these errors had not been identified and addressed.

We found the service continued to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

At our previous inspection on 16 and 17 June 2015 we found that some people were not supported to have sufficient to eat and drink. We found that some people required their fluid intake to be monitored however, fluid charts were not completed correctly. There was no target fluid intake and the fluid they had received had not been totalled, meaning staff could not monitor whether people were receiving the fluids they required. We saw there were delays in people receiving drinks. One person had not received a drink for over 17 hours and there was a delay in people receiving fluids upon waking. We saw that information regarding people's specific dietary needs had not been shared with the kitchen staff.

At this inspection we found people's nutrition and hydration requirements had been reviewed. People's dietary requirements, any allergies and food preferences had been identified and shared with the kitchen staff so that appropriate meals were provided. We saw that the menu offered two choices at each meal time and people were able to request an alternative if they did not like what was available. One person liked to have a curry each day and this was provided for them. The chef took part in the 'resident of the day' programme. This programme reviewed one person's needs each day of the month on each floor to ensure the care provided met people's needs and if required changes were made. The chef visited the floors during mealtimes to obtain feedback from people about the food, and also reviewed feedback from staff about the amount people ate to assess whether people enjoyed the meals. The majority of people told us they enjoyed the food at the service.

Some people were at risk of dehydration and for these people staff monitored the amount of fluid they received. A target amount was identified for each person and the total amount of fluid intake was calculated each day. For the majority of fluid records we reviewed the target intake was achieved. However, one person was on restricted fluid intake and we saw that they had received more than double that amount which could have been harmful to their health. We informed the management team of this and they told us they would remind all staff about the amount of fluids appropriate for this person.

Staff referred people to other healthcare professionals including dieticians and speech and language therapists when necessary. Staff followed the advice provided to ensure people had their nutrition and hydration needs met, and their safety was maintained whilst eating and drinking. We saw that care staff assisted people at mealtimes as appropriate.

We found the service was now meeting Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

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 registered person did not ensure care and treatment was provided in a safe way for service users, as they did not ensure the proper and safe management of medicines. Regulation 12 (1) (2) (g).