HC-One Limited

Tower Bridge Care Centre

Inspection report

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09 August 2022
17 August 2022
23 August 2022

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

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 114 people living in the home at the time of the inspection.

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

People's medicines were not managed safely. There were significant and widespread issues with the ordering, storage and administration of people's medicines. Staff were administering some medicines without having the appropriate training to do so and people were often missing their medicines due to issues with ordering. These incidents were often not reported and although managers knew about the issues, they had not been rectified by the time of our inspection.

The provider was not always following the principles of the Mental Capacity Act 2005. Where people required decision specific mental capacity assessments and best interest processes to be followed due to needing their medicines to be administered covertly, we found this was not being done.

Although the provider scheduled enough staff to provide people with care, they did not always ensure there was cover when staff called in sick. The service was understaffed on two floors of the building during the first day of our inspection.

The provider had clear risk assessments and support plans in place, in areas such falls or skin integrity. However, we found people's turning charts were either not being filled in or were not being filled in after people were repositioned.

We were not always assured that the provider was preventing and controlling infection including by ensuring the cleanliness of premises.

Managers and staff were not always clear about their roles as numerous issues had been identified with medicines management and responsibilities for managing those issues were not clear. We found there was a lack of structure in responsibilities and accountability for reporting issues and securing improvement among clinical staff.

Suitable systems were not in place to learn and improve care. The provider was completing audits in a number of areas, including medicines management, but these did not identify the issues we found.

The provider was not promoting a positive culture as staff told us they felt under-appreciated and sometimes felt overworked. The provider did not always work effectively with other professionals. Issues that had been identified with the pharmacy had not been resolved.

The provider engaged with people and their relatives in the running of the service, but did not always effectively engage with staff.

The provider had appropriate systems in place for managing and acting on allegations of abuse.

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 requires improvement (published 17 June 2021).

At our last inspection we found a breach of the regulations in relation to safe care and treatment. The provider completed an action plan after the last inspection to tell us what they would do and by when to improve.

At this inspection, we found the provider remained in breach of regulations.

Why we inspected
We received concerns in relation to a number of safeguarding allegations. As a result, we undertook a focused inspection to review the key questions of Safe and Well-Led only.

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

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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

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.

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 and will take further action if needed.

We have found breaches in relation to safe care and treatment, consent, staffing and good governance 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
The overall rating for this service is inadequate and the service is therefore in special measures. This means we will keep the service under review and will re-inspect within six months of the date we published this report to check for significant improvements.

If the registered provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question, we will take action in line with our enforcement procedures. This usually means that if we have not already done so, we will start processes that will prevent the provider from continuing to operate the service.

For adult social care services, the maximum time for being in special measures will usually be 12 months. If the service has shown improvements when we inspect it, and it is no longer rated inadequate for any of the five key questions, it will no longer be in special measures.

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

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

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, two specialist professional advisers and an Expert by Experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

The specialist professional advisors were a nurse specialising in the care of older people as well as a Pharmacist.

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.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included any notifications of significant incidents that occurred at the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the previous inspection report and contacted the local authority commissioning team and safeguarding team. We used all of this information to plan our inspection.

During the inspection
Inspection activity started on 9 August 2022 and ended on 23 August 2022. We visited the service location on 9, 17 and 23 August 2022. 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 11 people using the service and two relatives about their experience of the care and support provided. We also spoke with the Area Manager, the Registered Manager, the deputy manager, the clinical lead, six nurses, a nursing assistant, eight care workers, two activities co-ordinators. We reviewed a range of documents which included seven people's care plans and risk assessments, nine staff files, safeguarding, complaints, audits and incidents logs.

After the inspection
We asked the registered manager to send us a range of information to review off-site. This included policies and procedures. We used this information to help us make our judgements about the operation of service and standards of care.

Inadequate

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 requires improvement. At this inspection we have rated this key question inadequate.

This meant people were not safe and were at risk of avoidable harm.
At our last inspection in April 2021 we found the provider did not always assess the risks to the health and safety of service users of receiving care and do all that is reasonably practicable to mitigate any such risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the provider remained in breach of regulations.

Using medicines safely
● People's medicines were not managed safely. There were significant and widespread issues with the ordering, storage and administration of people's medicines. The provider used 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 the electronic tablets not working properly. On the first day of our inspection we found significant discrepancies between physical stock and the stock that was recorded on the electronic system. On the third day of our inspection we found the amount of medicines recorded on the electronic system had been adjusted to match the stock available. This meant records did not indicate whether people had actually taken their medicines, if there were any missed or any other issues.
● Not all staff who administered people's medicines had the required skills to do so. The provider employed Nursing Assistants to carry out some delegated nursing tasks for which they had received specific training. We saw Nursing Assistants were regularly carrying out tasks they were not trained or authorised to perform. This included administering medicines such as insulin and also administering medicines via a PEG feed without having the training, supervision or competency to do so. We also saw staff were not using pain management tools to assess and treat people's pain. When questioned, staff could not explain how they assessed people's pain and there was no training to assist them in doing so.
● There were significant issues with medicines storage. We saw fridge temperature gauges showed medicines fridges were not a safe temperature for the storage of medicines, but it was not clear if the fridges or temperature gauges were working properly. We also found two medicines trollies and a fridge had broken locks, so medicines were not being stored safely.
● Staff did not appear to understand the importance of people only using medicine that had been specifically prescribed and obtained for them. Cream was being used from the same tub, where people had been prescribed the same cream. Internal and external medicines were stored together for one person, which contravened the provider's medicines management policy. There were also examples of medicines that had passed the expiration date on the container in use.
● There were numerous examples of missed doses of medication that had not been reported and investigated. This issue was identified through a reporting function on the electronic system. Senior staff, which included the registered manager, were aware of issues in relation to medicines orders with the

pharmacy, but they were not aware of how widespread the issues were.
● Controlled drugs were not denatured correctly. On several units the single use DOOM kits were being used for multiple destructions and further medicines had been added after the kit had been activated. DOOM kits are containers for the safe destruction of controlled drugs.

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

Learning lessons when things go wrong
● The provider did not always investigate and learn lessons from incidents when things went wrong. Accidents and incidents were supposed to be recorded on the provider's incident reporting system. The system prompted questions such as what happened, what immediate actions were taken as a result and what future actions were required to mitigate risk. However, we found numerous examples of medicines errors not appropriately reported through this system. This meant there was no record of incidents such as missed medication and as a result, no measures in place to prevent a reoccurrence.

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

● For other types of incidents such as falls, the provider ensured people's risk assessments were updated with details of the incident and updates to the actions required to mitigate risk. We reviewed three people's records and found their risk assessments had been updated with the relevant details.
●Learning from incidents not involving medicines management was embedded through daily handover meetings to ensure staff were aware of the most up to date information about risks to people's care. For more serious incidents, we found information was discussed in 'lessons learned' meetings and the results were recorded, displayed on a 'lessons learned' notice board, with the results again being relayed in daily meetings to ensure the principles from incidents were embedded to bring about changes to practice.

Staffing and recruitment
● 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. During the first day of our inspection we found there were not enough staff to support people on two floors within the building. Although the provider had attempted to fill the shortage by contacting other off- duty staff, they were unable to meet this need due to a lengthy process they followed in obtaining senior authorisation for agency staff cover. As a result, they redeployed staff within the building.
● Shortages of staff impacted on people's wellbeing. We observed people being told they would have to wait for staff to fulfil their requests due to the shortage. Staff appeared to be tired and rushed and people appeared unkempt. For example, we saw numerous people wearing stained clothing. Staff told us there had been occasions where they were short- staffed during the month of August, but it was not a regular occurrence throughout the year. On the second and third days of our inspection we found the situation was much improved as no staff had called in sick.

The above issues constitute a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider conducted appropriate pre- employment checks before hiring staff. We reviewed nine staff files and found the provider routinely requested two references, a full employment history, evidence of their right to work in the UK and Disclosure and Barring Service (DBS) checks. DBS checks provide information

including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Assessing risk, safety monitoring and management
● At our previous inspection, we found numerous inconsistencies within people's care records. At this inspection we found some issues remained with the completion of people's turning charts. We saw people's turning charts were being filled in retrospectively for a number of people at once and as a result, we found one person's record did not accurately reflect their current position. We also found night staff had failed to make any record of whether two people had been repositioned for the night before the third day of our inspection. We therefore could not be assured they had been repositioned as required by their care plan.

The above issues constitute a breach of Regulation 12 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, skin integrity or dietary related risks such as their risk of choking. Specific risk assessments were also completed in areas of individual risk to people, such as their risk of seizures. Where risks were identified, we found clear risk management guidelines in place to support staff. For example, we read a 'stress and distress' risk assessment for one person, which gave details of the type of issues that brought the person anxiety. There was recorded information for care staff to support the person, which included speaking calmly with them and we saw staff doing this in practise when we observed them becoming distressed.
● Some people required further observation if they were at risk of not using their call bells. For example, three people whose records we reviewed were required to be observed every two hours to ensure they were safe. Records indicated these checks were being done.

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.

● 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.

The above issues constitute a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care staff had a good understanding about the importance of obtaining people's valid consent before delivering day to day hands on care. One care worker told us "I always ask for people's permission before I do anything."

Preventing and controlling infection including the cleanliness of premises
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. The medicines rooms and electronic tablets used for recording medicines were dirty.

● We were not assured that the provider was using PPE effectively and safely. On the first day of our inspection, staff were not wearing their face masks consistently.

● 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 accessing testing for people using the service and staff.

● 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.

We have also signposted the provider to resources to develop their approach.

The above issues constitute 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 from abuse
● The provider had systems in place for managing and acting on allegations of abuse. People told us they felt safe using the service. Their comments included "They`re all very kind to me here" and "They take good care of me".
● Care staff had a good understanding of what constituted abuse and knew what to do if they suspected this was happening. They had received annual training in safeguarding adults. One care worker told us "You get to know people when you're working with them, so you learn to pick up on the cues when there's something wrong. Abuse isn't always physical."
● This inspection had been prompted by an increase in safeguarding referrals being made. We found the provider had appropriately reported allegations of abuse to both the local authority and the CQC and had carried out investigations in respect of concerns.

Inadequate

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 requires improvement. At this inspection we have rated this key question inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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 did not always act appropriately when things went wrong. We identified numerous issues with medicines management, which included people missing their required medicines. However, these issues were not reported and investigated as required.
- The provider sent notifications of notifiable incidents to the CQC as required.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Managers and staff were not always clear about their roles as numerous issues had been identified with medicines management and responsibilities for issues were not clear. We found there was a lack of structure in responsibilities and accountability for reporting issues and securing improvement among clinical staff. We found untrained staff were conducting tasks such as administering insulin and no consideration had been given to the risks emanating from this.
- Care staff understood their responsibilities as this was made clear to them before they started work and their experience aligned with their initial expectations. One care worker told us "We know what we're expected to achieve. We want to make people a comfortable as possible, to meet their needs and help them to live as independently as they can and we're all working towards that".

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

- The provider was not learning lessons and improving care as a result. The provider conducted a range of audits, including audits in medicines management and care planning audits. Care planning audits did not include checks of contemporaneous notes that were made for people's care and this included the completion of repositioning charts. Therefore, these issues could not be identified.
- Medicines management audits did not identify the concerns we found in relation to medicines management or following best interest processes for people taking their medicines covertly. Furthermore, as issues relating to medicines management were not reported, the provider did not have the information with which to conduct learning and mitigate risks to people using the service.
- The provider did not promote a positive culture that was achieving good outcomes for people. Staff told us they felt under-appreciated and sometimes overworked. Care workers comments included "[It] feels like

there's no appreciation here. I don't feel supported", "We have the best team ever, but sometimes when staff are moved, things are going to go down. We will have staff who don't know the residents as well, then you have to carry them" and "They don't say thank you- a little thank you goes a long way, they always come back to say something is wrong."

The above issues constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

● The provider did not work consistently well with multi- disciplinary professionals. Whilst we found care records demonstrated joint working took place with professionals such as Speech and Language therapists, people's social workers and the GP as needed, we did not find the provider worked consistently well with the pharmacist. There had been issues identified with the delivery of medicines and whilst discussions had been held in relation to this, a resolution had not been reached at the time of our inspection.

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

● The provider engaged with people in the running of the service but did not always engage effectively with staff. conducted monthly staff meetings in which important information was relayed to staff on incidents. However, staff did not always feel appreciated or listened to.

● Monthly resident's and relatives' meetings were held, and minutes were kept of these. Discussions were held in areas such as the food and activities.

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 18 HSCA RA Regulations 2014 Staffing The provider did not always ensure sufficient numbers of staff were deployed to meet people's needs. Regulation 18(1).

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not always act in accordance with the 2005 Act for those people who were aged 16 or over and unable to give such consent because they lacked capacity to do so. Regulation 11(3).

The enforcement action we took:

Proposed a condition.

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 risks to the health and safety of people using the service and do all that is reasonably practicable to mitigate those risks. 12(1) and 12(2)(a) and (b); The provider did not always ensure the proper and safe management of medicines; 12(2)(g); The provider did not always prevent, detect and control the spread of, infections, including those that are health care associated; 12(2)(h).

The enforcement action we took:

Propose a condition.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care

Treatment of disease, disorder or injury

governance

The provider did not always ensure systems and processes were established and operated effectively to assess, monitor and improve the quality and safety of services and mitigate the risks relating to the health and safety of people using services.

Regulation 17(1), 17(2)(a) and (b).

The enforcement action we took:

Propose a condition.