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Tunnickliffe 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

Tunncliffe House is a residential care home that provides accommodation and personal care for up to 16 people. Tunncliffe House is a small domestic style building in a quiet cul-de-sac that offers accommodation over two storeys. At the time of our inspection there were 10 people using the service.

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

Some lessons had been learnt since the last inspection and improvements had been made to health and safety systems. All required environmental and smoking risk assessments were now in place.

Risks to people were not always managed effectively to protect them from potential harm. Additional risk assessments needed to be in place to mitigate risks around skin integrity and continence care for one person and another person who required blended foods. The provider had learnt lessons following incidents and accidents but had not recorded them.

People told us they received support from a consistent team of staff that knew them well. Staff were safely recruited and received training. There were enough staff to ensure people's needs were met.

Medicines were managed safely by trained and competent staff. Infection controls procedures were in place and followed by staff.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People told us they felt involved, listened to and consulted. They said they attended regular residents' meetings held at the service. People spoke positively about the provider and management team and said they were visible and approachable at the service.

The service worked in partnership with other agencies to support people's physical and mental health needs.

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 requires improvement (published 22 July 2019) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found that although some improvements had been made the provider remained in breach of regulations. This service has been rated requires improvement for the last two consecutive inspections.

At the last inspection a recommendation was put in place for the provider to review best practice guidance in relation to the principles of 'Registering the Right Support.' At this inspection we found the provider had done this however; all the people they continued to support had mental health needs and no new admissions had occurred since the last inspection.

Why we inspected

This inspection was prompted by a review of the information we held about this service.

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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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 read the report from our last comprehensive inspection, by selecting the 'all reports' link for Tunnicliffe House on our website at www.cqc.org.uk.

Enforcement and Recommendations

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 identified breaches in relation to Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) at this inspection. The provider had not ensured all risks relating to people were considered and had not always taken prompt action following incidents that had occurred at the service. Systems were not always effective at identifying risks to people and taking prompt action to address them. Lessons learned were not consistently recorded.

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

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. 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?

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.

Tunnicliffe 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 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 one inspector.

Service and service type

Tunnicliffe House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Tunnicliffe House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. 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. We sought feedback

from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used information gathered as part of monitoring activity that took place on 31 March 2022 to help plan the inspection and inform our judgements. We used all this information to plan our inspection.

During the inspection

We spoke with five people who used the service and eight relatives about their experiences of the care provided. We spoke to six members of staff including the registered manager, deputy manager, senior support worker, support worker, housekeeper and one of the owners of the service. We looked at three people's care records and multiple medicines records. We looked at two staff files in relation to recruitment. 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.



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 the rating has remained the same. 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.

Assessing risk, safety monitoring and management

At the last inspection we found systems were either not in place or robust enough to demonstrate that risk management and safety was effectively managed. This placed people at risk of harm. At this inspection not enough improvement had been made and the provider was still in breach of regulation. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There had been a delay in seeking medical assistance on two occasions following falls experienced by people.
- Risks associated with people's care and support needs had been assessed. Care plans and risk assessments held some information and guidance for staff to manage risks relating to people.
- Some people required additional risk information to be considered. For example; in relation to one person having blended food, another their skin integrity and continence care.
- Improvements had been made to the monitoring of health and safety systems. All health and safety risks relating to the premises and equipment had been identified. Regular monitoring, servicing, maintenance and where appropriate certification was in place to ensure their safety.
- A fire risk assessment was in place and all associated fire equipment had been regularly serviced and monitored. Risk assessments were now in place for people that smoked.
- People had individual personal emergency evacuation plans (PEEPs) in place should an evacuation be required.

Learning lessons when things go wrong

At the last inspection we found a failure to provide good governance and checks to monitor the quality for managing risks. This was a breach of regulation 17 (Good Governance) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation.

- Accidents and incidents were recorded however; written analysis was not in place to demonstrate lessons learned and actions taken to mitigate future risk.
- The provider clearly described their learning from recent accidents and incidents. New systems had been

introduced that they and their staff team would now follow to keep people safe.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA.
- People had their capacity assessed. Nobody living at the service had a DoLS in place.

Systems and processes to safeguard people from the risk of abuse

- People we spoke with told us they felt safe. Their comments included; "I feel safe here. There are always staff around" and, "All the staff know me well and understand when I need extra support because of my mental health."
- Relatives told us family members were safe. Comments included; "He is safe, he cannot smoke in his bedroom which is safer for everyone" and, "She is safe, she could be vulnerable if not at Tunncliffe House."
- Systems and processes protected people from the risk of abuse. Staff received training to ensure they knew the correct procedures to follow to keep people safe. Staff knew how to report any concerns they may have and felt confident they would be listened to.

Staffing and recruitment

- People told us there were enough staff to support them. They knew staff well and said they had very good relationships with them. Comments included, "[Staff name] is amazing, they know me really well and I feel comfortable with them", "There are always staff available when I need help or support. Nothing is too much trouble" and, "Most of the staff have been here as long as me. The staff are like a family to me."
- There were enough staff recruited to meet the individual needs of the people living at the service.
- Staff were recruited safely. Staff records included all required information, to evidence their suitability to work with people at the service. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. DBS checks had been completed for staff.

Using medicines safely

- Medicines were managed safely. A clear process was in place for the safe ordering, storing, administering and disposal of all medicines.
- People were supported with 'as required' (PRN) medicines. There were clear protocols in place to guide staff about how and when these medicines should be administered.
- Staff were trained in the safe administration of medicines and had their competency checked.
- The registered manager completed medicines audits every week. Any actions identified were investigated and promptly addressed.

Preventing and controlling infection

- 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 in care homes

The provider was facilitating visits for people living at the service in accordance with current guidance.

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. The rating for this key question has remained 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 the provider had failed to ensure people who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate quality assurance measures to monitor, assess or improve the quality and health and safety of care being provided. There were no audit tools and recorded checks on the management of medication. There was no auditing tool and checks of support plans, complaints records, use of CCTV, safeguarding and incidents. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Auditing systems were not always effective in identifying and mitigating risks to people. For example, risks in relation to one person's skin integrity, catheter care and mobility had not been assessed. Another required additional information regarding blended food to ensure they received their food safely.
- There had been a delay in seeking medical assistance under the guidance of the provider.
- Lessons learned were not clearly recorded following incidents and accidents. The provider was able to give a clear description of actions they had taken to mitigate future risks.
- Improvements had been made to the audit systems in relation to the management of medicines. Areas for development and improvement were clearly identified.
- Improvements had been made to the safety of the premises. All required environmental and smoking risk assessments were in place.
- Improvements had been made to the monitoring of the care plans and risk assessments.
- Staff knew and understood the provider's vision and values and how to apply them in their role and also as part of their team.
- Team meetings were held regularly. Minutes were shared with any staff who were unable to attend.
- The provider demonstrated through discussion, they understood their regulatory role and responsibilities. They had a clear understanding of people's needs.

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

outcomes for people

- Feedback from people about Tunnicliffe House was positive. Comments included; "Tunnicliffe House is my home and I like it here. I can go out for walks or watch television or listen to music. Nothing is too much trouble when I ask staff or managers for anything" and, "Staff are alright, very good. I get well looked after and the food is very good."
- The provider and management team were visible and accessible within the service. They took a genuine interest in what people, relatives and professionals had to say.
- Staff told us the management team were 'approachable' and felt confident to raise any concerns they had. They said they felt supported in their roles. Comments from staff included; "It's a good place to work", "I am definitely well supported" and, "As such a small team we all get on really well."

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 and registered manager understood their responsibilities around duty of candour. They explained it was about being open and honest when things went wrong and saying sorry.
- The provider had displayed the last inspection rating within the service.
- The provider and registered manager notified the CQC of incidents they were required by law to tell us about. This is so we can check appropriate action has been taken

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

- People told us they felt involved, listened to and consulted. One person said; "I speak to [Name] provider and [Name] registered manager all the time. They help me with all sorts of things. I can talk to them about anything."
- Residents meetings were held regularly. One person told us, "The meeting is used to share important information with us. Recently it's been about COVID-19, visiting etc. It is also a chance for us to ask questions and get answers." Minutes showed actions had been taken to address concerns or issues raised.

Working in partnership with others

The service worked well in partnership with health and social care professionals, to promote and improve the wellbeing of each person using the service.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always managed effectively to protect them from potential harm.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems had not identified areas found during inspection for development and improvement.