HC-One Limited

Tower Bridge Care Centre

Inspection report

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Date of inspection visit:
20 April 2021
23 April 2021

Date of publication:
17 June 2021

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
Tower Bridge Care Centre is a residential care home providing nursing and personal care for up to 128 people aged 65 and over, including people living with dementia and people who have nursing and end of life care needs. There were 117 people living in the home at the time of the inspection.

Tower Bridge Care Centre has four floors that supports people over five units. Each unit has separate adapted facilities.

People's experience of using this service and what we found
People and their relatives were positive about the kind and caring attitude of the staff team and were confident with the level of support received. One relative said, "It's really good care, I am very pleased, they are lovely people and are looking after them well. I have no complaints and couldn't be happier, it has taken a lot of stress off my shoulders."

People and their relatives told us they had been well supported during COVID-19 and the staff team had helped them to stay in touch with each other due to visiting restrictions. One relative said, "Staff take the phone through to them and they are always glad to see them. I can tell by the interaction between them they are treated with dignity and respect."

The provider worked in line with current guidelines to support safe visiting. We saw they had been flexible and understanding during visits at the end of people's lives. One relative praised the emotional support and kindness given to them and their family member at a difficult time.

Health and social care professionals involved in regular multidisciplinary meetings with the home spoke of a positive relationship across the staff team. They felt staff had a good oversight of people's needs and were regularly contacted for advice and support.

Staff were positive about the support from the senior management team and the newly appointed clinical lead. However, there had been no permanent registered manager since January 2021, which had impacted on the management of the service.

Where the provider had identified areas for improvement across the home, plans were being implemented and had not been fully addressed at the time of the inspection. Our records showed the provider had not always notified us about incidents that occurred across the service in a timely manner.

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 21 April 2020).

Why we inspected
The inspection was prompted in part by notifications of recent incidents, which included how the provider managed an incident of a missing person and an incident related to staff misconduct. A decision was made for us to inspect and examine those risks.

As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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.

We also 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 coronavirus and other infection outbreaks effectively.

Enforcement
We have identified a breach of regulations in relation to safe care and treatment. You can see what action we have asked the provider to take at the end of this full report.

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 commissioning authorities to monitor progress. 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.

Tower Bridge Care Centre

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 consisted of two inspectors, a nurse specialist professional advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

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. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. A registered manager similar to the provider is a person who is legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager position had been vacant since 27 January 2021. The provider had appointed an interim manager who started the day before the inspection.

Notice of inspection
This inspection was unannounced. The provider knew we would be returning on the second day of the inspection.

We visited the home on 20 and 23 April 2021. An Expert by Experience made calls to people and their

relatives on 23 April 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included any significant incidents that occurred at the service. The provider was 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 reviewed the previous inspection report and the recent infection prevention and control (IPC) assurance inspection report carried out on 21 August 2020. We contacted the local authority commissioning team and safeguarding team. We used all of this information to plan our inspection.

During the inspection
We met and had introductions with people who used the service and spoke with seven of them in more detail. 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 observed the care and support provided to people in the communal areas across different parts of the day, including mealtimes.

We spoke with 15 staff members. This included the new manager, an area director, the deputy manager, the clinical lead, two administrators, two nurses, a senior care assistant, four care assistants and two members of the domestic team. We also spoke with two health and social care professionals who were visiting during the inspection.

We reviewed a range of records. This included nine people's care and medicines records and six staff files in relation to recruitment, training and supervision. We also reviewed records related to the management of the service, which included incident reports, handover records, quality assurance checks and minutes of staff and management meetings.

We carried out observations throughout the day in relation to infection prevention and control procedures and staff awareness of best practice. We also checked the procedures in place for the management of people's medicines.

We contacted nine relatives over the phone on 23 April 2021 and spoke with eight of them.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at further quality assurance records, which included infection prevention and control and medicines audits. We also reviewed recruitment records that were not available during the inspection and further records related to incidents we reviewed during the inspection. We provided formal feedback to the area director and interim manager via email on 8 May 2021.

We asked the provider to share a questionnaire with the staff team to give them an opportunity to give us feedback about their experience of working in the home and heard back from a further four staff members. We also spoke with a further four health and social care professionals who had experience of working with the 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 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 an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Although we saw risks to people were assessed and scheduled to be reviewed each month, there were inconsistencies within the records we reviewed related to people's risks and the support they needed.

● There was limited information for three people regarding behaviours that challenged the service and what measures were in place to reduce any agitation, distress and aggression. Incidents that regularly occurred for one person were not recorded in their care plan. For a second person, there was no challenging behaviour risk assessment in place and their care plan had not been updated regarding a recent incident.

● We discussed this with the area director and they sent correspondence to us on 13 May 2021 that both of these people had been reviewed between February and March 2021 during multidisciplinary meetings. We spoke with two health and social care professionals involved in the meetings who felt staff had a good understanding of people's needs. However, this was not reflected in their care records.

● One person's records were unclear regarding their repositioning regime to reduce the risk of developing pressure ulcers and we were told conflicting information from staff members about how often they needed to be turned. This was acknowledged by the provider and the care plan was updated and sent to us after the inspection.

● There were risk assessments in place and guidelines for staff to follow to support people who were at risk of choking, with further input from the relevant health and social care professionals. However, we found fluid charts for two people were not always fully completed. The manager acknowledged they had observed this during their first day at the home and had already raised this with the unit managers.

● The clinical lead told us they were aware of some of the issues and were working towards updating people's records and discussing this across each unit. Examples of gaps in risk assessments and care records had also been identified during the provider's home monitoring visit on 11 March 2021 and internal investigation of a missing person which was completed on 14 April 2021. Actions were still in the process of being implemented at the time of the inspection.

Although we found no evidence that people had been harmed, the inconsistencies within risk assessments created a risk to people's health and safety. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Staff completed safeguarding training and had a good understanding of their responsibilities and the importance of reporting any concerns to the unit manager or management team. One staff member said, "I and the care staff would not tolerate any kind of abuse." Two health and social care professionals were also positive about the frontline staff awareness of safeguarding.

● People and their relatives gave positive feedback about the safety of the home. Comments included, "The way the staff engage with me, them being available and accessible is visible assurance they are safe" and "I know [family member] is safe and being taken care of. They always call if anything happens."
● However, there was mixed feedback from some health and social care professionals as safeguarding referrals had not always been made if the provider felt the person did not come to any harm. There was also a delay in the provider making a safeguarding referral for the incident of a missing person.
● The provider also acknowledged their missing person's policy needed to be updated after liaising with the local authority safeguarding team. It highlighted their policy did not make reference to the safeguarding process.

Learning lessons when things go wrong
● There were procedures in place for the reporting of any incidents and accidents across the service. Incident forms were completed and staff told us they had regular discussions about incidents during handovers and daily flash meetings.
● Samples of incident and accident records showed there was an open environment where staff felt comfortable and able to report incidents when they occurred. Staff confirmed this and there were records to show how incidents had been used as learning and discussed across the staff team in group supervision.
● The provider had carried out an internal investigation in response to an incident in March 2021 where a person had been reported missing, and later found behind a locked door within the unit they lived on. Where anomalies were found and areas of improvement highlighted, an action plan was in place and still being implemented at the time of the inspection.
● There were some inconsistencies as two incident reports from January and February 2021 had not been updated on the system and were still awaiting review. We discussed this with the area director who acknowledged there had been a slight lack of oversight during the period where there had been no registered manager. They sent us the investigation reports after the inspection of the outcomes and action taken.

Using medicines safely
● There were procedures in place to ensure people's medicines were managed safely and in line with best practice. Medicines were stored safely and we observed staff were aware of the correct procedures to follow, with accurate records for daily fridge temperatures and controlled drugs.
● Electronic medicines administration record (EMAR) charts were completed accurately and contained sufficient information to ensure people received their medicines safely. Staff followed guidance in place on managing 'as and when required' medicines which ensured people had access to pain relief.
● Staff responsible for medicines administration completed training and had their competencies assessed annually. Staff confirmed this and were positive about the support and training they received. There were regular checks in place and monthly audits helped identify any errors or where improvements could be made.
● We saw time sensitive medicines for one person were not always given on time. We discussed this with the provider and saw they contacted their consultant geriatrician for advice. They confirmed due to the level of the dose the timing was less important and the slight delay would not have a negative impact on their health and wellbeing. As this information was not within their care records, we advised the provider to update the care plan accordingly to reflect this.

Preventing and controlling infection
● There were systems in place and the provider had regularly reviewed their infection and prevention control (IPC) policy during the COVID-19 pandemic. Daily walkarounds and regular meetings reminded staff about safe procedures to follow, with regular audits checking for best practice and picking up any issues.

The home was clean and hygienic and we observed regular cleaning throughout the whole inspection.

● We were assured the provider was preventing visitors from catching and spreading infections as there were robust visiting protocols in place. This included temperature checks and a questionnaire to complete. Visitors needed to take a lateral flow device (LFD) COVID-19 test and were provided with the necessary personal protective equipment (PPE) upon entry. This assured us the provider was facilitating visits for people living in the home in accordance with the current guidance.

● Staff completed IPC training and were observed to be wearing the correct PPE and following best practice. There was guidance for staff on how to don and doff their PPE and dispose of it safely. Staff were positive about the support they received during the pandemic. One staff member told us any changes in guidance were discussed across the staff team.

● Staff confirmed they were involved in regular testing and the provider was proactive in supporting and encouraging staff to increase the uptake with the COVID-19 vaccine. One care assistant said, "With the daily LFD tests and weekly testing it is very reassuring for us, knowing we are keeping our residents and our own families safe."

Staffing and recruitment

● The provider carried out dependency assessments and reviewed them on a regular basis to ensure staffing levels were appropriate to meet people's needs. Nurses and unit managers confirmed this and observations throughout the inspection showed people were supported by staff when needed and in a timely manner.

● Where one person raised concerns with us about staffing levels and told us there had been a recent incident where they had been neglected due to staffing levels, we followed this up with the provider and the local authority. The provider met with the person to discuss their concerns.

● The provider acknowledged this incident had been the result of staff sickness and were in the process of recruiting additional staff. The person confirmed with the social work team this incident had not happened again.

● The overall feedback from staff was positive about the staffing arrangements in the home and felt there was enough staff to support people and keep them safe. One staff member told us there was also support if there were staff shortages due to sickness or absence. They added, "Other staff do get involved and help out."

● One person said, "There are regular staff on reception, and carers and nurses. There's always staff walking past, I don't use my buzzer I just shout for them, I don't have to wait long." Relatives felt there were sufficient staffing levels in the home. They told us they assessed this during lockdown by response times to phone contact and the availability of staff during their visits.

● The provider followed safer recruitment procedures to ensure staff were suitable to work with people who used the service. Appropriate checks and references were obtained at the time of recruitment, including validation pin numbers for registered nurses. Where some information was not available during the inspection, the human resources department was able to send us confirmation the appropriate records for some staff were on file.

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 deteriorated to requires improvement. This meant the service management and leadership was inconsistent. However, positive feedback was received about the senior management team and the culture they created promoted high-quality, person-centred care.

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

- During the period where the home did not have a registered manager in post, there had been delays in notifiable incidents being reported to us, which is a legal requirement. The incident in March 2021 involving a missing person being reported to the police had not been notified at the time and had been picked up during the internal investigation. Information within the investigation report stated the incident had still not been notified to CQC 11 days after it happened and staff responsible were unaware it needed to be.
- We found another incident involving the police where a person went missing from the home on 29 January 2021 which had not been notified to us. Although the provider submitted the relevant notification during the inspection on 20 April 2021 when we raised it with them, they acknowledged this as an oversight and provided assurance they would send any future notifications in a more timely manner.
- The interim manager had only been in post for one day before the inspection started and was getting familiarised with the service. They had already met with some of the staff team, including a meet and greet with the night staff on 22 April 2021 and provided feedback about their initial findings. They were supported by the area director.
- Staff received regular reminders about their responsibilities through supervision, flash meetings and daily handovers. Handover books also helped to give staff an overview of each person on the unit they were working in. We received positive feedback about the new clinical lead and how they had provided advice and support since starting in February 2021. This included newly introduced focus groups to support staff understanding and knowledge.

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 was aware of their responsibilities to inform people's relatives and make them aware if their family member had an accident or had been involved in an incident. We saw samples of letters sent to people's relatives about incidents that had happened in the service and what action had been taken, including an apology where appropriate.
- The provider also covered the duty of candour during quality governance meetings and discussed the importance of updating relatives after incidents occurred. Relatives confirmed they were informed about any incidents that happened to their family members in the home and were kept updated.

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

outcomes for people

● People and their relatives were positive about the home environment and the level of care they received. Comments included, "They get to know you, there's a bond of friendship, they know you when you call. It is a family atmosphere and they don't treat you like an outsider" and "We recommend it because of how they treat you, like family, not just a care home. They treat you with love."

● We also received positive feedback about the emotional support and understanding provided by staff at difficult times during the pandemic, including when people were in their last hours. A relative told us staff made sure their family member was not on their own and also supported them at the funeral, which had been appreciated.

● We received some mixed feedback from staff about the support available to them and how they felt it had impacted the home environment. Positive feedback related to support from the senior management team, including the previous registered manager, especially during the peak of the pandemic.

● However, we also received feedback which highlighted a lack of support available when there was no permanent manager in the home and communication was less effective. Staff felt a lack of management had left them feeling unsupported with no clinical support, which impacted morale. Staff were pleased a new clinical lead was in post and were positive about the appointment.

● The area director, who had been the previous registered manager told us they had always tried to be as supportive as possible. Recruitment for a new manager had been impacted by COVID-19 and the interim manager, who worked for the provider as a 'turnaround manager', told us they would be in post for as long as it took to resolve the current issues and recruit a permanent manager.

Continuous learning and improving care

● There were a range of audits and checks across the home to monitor the service and ensure people received the care they needed. There were clinical, governance and management meetings that discussed events across the service. This included reports on each unit that covered risks to people, changes in health and quality of records.

● The provider carried out monitoring visits, including unannounced checks at the weekend. We saw from visits in January and March 2021 they had identified areas of best practice along with areas where improvement was needed. These improvements were still being implemented at the time of the inspection.

● There were a range of health and safety checks across the home, including fire safety and mobility equipment checks. We identified some minor gaps in cleaning schedule records on the first day of the inspection. The area director acknowledged this on the second day of the inspection and had carried out a supervision with the cleaning team to remind them of their recording responsibilities.

● Feedback from relatives highlighted that staff were accessible and approachable and would listen and follow up any issues they raised to make improvements. Where one person told us they felt they were not listened to, the clinical lead had visited them to discuss their concerns and provide any necessary reassurance.

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

● People and their relatives' views were sought through resident and relative meetings and updates, either directly from the home or via head office letters. One person told us they would go into the office if they had had any issues and staff would deal with it right away. They added, "If it is the menu, they get onto the chef. They are very obliging and do what they can for you and bend over backwards."

● One relative told us how they had discussed concerns around staffing at weekends at a meeting and they had taken on board the feedback. They added, "When we drop stuff off now at the weekend there are more staff around and they answer the door more quickly."

● Relatives were also positive about how some staff members kept them updated with videos and photos of

their family members, including making regular video calls when visiting restrictions were in place. Another relative said, "If there is a problem they will phone every day. When I visit, they will always ask if I have any questions."

● The interim manager also shared a compliment they had received after the inspection regarding their new Afro-Caribbean menu which had been implemented in the last two weeks. People and the staff team had been involved and contributed to the design of the recipes.

● Staff had access to a confidential employee assistance programme that was displayed throughout the home, including posters for a COVID-19 colleague wellbeing 24/7 support line. Staff were encouraged to engage if they were feeling anxious. However, not all staff members had completed their COVID-19 risk assessments at the time of the inspection. The provider said they would ensure staff completed these as soon as possible.

Working in partnership with others

● The provider worked with a range of health and social care professionals, with the home also facilitating monthly multidisciplinary meetings to discuss the needs of people and follow up any concerns or changes in health and wellbeing.

● One health and social care professional told us it was extremely organised and they worked closely with the home in a coordinated way, with other professionals being able to dial into the meeting to discuss relevant issues. They felt this input had helped to rehabilitate people, reduce discomfort and reduce unnecessary medical appointments.

● Feedback about the new clinical lead was positive about how they had been proactive in providing detailed updates and presentations for the meetings. Feedback included, "They have taken this role on off their own back and they are so on top of everything. They provide detailed information and they are fully aware of people's needs."

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 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. Regulation 12 (1)