HC-One Limited

Tower Bridge Care Centre

Inspection report

1 Tower Bridge
Tower Bridge Road
London
SE1 4TR

Tel: 02073946840
Website: www.hc-one.co.uk/homes/tower-bridge/

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30 June 2016
12 July 2016

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 28, 30 June and 12 July 2016 and was unannounced.

Tower Bridge Care Centre is a home registered to provide accommodation, nursing and personal care for up to 128 people. Some of the people who live at the home have dementia. At the time of our inspection, 95 people lived at the home.

The service did not have a registered manager in post. A manager had been recruited and in place since February 2016 and had submitted his application to the Care Quality Commission to become registered. At the time of the inspection the application was in progress. 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.

We last carried out a comprehensive inspection of this home on 18 and 23 November 2015 and we found three breaches of regulation.

We carried out a focused inspection on 28, 30 June and 12 July 2016 to look areas of concern identified at the last inspection. This report covers our findings at the inspection. 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

People were encouraged to participate in a wide range of activities and activity coordinators were developing the activity programme. People's preferences of activities were not always recorded in their care plans.

People were protected against identified risks. Risk assessments in place gave staff adequate guidance on how to manage identified risks in order to protect both people and staff safely. The manager responded to feedback in ensuring risk assessments were comprehensive. People's care plans were person centred and tailored to their individual needs. A new care plan system was being implemented at the time of the inspection. Care plans were comprehensive and detailed people's preferences, history and other aspects of their care needs.

People were supported by sufficient numbers of staff to rise from bed when they wished. Staff were available to support people throughout the day and night. People received care and support from staff that reflected on their working practice. Staff received on-going guidance and support from their seniors by means of supervision and appraisals.

People were supported to have their meals in a relaxed and encouraging environment. Staff supported

people to eat their meals independently whenever appropriate.

People received care from staff that were attentive to their needs. Staff maintained and encouraged people's dignity and treated them with respect. Staff were supported by the new management team who operated an open door policy and completed frequent audits to ensure the safety of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People and staff were protected against identified risks. Risk assessments gave staff clear guidance on how to manage identified risks.

The service provided suitable numbers of staff on each shift, to enable people to rise from bed when they wished.

People received their medicines safely and as prescribed.

Is the service effective?

Good

The service was effective. People were supported to have their meals in a relaxed and calm environment.

People were supported by staff that reflected on their working practices. Staff received on-going supervisions and annual appraisals.

Is the service caring?

Good

The service was caring. People received care and support from staff who treated people with dignity and respect.

People received care from staff who knew their preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive. People were encouraged to engage in planned activities, however these did not always reflect their preferences.

Care plans were being updated to a new format, that was person centred and detailed people's wishes.

Is the service well-led?

Good

The service was well-led. The manager had developed a service that had a welcoming and inclusive atmosphere where people appeared relaxed and at ease.

The provider had processes in place to monitor how medicines were managed, via daily and monthly medicines audits.

The manager operated an open door policy, whereby people, their relatives and staff could meet with the manager at a time that suited them.	

Tower Bridge Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 28, 30 June and 12 July 2016 and was unannounced. The inspection team was made up of one inspector, one inspection manager, a pharmacist, a specialist advisor who was a nurse 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 care service. Their area of expertise was in dementia care. On the third day of the inspection two inspectors visited the service.

Prior to the inspection we looked at information we held about the service, including notifications received. A notification is information about important events, which the service is required to send us by law.

During the inspection we spoke with 16 people who used the service, five relatives, eight care workers, four nurses, the dietician, activities coordinator, clinical lead, Clinical Commissioning Group pharmacist, deputy manager and the manager.

We looked at medicines administration records (MAR),11 care plans, 11 staff personnel files and risk assessments. We looked at other documents the service maintained in relation to the management of the service.

We undertook general observations and used the short observational framework for inspections (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

At our previous inspection on 18 and 23 November 2015, we found people's wishes and needs about when they received care were not always met because there were too few staff available to provide care when they preferred or needed to receive it. For example the time people rose from bed was dependent on when staff were available to assist them. People were restricted in their activities by the number of staff available to care for them. This was a breach of regulation 9(1) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

At our inspection in November 2015 the assessment and management of risks did not always protect people and staff. The care records of a person whose behaviour when distressed presented challenges did not include a risk assessment or recommended action to take to assist with the person's distress. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

At our last inspection of the service in November 2015, people's medicines were managed safely and the breach of the medicines regulation that we noted at our inspections in June 2015 and August 2015 had been addressed.

At this inspection, we found that the provider had made some improvements.

People were supported by sufficient numbers of staff to rise from bed when they wished. The manager informed us that when he began working at the service he noted that daily routines were focussed around staff convenience rather than people's needs and preferences. He said people were often ready for bed in the early evening. As a result people were waking early and staff were getting them ready for the day although this was not their preference. He had worked with staff to change the routines so they more closely reflected people's wishes.

We received mixed feedback regarding staffing levels. We found people were supported at a time of their choosing to receive care and support. However one person told us, "Sometimes there seem to be too few staff, and sometimes too many. During periods of changeover, between 07:00 & 10:00 and 18:30 & 21:30, it is hard to get attention". Another person told us, "There's never a problem getting help here. During the day there's staff walking around and popping in to see you're ok. At night I have my call bell, if I press it staff are with me in a matter of seconds." A third person told us, "There's always enough staff on this floor. They all help each other out and they're so friendly. I keep my door open and they walk past and say hi. I wouldn't move from here." Care plans did not always record people's preferences in relation to when they wished to receive support in the morning. We spoke with the manager who informed us the new style care plans would detail people's preferences regarding morning personal care. At the time of inspection we found the new style care plans documented more information relating to people's preferences.

People were not always protected against identified risks because care plans did not always give clear guidance on how to manage all identified risks. One staff member who had been with the service for two

months, told us, "I've not read any risk assessments yet. No one's asked me to. When I first started, staff told me who were at risk of falls and showed me how to support them". Another staff member told us, "I've not seen any risk assessments but I have been told about them. I think they may be kept in the office." We raised this with the manager who confirmed all staff had read the risk assessments upon commencing employment. The service had risk assessments in place that detailed the risk, what the person could manage independently, the aim and objective and the care and support needs required. Risk assessments covered, mobility, eating and drinking, daily activities and other areas of care provided. However records did not always give staff clear guidance on how to manage risks that placed staff at risk of harm. For example, one risk assessment stated that when one person displayed behaviours that others may find challenging, staff were to ask another staff member to address the person. There were no clear steps for staff to follow should the behaviour escalate. This meant that staff were placed at risk of harm from people. As a result of our feedback on the third day of inspection the manager had reviewed the risk assessment and devised a robust risk assessment, that gave staff clear guidance on how to manage safely behaviours they may find challenging. The manager informed us, all risk assessments would be reviewed to ensure clear guidelines were in place for staff guidance.

We assessed medicines again at this inspection to check whether the improvements had been sustained. We found that people's medicines were managed safely. There was one area for improvement. Guidance for staff on how to assess pain for people prescribed "when needed" or PRN, pain medicines was not detailed enough.

We checked a sample of medicines records and medicines supplies throughout the home and there were no discrepancies. All prescribed medicines were available. Medicines administration records (MAR) were completed clearly, including information about people's allergies. Medicines were given at the correct times in relation to food, the exact times of administration were stated on the MAR for medicines where the timing is critical such as medicines for Parkinson's Disease and osteoporosis. There were no gaps or missed doses on any of the MAR. For people with swallowing difficulties, medicines had been obtained in liquid or soluble forms. Stock balance checks were carried out daily for medicines not in blister-packs, to check for accurate administration. All members of staff with responsibilities for medicines had received medicines refresher training and had their medicines competency assessed.

People's medicines were reviewed every 3 months by a multidisciplinary team which included a pharmacist and a doctor. There was specialist input for people with mental health issues or dementia who were prescribed antipsychotic medicines. There was no inappropriate or overuse of sedating medicines. When people without capacity to consent to take their medicines were refusing medicines, placing their health at risk, suitable arrangements had been made to administer their medicines covertly, ensuring that people continued to receive essential medicines. A Mental Capacity Act assessment had been completed for people receiving their medicines covertly. Although the pharmacist had been consulted to advise on safe methods of covert administration, people's individual covert administration protocols did not indicate whether a medicine should be crushed or placed whole in food. Staff told us that they would always place tablets whole in food, however it would be safer to specify the method of covert administration on the protocol.

Medicines rounds took place at the correct times on the day we inspected. There were now two nurses administering medicines at each drug round on each of the two nursing units, to ensure that medicines were administered on time. When people were prescribed food supplements and fluid/food thickeners, staff made a record when these were given. So this provided assurance that people were receiving their medicines as prescribed.

There were protocols in place for the administration of medicines that were prescribed to be given "when

needed" (PRN). Some of these were not detailed enough. For example the PRN protocols for pain relieving medicines did not indicate whether staff needed to carry out an assessment of someone's pain, and how often they needed to do this. Staff were confident that people were not left in pain however we noted that people did not have regular formal pain assessments. We noted a few minor recording issues on one of the units, as staff had not made a record of the quantities in stock of some PRN medicines, and some PRN protocols had been removed from the MAR chart folder, so these were not available for staff to consult. These were located and replaced during the inspection.

The GP visited the home regularly, and there was evidence that staff contacted the GP promptly when people's medicines needed to be reviewed. Staff told us that the arrangements for obtaining medicines had improved, however we did note that one person had run out of a medicine in June 2016 for a few days due to miscommunication between the pharmacy and the GP's surgery. The manager told us that they had met with the pharmacy and surgery to try and improve the ordering process.

We identified examples of positive medicines management, for example, the home had an arrangement in place whereby they received weekly medicines support from the Clinical Commissioning Group (CCG) pharmacist and they told us that falls risks due to medicines were considered as part of someone's overall falls risk assessment.

Good

Is the service effective?

Our findings

At our previous inspection on 18 and 23 November 2015, we found people did not always benefit from support at mealtimes provided by staff who understood how to meet their needs. We saw a member of staff assisting a person with a meal whilst standing behind and over them. Staff sat down to support the person when the manager intervened, however stood back up once the manager had left the room. When the staff did sit down they sat, slightly behind the person so they could not see each other clearly. The staff member overloaded the person's spoon with food and when they ate only half, they tipped the remainder back into the bowl and mixed it up with the fresh food. The staff member had not told the person what the meal consisted of and did not talk with the person while they helped them. They were disrespectful to the person and did not meet their needs.

The infrequency of formal supervision sessions limited staff's opportunities for support and to have their training and development needs assessed. This also restricted the manager's ability to ensure their on-going competence for their roles.

We recommended that the provider consider advice and guidance from a reputable source about best practise regarding the frequency of formal supervision sessions for staff.

At this inspection, we found that the provider had addressed our concerns.

People were supported to have their meals in a relaxed and calm environment. We received mixed reviews about the quality of the food. One person told us, "There's always plenty to eat. It's all nice". Another person told us, "Everything is mushed up. It keeps you alive, that's all I can say. They [staff] do their best, but it's not like home cooking". During the inspection we observed lunchtime on the second floor. We observed staff showing people two different meals available to them, this meant that people could see the meals and then choose what they wanted to have. We found that despite an initial delay in food being provided, people were encouraged to eat their meals independently of staff. Where possible, people were supported to hold their cutlery to eat their meals, however where required staff supported people. The atmosphere was relaxed and staff were observed encouraging people to remain at the table during the meal time. Staff were observed talking to people in a respectful and kind manner. People who received assistance with their meals, were supported in a way that maintained their dignity. For example, staff sat with them at their level and supported them if they had spilt food. Meals looked appetising.

People were supported by staff that reflected on their working practices. One staff member told us, "I find the supervisions helpful. You can talk about things that you're finding hard and the nurse's help you find a way of working though the issues". Another staff member told us, "I have had a supervision in the last month. We talk about my progress and how the floor I work on is doing, staffing and team work. We discuss how we can improve and then we review how things have gone at the next supervision". We looked at staff files and found that all files had supervisions recorded. Supervisions looked at all aspects of staff roles, for example, concerns, safeguarding and whistleblowing, training, achievements made and conduct. Supervisions took place quarterly with a group supervision in between these times. Action plans to respond

to identified concerns or goals were then assigned to staff to complete and addressed at the following supervision.

Good

Is the service caring?

Our findings

At our previous inspection on 18 and 23 November 2015, we found people did not always receive care from people who knew their preferences. Each person had a personal profile in their care record that included a page titled 'What people like and dislike about me' to help staff understand them. However, we found that the profiles were not completed consistently and in one care record, the profile was blank.

At this inspection, we found that the provider had addressed our concerns.

People received care from staff who knew their preferences. One person told us, "The staff know how I like things to be. They know how I like my tea, but they always ask me anyway just to be sure". Another person told us, "Yes, they [staff] know how I like things done." Staff were aware of people's preferences however these were not always recorded clearly in the old style care plans. New style care plans recorded people's wishes in relation to the care they received. For example, in one care plan it detailed that a person preferred to have two care workers support them with self care and did not mind what gender they were. Other examples included people's preferences in what they liked to be called, food they liked to eat and what they liked to do during the day. This meant that staff were able to meet people's needs in line with their preferences.

People were treated with dignity and respect. One person told us "Absolutely, they [staff] are very respectful. I couldn't' ask for better." Another person said, "If I do need help, they [staff] keep the doors closed so others can't see when they walk by my room. They [staff] are respectful, can't say otherwise." Staff told us, "You have to treat people with respect at all times. Ask they what they want to have done, don't assume you already know." During the inspection we observed staff maintaining people's dignity. For example, one person wished to use the restroom and staff spoke in a quiet voice, so as to ensure others could not hear their conversation. We also saw staff treating and talking to people with respect. For example, staff were observed talking to people, taking their views on board and listening to what people had to say.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection on 18 and 23 November 2015, we found staff did not consistently record people's preferences regarding activities in their care records. One person's care record stated that their daily activities were, "wandering the corridor" and "lying in bed." We did not find evidence that staff had tried to engage the person in social activities to reduce the risk of social isolation and boredom. This was a concern as the person's social and psychological needs assessment stated that they needed daily stimulation and that they enjoyed flower arranging and gardening. Daily notes did not indicate that they had been offered these activities.

At this inspection, we found that the provider had made some improvements.

The manager was introducing a new care plan format that was person centred and detailed the views of the people. We looked at care plans and found that whilst the new style care plan was more person centred, these were not in place for all people. For example one person's care plan stated their preferences around self care and the number of staff to support them, but it did not document when they wished to receive support. The new style care plans had a 'resident profile', which detailed, 'important things about my life, during the day I like to…, how I tell you what help I need and my personal care needs are….'.

People were encouraged to engage in planned activities, however these were not always representative of their preferences. One person told us, "There's lots of activities to participate in. Sometimes I do and sometimes I don't. I attend the indoor activities, like the choir, jazz bands and animal visits. There's plenty of things to do if you wish." Another person told us, "I don't always want to do the activities. I know I can but today I don't want to, it's my choice". A third person we spoke to said, "They had a jazz band here the other day in the garden. I didn't attend, but I opened my bedroom window and could hear it all. They were really good."

Each unit had an activities plan that was situated on the notice board by the lift. This was not easily accessible to people who did not pass by the lift. The home employed two activities coordinators and was recruiting a third, who arranged activities for people to participate if they chose. Staff told us, "The activities coordinator will visit each unit and remind people what activity is taking place that day. She will ask if people want to join in and if they do we can take them downstairs". Old style care plans did not always document people's preferences in relation to activities, however the new style activities were in the process of being implemented.

Good

Is the service well-led?

Our findings

At our previous inspection on 18 and 23 November 2015, we found people were supported by staff that did not always act appropriately resulting in a negative unfriendly atmosphere. Staff did not always work effectively together and this detracted from the teamwork that is necessary to provide good quality care. We observed a lack of teamwork amongst the staff at the home. Staff did not always speak to each other with respect or appropriately in front of people and their visitors. For instance, whilst lunch was being prepared in one of the dining rooms, staff just outside began arguing loudly over whose responsibility it was to take food trolleys to other floors. The argument escalated until a care worker in the dining room intervened. We also saw examples of staff speaking to each other unkindly and with unnecessary force, including a member of the catering team speaking to a care worker in an aggressive tone in front of people.

At this inspection, we found that the provider had made some improvements.

People, their relatives and staff spoke highly of the manager and the deputy manager. People told us, "He's [manager] fantastic, he comes and checks on me. We get along well and I can talk to him whenever I need to." Another person told us, "He seems very nice. I've not had a great deal to do with him as I don't need to. But he talks to me and seems very pleasant." A relative we spoke to told us the service was much better than it was. They went on to say, "It's the manager and the deputy that have made the difference. I feel confident in the management of the home. I can talk to them if there's a problem, they listen, and then they put it right." Staff told us, "The manager is very supportive, he's made a lot of changes and he's always asking us [staff] how we are getting on and if we need any help". A nurse told us, "He's [manager] really made a difference".

The manager had developed a service that had a welcoming and inclusive atmosphere where people appeared relaxed and at ease. Staff told us there had been an increase in the morale amongst the staff, and felt this was due to the new management style. Throughout the inspection we observed the manager supporting staff and offering guidance. The manager operated an open door policy, whereby people, their relatives and staff could speak with the manager at a time that was convenient to them. One person told us, "He's [manager] always checking on people, you see him walking the corridors to make sure everything is going to plan." One staff told us, "I can speak to him [manager] if I have a problem or a question. He's very helpful and makes time to talk to me."

The provider had processes in place to monitor how medicines were managed, via daily and monthly medicines audits. The supplying pharmacist had also carried out a detailed audit in May 2016, and the Clinical Commissioning Group (CCG) pharmacist also audited medicines. We looked at the completed audits and saw that these were effective in identifying issues with medicines, and the home had taken action to address the findings, so we were assured that issues picked up with medicines were being addressed promptly.