Mr & Mrs C Thomlinson

Tweedmouth House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service
Tweedmouth House is a residential care home providing nursing and personal care for up to 55 people, some of whom are living with dementia, across two units. At the time of our inspection there were 48 people using the service.

People's experience of using this service and what we found
People were safe from the risk of abuse. Risks were assessed and regularly reviewed when people's needs changed. The building was well maintained and had some new fire safety precautions in place.

Medicines were managed safely. The provider employed sufficient staff, staff were trained appropriately and recruited safely. Staff worked effectively with visiting professionals and wore PPE to keep people safe. Infection control measures were in place, and visiting was managed safely.

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.

There was a positive culture. Staff and relatives said the management team were effective. Lessons had been learnt from the last inspection and an action plan put in place to improve. Lots of positive changes had been implemented to ensure people received good quality, safe care.

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 28 June 2022).

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 improvements had been made and the provider was no longer in breach of regulations 12, 13, 18 (Health and Social Care Act regulations 2014) and 18 (Registration regulations 2009)

Why we inspected
We carried out an unannounced focused inspection of this service on 9 September 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, safeguarding and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-

led which contain those requirements.

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 good. This is based on the findings at this inspection.

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

Follow up
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?

Good

The service was safe.

Details are in our safe findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-led findings below.

Tweedmouth 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.

Inspection team
The inspection was carried out by 1 inspector 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.

Service and service type
Tweedmouth 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. Tweedmouth House is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at 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
We gave the service 48 hours' notice of the inspection.

What we did before the inspection
We reviewed information we had received about the service. We contacted the local authority commissioning team and safeguarding team for their feedback about 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 all this information to plan our inspection.

During the inspection
We spoke with 5 people and 12 relatives about their experience of the care provided. We observed interactions between staff and people in communal areas. We spoke with 8 members of staff including the registered manager, deputy manager, nurses, activities coordinator, and care staff. We spoke with 2 visiting relatives and 10 relatives by telephone. We reviewed a range of records. This included 3 people's care records and multiple medication records. We looked at 3 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures, were reviewed.

Good

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 changed to good. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to have an effective safeguarding system in place. This was a breach of Regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

- People were safeguarded from the risk of abuse. Safeguarding incidents were reported to the relevant authorities. Staff had received additional safeguarding training.
- People were receiving support from services such as the behaviour team and mental health specialists following incidents.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to have an effective system to assess, monitor and manage risk. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They had also failed to ensure accurate records were maintained in relation to accidents and incidents was also a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulations 12 and 17.

- Risks to people had been assessed and mitigations put in place. Health and safety assessments had been carried out. Work had been undertaken to improve the fire safety of the building since the last inspection.
- Accidents and incidents were recorded appropriately.
- The management team had learnt lessons when things had gone wrong. Following the previous inspection an action plan had been put in place based on lessons learnt and improvements had been made.

Preventing and controlling infection

At our last inspection the provider had failed to maintain accurate and contemporaneous infection control

records. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● 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 responding effectively to risks and signs of infection.
● 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.
● People were able to receive visitors in line with current guidance. A small café environment had been created for people to spend time with their families. One relative said, "[The service] is strict with wearing PPE."

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 and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. People and their advocates were involved in decisions about their care.

Staffing and recruitment
● There were enough appropriately trained staff to care for people safely. One relative said, "The nurses really know how to nurse, and staff constantly pop their head in to check on [person]."
● Staff were recruited safely, in line with best practice guidance.

Using medicines safely
● Medicines were managed and stored safely. Medicines records were well maintained. Staff had received appropriate training to manage medicines safely and administered medicines to people in a supportive and caring way.
● Medicines audits were carried out regularly. Where issues were identified, action was taken to ensure this did not happen in the future.

Good

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 the rating has changed to good. This meant the service was consistently managed and well-led. Leaders 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; Continuous learning and improving care

At our last inspection the provider had failed to monitor the safety of the home effectively. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had also failed to notify CQC of some incidents. This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009. We are dealing with this matter outside of the inspection process.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulations 17 and 18 (Registration).

- The management team understood their roles. Managers had received additional training in a number of areas since the last inspection including safeguarding.
- Lessons learnt were documented and actions had been put in place.
- CQC had received notifications about incidents in line with expectations.

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

- The provider had created a positive culture. Staff were proud to work at the service and some had worked there for many years. One staff member said, "The management are very supportive, we are a family here."
- Good outcomes were being achieved for people. One person had adjustments put in place to support them when they become distressed. This had resulted them being calmer and more settled at the service.
- Staff treated people kindly, and promoted their independence, this was observed throughout the inspection.

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

- There had been no incidents which required the provider to act on this duty.

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

- People, their relatives and advocates were involved in the service. The menus had recently been changed

based on feedback from people. People had said they wanted to be able to go out of the service more often. An additional activities coordinator was employed specifically to support people going out for walks, to the gym and to the supermarket.

Working in partnership with others

● The management team worked effectively with visiting professionals. We received feedback from one visiting professional who said, "We are pleased with everything Tweedmouth House has implemented."