Heathfield Care Homes Limited

Tudor Lodge Nursing Home

Inspection report

229 Newgate Lane
Fareham
Hampshire
PO14 1AU

Tel: 01329220322
Website: www.nursinghomefareham.co.uk

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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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Tudor Lodge is a residential care home for up to 56 older people, some of whom have dementia. The building offers accommodation over two floors with lift access to each floor. People have access to communal lounge and dining areas, an accessible garden and outside space. There were 52 people living at the home at the time of inspection.

Tudor Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

People were protected from avoidable harm because staff understood how to recognise signs of abuse and how to report any concerns. There were enough staff to provide safe care and recruitment checks had ensured they were suitable to work with vulnerable adults. Staff understood the risks people faced and ther role in managing these safely. The service was responsive when things went wrong and reviewed practices in a timely manner. Medicines were administered and managed safely by trained staff.

Pre-admission assessments included information about peoples' physical, religious, emotional and mental health needs to ensure that these could be effectively met. There were assessments of capacity and decisions made in people's best interests where required. Feedback about the meals and drinks available was positive and where people needed foods prepared in a certain way to eat safely, this was accommodated. Staff received support through supervision and had access to relevant training opportunities to provide them with the correct skills and knowledge for their role.

People were supported by staff who were kind and compassionate in their approach. We observed informal interactions, the use of tactile contact and staff communicating with people in ways which were meaningful for them. People were offered choices about how they spent their time and were supported with respect by staff who protected people's dignity and promoted their independence. Visitors were welcomed whenever they wished to visit and were encouraged to feedback through informal discussions, resident and relative meetings and surveys.

People received person centred care which was responsive to their changing needs and wishes. There were regular reviews of people's care plans and staff were kept up to date with any changes. People were supported by staff to engage in a range of social opportunities which included some group activities, one to one time with staff and a range of visits from external providers. People and relatives were aware about how to raise concerns if needed and where complaints had been received, these had been investigated and

responded to. End of life care was person centred and planned with people to ensure that wishes and preferences were understood and respected.

The service had an open and positive culture. Leadership was visible and promoted good teamwork. Staff spoke highly about the management and had a clear understanding of their roles and responsibilities. Audits and quality assurance processes were effective in driving service improvements. The service understood their legal responsibilities for reporting and sharing information with other services.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good	**Good**
Is the service effective? The service remains Good	**Good**
Is the service caring? The service remains Good	**Good**
Is the service responsive? The service remains Good	**Good**
Is the service well-led? The service remains Good	**Good**

Tudor Lodge Nursing Home

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.

The inspection took place on 14 and 20 November 2018. The first day was unannounced and attended by one inspector, an assistant 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. They had experience in dementia care and care home services. The second day was announced and attended by one inspector.

Before the inspection we reviewed all the information we held about the service. This included notifications the home had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We contacted the local authority to obtain their views about the service.

We had not requested a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We gathered this information during the inspection.

During the inspection we spoke with nine people who used the service and seven relatives. We also spoke with nine members of staff, the registered manager and the provider. We gathered feedback from three professionals who had knowledge about the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at a range of records during the inspection, these included five care records. We also looked at information relating to the management of the service including quality assurance audits, health and safety records, policies, risk assessments and meeting minutes. We looked at five staff files, the recruitment process, training and supervision records.

Following the inspection we asked the registered manager to send us some further details about the training staff received and infection control measures. These were sent to us as requested via email.

Good

Is the service safe?

Our findings

People received safe care and treatment. We observed staff supporting a person to walk using a mobility aid. One staff member was offering reassurance and another followed with a wheelchair in case the person needed this. Comments from people and relatves included "I feel safe here thanks to the staff", "This is a very safe home with lots of people around to support me" and "I have peace of mind now that (peron's name) is here".

People were protected from the risks of abuse by staff who understood the potential signs to be aware of and their responsibilities to report. A staff member explained that they would report anything they saw which they had concerns about and that they would be confident to whistleblow if they needed to. We saw that where concerns about potential abuse had been raised, the home had woked with the safeguarding team at the local authority and shared learning with staff through team meetings.

People were supported by staff who understood the risks they faced and their role in managing these. Care plans included personalised risk assessments which explained the risk and what actions were needed to manage these. Examples included provision and monitoring of pressure equipment for a person who was at risk of developing sore skin, guidance for staff about what foods a person could safely eat, and information about how to safely support someone who had a catheter in place.

Some people at the home had risk assessments which identified that they required bed rails to manage the risk of them falling out of bed. We noticed that some people with bed rails, also had bumpers in place, but others did not. Bed rail risk assessments did not include details about whether people were at risk using bed rails without bumpers or how these decisions had been made. This was important because people could be at potential risk of injuring themselves or becoming trapped by bed rails. We spoke with two staff members who were able to explain how these risks had been assessed. The registered manager advised that they would ensure that assessments for bed rails included details about whether bumpers were required and the reasons for this to ensure that any risks around this were documented.

People were supported by sufficient numbers of staff to meet their needs and call bells were answered without significant delay. The registered manager explained that they had started to monitor call bells and were looking for any trends about times which were busiest. They were also looking to introduce a dependency tool to further consider staffing levels.

People were supported by staff who had been recruited safely, with appropriate pre-employment checks. Staff files included application forms and interview records. Checks with the Disclosure and Barring Service (DBS) were in place before staff started in their role to identify whether staff had any criminal records which might pose a threat to people. Some staff files did not have sufficient evidence of applicants conduct in their previous employment. We spoke with the registered manager about this and they responded promptly by developing a risk assessment which would be used if evidence of previous conduct was not able to be obtained for potential new staff. This ensured that this potential risk was safely managed.

People received their medicines as prescribed. Duty managers had oversight of medicines and were responsible for ordering and auditing medicines. Any medicine errors had been investigated and lessons learnt to prevent them from occurring again. Qualified nurses administered medcines and received training and competency checks. We saw that medicine administration records(MAR) included a photograph and room number for each person to confirm their identity and identified any allergies. Where medicines were prescribed to be taken 'as required' , there were protocols in place and administering staff were aware when people needed medicines which were time specific. Medicines were administered in line with peoples preferences. For example, one person was administered their medicine outside of the normal medicine rounds to reflect how the person had taken their medicine when they lived at home. Nurses knew people and their medical history well.

People were supported in an environment which was safely managed with regular checks on amenities and equipment. Specialist contractors were commissioned to carry out fire, gas, water and electrical safety checks. Regular health and safety checks were also carried out by the provider. Maintenance records showed us equipment, such as fire alarms, extinguishers, and emergency lighting were regularly checked and serviced in accordance with the manufacturer's guidelines. Fire evacuation procedures were in place and each person had a Personal Emergency Evacuation Plan (PEEP) which included details of what support they would need to evacuate the premises safely.

Staff were clear about their responsibilities with regards to infection control and keeping people safe. All areas of the home were kept clean to minimise the risks of the spread of infection. There were hand washing facilities and hand sanitising dispensers throughout the building and staff had access to personal protective equipment (PPE) such as disposable aprons and gloves. Where people needed equipment to assist them to move safely, staff explained that each person had their own equipment to prevent any infection control risks and these were labelled with people's details and kept in their rooms. One person explained "This home is clean and tidy and we are looked after by some good professionals".

Staff understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and report these internally and externally as necessary. Accident and incident records were all recorded, analysed by the registered manager and actions taken as necessary. We saw evidence that learning was shared through staff meetings and also using the electronic care planning system. This ensured that any lessons learned were shared promptly and efficiently to all staff.

Good

Is the service effective?

Our findings

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 Act 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.

Where people were unable to make decisions in relation to specific areas of their care and treatment, assessments of capacity and decisions in people's best interests had been made. MCA assessments were decision specific and included explanations of how decisions had been made.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. Where people required consideration of DoLS, applications had been made to the Local Authority to assess these. The registered manager monitored when authorisations were in place to ensure that further applications were made in a timely manner when existing DoLS were due to expire. They told us that no-one had conditions attached to their DoLS at the time of our inspection.

People were involved in pre-assessments which considered their physical, social, religious and mental health needs before moving to Tudor Lodge. These assessments formed the foundation of people's care plans and identified what support people required and how needs were met effectively.

Staff had the correct knowledge and skills to support people and received relevant training and development opportunities for their roles. People's comments included "I can ask the staff for anything and they are always willing to help me" and "Nothing seems too much problem for the staff". Staff received training in a number of areas which the home considered essential. These included moving and assisting, food safety and infection prevention. In addition, staff received training in topics including dysphagia, positive and proactive care and palliative care. The home was in the process of considering additional dementia training opportunities for staff.

New staff completed an induction and probation period at Tudor Lodge. The induction included time spent getting to know policies and procedures, understanding their role and shadowing more experienced staff. The induction followed the national standards set out in the Care Certificate. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training.

People were supported to have a balanced diet and where people needed foods prepared in a certain way to eat safely, this was accommodated. People had choices about their meals and staff gathered this information for the chef on the day. If people did not want either choice offered, the chef explained that they would make an alternative for the person. We saw that there were enough staff to support people with

meals where this was required and people chose whether they wanted to eat in their rooms, or in the communal areas of the home.

Tudor Lodge used the 'red bag pathway', designed by the National Institute for Health and Care Excellence (NICE) to support transitions for people. The red bag is used to transfer standardised paperwork, medication and personal belongings and stays with the person throughout their hospital episode and is returned home with them. The registered manager explained how they had used this for people and what information and personal belongings they provided to ensure that important information about people was shared appropriately.

People had access to health care services as and when needed. Health professional visits were recorded in people's care files which detailed the reason for the visit and outcome. Recent health visits included; district nurses, GP's and physiotherapy. We observed that details of health professional visits were shared using the electronic care planning system so all staff were aware any treatment plans.

People were able to access both floors of the home using a lift. There was ramped access to the enclosed rear garden so people could access outside space if they wished. People were supported to find their way around the home with pictorial signs. For example, for the toilets, lounge and dining rooms. The day and month were also displayed, along with the weather and season to assist people to orientate to date and time of year. The registered manager explained that people were able to choose the decoration and layout of their bedrooms and we observed that people had personal items including pictures and ornaments displayed in their rooms.

Good

Is the service caring?

Our findings

People, professionals and their relatives told us staff were kind and caring. Comments included "I think the staff all do a good job of caring for our needs", "Staff are marvellous and always checking to see how I am doing", "Staff are always kind and caring in their approach, chatty with residents" and "we actually see (persons name) smiling now which is lovely". We observed staff laughing and informal banter during the inspection.

People were offered choices about their care and treatment and the home was flexible in its approach to ensure that support was person centred. One person explained "I can choose my own times to get up or go to bed". We observed that staff communicated about people's choices throughout the day and that these were respected. Examples included a person choosing to have their lunch in their room and whether a person wanted to get up later in the morning.

Staff communicated in ways which were meaningful for people and we observed that interactions were relaxed and punctuated with moments of laughter. People responded positively to staff speaking with them, staff used tactile contact to connect with people where appropriate. We observed that people appeared comfortable in the presence of staff. One person was celebrating their birthday, several members of staff were observed congratulating them and chatting about their plans for the day.

Staff were respectful of people's privacy and dignity and we observed that they knocked and waited before entering people's bedrooms. For example, one person was being visited by their relative. They politely asked the relative to leave the person's bedroom to enable them to provide the person with intimate care. A staff member explained how they used privacy screens when they were in a shared or double occupancy room with another person to ensure their privacy was respected. One person told us "I am treated with dignity and respect at all times".

Staff did not always use language which was respectful when speaking about people living at Tudor Lodge. We observed a staff member explaining to a person that staff would be in shortly because they were 'doing' another person. Another staff member referred to 'feeding' a person. The registered manager had already done some learning with staff around respectful language and explained that they were continuing to work with staff to ensure that the use of language was consistently respectful.

People were supported to maintain their independence. Tudor Lodge arranged for physiotherapy input for people and we saw that people were supported by staff as recommended by a physiotherapist. For example, there was a recommendation for one person to be supported to walk for a minimum time each day. We observed the person being assisted in this way.

Relatives explained that they felt welcomed when they visited Tudor Lodge and were able to come whenever they wished. Staff encouraged people to receive visitors in a way that reflected their own wishes and cultural norms, including time spent in privacy. Feedback was positive and comments included "family can visit at any time and if I want to go out the staff are always willing to help me" and "We can come in

whenever we want and we are welcomed". Communication with relatives was good and we saw examples of relatives being updated in person and via email.

Good

Is the service responsive?

Our findings

Care Plans were person centred and included details of peoples likes, dislikes and how they wished to be supported. There were summaries in place which provided staff with an overview about that person and electronic care plans were holistic, covering areas including spiritual and cultural needs, communication, dietary and physical needs. Reviews were carried out regularly and where changes were required to people's care, these were recorded.

Communication between staff was effective and meant that staff could be responsive to people's changing needs. A staff member explained that they had regular handovers and that where people's needs had changed, they were alerted immediately using the electronic care planning system. Staff explained that this enabled them to stay updated about people's changing abilities. One staff member told us "We have handover and get updates……..there is a red bell(alert on the electronic care planning system) for anything important". One person had suffered a number of falls, after analysing the accident and incident records it was identified that the person was at increased risk at a particular time of day. Staff were updated and ensured that this person was supported at an earlier time. This had reduced the persons falls.

People had calls bells available to ask for staff assistance when needed and other technology was used by staff to alert them if a person got up to walk, if they were at an identified risk of falls. Where people spent time in communal areas of the home, they had portable call bells to call for assistance if needed. We saw these in place as described.

People had access to a range of social opportunities at Tudor Lodge. There was an activities co-ordinator who worked during the week and the registered manager advised that they were planning to implement some weekend activities staff also. There was a weekly planner to let people know what was available and people had input into the choices. For example, some people had asked about having films to watch and the home had arranged regular film afternoons. Where people did not wish to participate in any group activities, one to one time was available to spend time as people wished. For example, staff regularly offered manicures with people in their rooms. A relative explained "There's plenty going on here, (name) is looking forward to this afternoon and watching a film with snacks and drinks".

People's spiritual and cultural needs were understood and respected. One relative explained "someone from the church comes in which is important to (persons name)". Care plans included whether people had any preferences and what support they needed to meet these. The local church visited regularly to hold services at the home.

The service promoted Equality Diversity and Human Rights (EDHR). Staff had received equality and diversity training. The registered manager explained that they treated everyone equally and advised that if any issues were raised they would address these.

The service met the requirements of the Accessible information Standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information

they can understand, and the communication support they need. People's communication needs were assessed and detailed in their care plans. This captured the persons preferred methods of communication and how best to communicate with them.

People and relatives told us that they would be confident to raise any concerns if they needed to and felt that these would be listened to and acted upon. There was a complaints procedure in place which included details about how to complain and timescales for complaints to be investigated and responded to. We saw that where complaints had been received, these had been recorded, investigated and responded to and outcomes recorded. People's comments included "I only have to talk to the staff if I have any concerns and they deal with it straight away" and "I feel I can talk to anyone about anything and I am listened to."

People were supported with end of life care and preferences were recognised, recorded and respected. Care Plans included any end of life medical decisions and staff ensured that these were understood and followed. One compliment received from the relatives of a person who had received end of life care said 'The last few months at Tudor Lodge was (person's name) happiest times. (name) loved being there and in your care. We did not have to worry to much about (name) which helped us to know (name) was in safe hands'.

Good

Is the service well-led?

Our findings

Tudor Lodge had a registered manager in post. 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.

Feedback was consistently positive about the registered manager from people, relatives and staff. The registered manager shared an office with the deputy managers and explained that they had moved their office to the front of the home, by the entrance. This ensured that the management of the service were available and visible. Comments included "I feel the home is well managed and run" and "I am quite happy with how this home is being run".

Staff understood their roles and responsibilities within Tudor Lodge. The registered manager was supported by deputy managers and a nurse support manager. Staff were able to explain their roles and how they would escalate any concerns they had about people and share information using the electronic care planning system. Comments from staff included "I feel like everybody works well as a team, the nurses check on each other and the carers are really good. There is good camaraderie and the carers respect the nurses" and "We have a lot of fun and we help each other a lot".

Staff felt that the service was well led. Examples included the on call rota which staff told us was responsive, supportive and flexibile when staff needed to change their working hours or patterns and offering training opportunities which were relevant to people's needs. Several staff told us that they were proud to work at Tudor Lodge and gave examples of why. These included promoting individuality, providing good end of life care and the activity programme which was provided for people.

Tudor Lodge worked to build community links and gave examples of improvements they had made or were planning to make at the service. The service held fundraising events to support a local childrens football club and also raised money for national charities. They had developed the social opportunities available to people since the last inspection and planned to further develop activity options at weekends for people.

People, relatives and staff were involved and encouraged to feedback about the service through informal discussions, meetings and surveys. Examples of changes included implementing film afternoons with films people had chosen, providing freshly made cakes with people's afternoon tea and implementing a suggestion box which was in place in the reception area of the home.

Some relatives had used internet systems to provide feedback about Tudor Lodge. Comments included 'Excellent person centred care…..They(staff) really take the time to get to know the person and their family', It's everything you would want for your loved ones…everyone that works there deserves a pat on the back' and 'you(staff member name) really do an amazing job as you all do(staff) at Tudor Lodge'.

The service worked in partnership with other agencies to provide good care and treatment to people. We

saw evidence of staff working with a range of other professionals and saw that advice and guidance was regularly sought from external agencies including the Local Authority, GP's and the Clinical Commissioning Group. The registered manager explained that they involved the Local Authority early if they had any concerns or queries so that they would work in partnership

The registered manager had spoken with staff about the new General Data Protection Regulation. This is a legal framework that sets guidelines for the collection and processing of personal information of individuals within the European Union. This means that people at the home will have more say over the information that the home holds about them.

The registered manager understood the requirements of duty of candour that is, their duty to be honest and open about any accident or incident that had caused, or placed a person at risk of harm. They would fulfil these obligations where necessary through contact with families and people. We saw examples of this during our inspection.

Quality monitoring systems and processes were in place and up to date. These systems were robust, effective, regularly monitored and ensured improvement actions were taken promptly. Audits covered areas such as call bell response times, infection control, care planning and medicines. Where actions were required, these were recorded and acted upon.