Margaret Homes Limited

Tudor Manor

Inspection report

2 Brook Street
Stourbridge
West Midlands
DY8 3XF

Tel: 01384379165

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Tudor Manor is a residential care home providing personal care for maximum of 22 people. The service provides support to people aged 65 and provides dementia care to individuals. At the time of our inspection there were 20 people using the service.

People's experience of using this service and what we found
Risks to people were not continually assessed and mitigated. Fire safety practices were not robust. There was a lack of oversight and monitoring of daily care. Safeguarding concerns were not consistently escalated to external professionals. Systems and processes to safeguard people from the risk of abuse were not embedded in the home. .

Staff were not recruited safely, safety checks carried out on individuals employed by the home were not carried out to ensure vulnerable people living in the home were safe.
There were infection control measures in place, however we were not assured the provider had considered shielding and social distancing rules, when people shared bedrooms. Accidents and incidents were recorded but not analysed for themes and trends. People received their medications as prescribed. Relatives were encouraged to visit their loved ones.

The provider lacked understanding around the Mental Capacity Act, we found that people were not correctly assessed for their mental capacity, meaning decisions people could make were unclear. Care records lacked personal characteristic and information about how to support people with specific health needs. We found people who were receiving respite care did not have a care plan in place.

Staff training records showed gaps in mandatory essential training, meaning staff were not fully trained.

Staff worked with external professionals to promote a partnership approach to care. However, staff did not always escalate concerns in a timely manner. The service had not been adapted to meet people's needs and lacked person centred detail.

People were supported to eat and drink and told us they enjoyed the food. People had choices in the food they ate and could change their mind and have alternative meals.

Improvements were needed to ensure people's end of life documents were up to date and reflected their wishes. The provider did not always explore the most effective way to communicate with people.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement 11 February 2022.
At our last inspection we found breaches of the regulations in relation to good governance. The provider completed an action plan after the last inspection to tell us what they would do and by when to improve.

At this inspection, we found the provider remained in breach of regulations.

Why we inspected
We received concerns in relation to the management of the service and people's safety. As a result, we undertook a focused inspection to review the key questions of safe, effective, responsive, and well-led..

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

We have found evidence that the provider needs to make improvements.
Please see the safe, effective, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We have found breaches in relation to safe care and treatment, safeguarding people from abuse and improper treatment, need for consent, fit and proper persons employed and good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is inadequate and the service is therefore in special measures. This means we will keep the service under review and will re-inspect within six months of the date we published this report to check for significant improvements.

If the registered provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question, we will take action in line with our enforcement procedures. This usually means that if we have not already done so, we will start processes that will prevent the provider from continuing to operate the service.

For adult social care services, the maximum time for being in special measures will usually be 12 months. If the service has shown improvements when we inspect it, and it is no longer rated inadequate for any of the five key questions, it will no longer be in special measures.

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 was not safe. Details are in our safe findings below	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Tudor Manor

Detailed findings

Background to this inspection

Inspection team
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 three inspectors 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
Tudor Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and we looked at both during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return. 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 reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used this information to plan our inspection.

During the inspection
We spoke with 2 people, 11 relatives about their experience of the care provided. We spoke with 6 members of staff, including the nominated individual, carers, domestic staff and the chef. We spoke with one visiting professional who was a social worker.

We reviewed a range of records, this included 3 people's care records and multiple medication records. We looked at 5 staff files in relation to recruitment and supervision. We reviewed a variety of records relating to the management of the service, including policies and procedures.

The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Inadequate

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 inadequate.

Inadequate: This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk from abuse

- Risks to people were not consistently assessed, nor measures put in to place to mitigate the risk to people.

- During the inspection we identified the call bell system on the second floor was not working correctly. There were people on the floor who were nursed in bed and required assistance to mobilise. This put people at risk of not receiving support in a timely manner. We also identified the call bell in the toilet on the second floor was not working. This was rectified following the site visit.
- Relatives told us the call bell buzzer was not always in reach. One relative said, "Often the buzzer is out of [Person] reach." Another relative told us, "When I visited the call bell was not in reach of [Person]."
- We identified concerns around fire safety practices. The last fire risk assessment had been completed in 2021 and identified actions, these had not been followed up at the time of inspection. The policy outlined fire evacuations should be undertaken every 12 months, an evacuation had not been carried out since 2021.
- We found 2 peoples personal emergency evacuation plans contained incorrect information about where they would be located during daytime hours. These documents were updated following the inspection.
- The entrance to a fire door on the second floor was blocked due to an armchair being placed in front of the door. This placed the people in the home at risk in the event of a fire. We raised this with a staff member who removed this immediately.
- We identified 3 people who had diabetes. For 1 person, there was no care plan or risk assessment in place and no guidance for staff to follow to support the person with this condition or in the event of an emergency. The other person's care plan outlined staff should take their blood sugar readings daily. The recording of the was inconsistent and contained several gaps. The remaining person had a basic care plan in place; however, it did not outline what steps staff should take in the event of an emergency.
- We identified 1 person who self neglects and was resistant to personal care. There was no care plan or risk assessment in place for staff to follow when supporting this person. This meant that the person was at risk of isolation and did not have their care needs met.
- One person displayed inappropriate behaviours. There was no care plan, risk assessment or monitoring sheets in place for this. However, a care plan and risk assessment were put in to place following the inspection outlining that staff should record incidents of inappropriate behaviour and escalate concerns when necessary.
- People who require skin protection care were not always receiving timely repositioning. 2 people who required regular repositioning to prevent skin damage had inconsistent records and gaps were present. We

could not be assured that people were receiving the appropriate repositioning care.
● Bowel monitoring in the home was inconsistent and left people at potential risks. We identified 5 people who required bowel monitoring. The records highlighted long periods where people did not have any bowel movements. There was no evidence monitoring of bowel charts was in place or that this had been escalated to relevant professionals to ensure people's health was not impacted.
● We found hazardous substances were not always stored correctly. No risk assessments on cleaning products used in the home had taken place. Several people at the home lived with dementia and this posed a high risk to them.
●Systems and processes in place to safeguard people from the risk of abuse were not effective. We identified 4 incidents where people had sustained harm that had not been reported to the Care Quality Commission or the local safeguarding team. We raised this during the inspection, the nominated individual submitted past notifications we had identified as the inspection took place.
● Staff knew how to recognise and report signs of abuse. However, this was not always reflected in practice as not all incidents were reported to the appropriate agencies.

We found no evidence people had been harmed; however, the provider had failed to assess, monitor and mitigate risks to people's health, safety and welfare. This was a breach of regulation 12 (1) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found no evidence people had been harmed; however, the provider failed to ensure service users were protected from the risk of abuse and improper treatment. This was a breach of regulation 13 (1) (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff were not recruited safely, this put people at risk of receiving care and support from unsuitable staff.
● At the last inspection we found references were not always sought from the applicant's last employer and there were gaps in employment history. At this inspection we found improvements were still needed. One staff file contained no references and for further staff member only 1 reference had been sought which was not in line with their recruitment policy.
● One staff member had commenced work prior to their DBS certificate being returned. Several staff members had used their DBS from previous employment, staff had not signed a declaration to indicate the information remained accurate nor had a risk assessment been completed. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● There was no staffing dependency tool in place to enable the provider to determine how many staff were needed on shift to meet people's needs. However, during the inspection we did not observe people waiting long periods of time for care and support.
● One relative said, "Staffing issues seem to be an issue." Another relative told us, "No, there is not enough staff. I visit mainly on the weekends.
● We discussed staffing levels with staff. One staff member said, "I suppose we could do with one more staff member." Another staff member told us, "There's not enough staff." We discussed this with the provider who told us they would be adding an additional staff member on each shift.

We found no evidence people had been harmed; however, the provider had failed to implement robust recruitment processes. This was a breach of regulation 19 (1) (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● People received their medications safely and as prescribed.
● There were gaps in recording of the medicine's fridge temperature, and we were unable to locate records following the 18 July.
● There were two people who were prescribed thickener for their drinks to assist them with swallowing difficulties. Drinking thickened liquids can help prevent choking and stop fluid from entering the lungs causing aspiration. During the inspection we identified 2people were sharing a container of prescribed thickener despite each person having their own prescription for thickener.
● At the last inspection we found there were no protocols in place for 'as required' medication. At this inspection improvements had been made and protocols were in place.

Preventing and controlling infection including the cleanliness of premises
● We were not assured that the provider was preventing visitors from catching and spreading infections. The provider had not considered the risk to visitors in instances where people shared bedrooms.

● We were not assured that the provider was meeting shielding and social distancing rules. A number of people shared bedrooms and they did not have risk assessments in place to outline what measures should be taken in the event of an outbreak.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● People were supported to maintain contact with their loved ones. ●
During our visit to the home we saw many relatives and friends of people coming and going throughout the day.
Learning lessons when things go wrong
● Accidents and incidents were recorded, however lessons learnt were not evidenced or seen to take place following an incident. This did not mitigate the risk of incidents reoccurring. We discussed this with the provider who told us going forward they would analyse accidents and incidents and complete lesson learned.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection we have rated this key question requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 MCA.
When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The provider lacked an understanding around the Mental Capacity Act which posed a risk that people's rights may not be upheld.
- A DoLS application had been made for two people without evidence of decision specific capacity assessments or best interest's decisions being completed. This put people at risk of being deprived of their liberty unlawfully.
- We identified two residents that shared a bedroom, their care records outlined they lacked capacity. No best interests' decisions had been completed to support this.
- We observed staff members entered people's bedrooms without knocking and seeking their consent on several occasions.

We found no evidence that people had been harmed however, the provider had failed to ensure care and support was being provided with the consent of the relevant people. This was a breach of regulation 11 (Consent to care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were not continually assessed.
● We identified 1 person who had moved into the home several weeks prior to inspection. At the time of inspection, this person did not have a care plan or any risk assessments in place. This person's cultural needs had not been considered to try and understand their personal preferences. We discussed this with staff who had limited knowledge of the person.
● Care plans lacked personal characteristic and information about how to support people with specific health needs such as diabetes.

Staff support, training, skills and experience
● Staff were not fully trained. Gaps in training records were identified. The provider told us they were working towards ensuring all staff had mandatory training and would be embedding a continuous learning approach.
● Staff told us they felt supported by the management team.
●Staff told us they had noticed a positive change since the new nominated individual had taken over in May 2023. 1 staff member told us, "Things were not good and had become run down, since [person] has come in they are improving".

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff worked with other external professionals to ensure people received a joined-up approach to their care. However, they did not always escalate concerns to external professionals in a timely manner or consistently follow the advice given.

Adapting service, design, decoration to meet people's needs
● The service had not been adapted to meet people's needs.
● The environment was not dementia friendly. There was no signage to assist people to navigate their way around the building. A staff member told us improvements were planned. Here I would put after feedback the nominated individual and registered manager had signage implemented.
● The structure of the building made mobilising difficult for people with mobility needs. Corridors were narrow and we found some peoples rooms to be small in size.

Supporting people to eat and drink enough to maintain a balanced diet
● People received support to eat and drink.
● There was a menu in place which people used to select their preference for breakfast, lunch and dinner. People told us they were offered alternative meals if they didn't want meal choices on the menu.
● Relatives told us people enjoyed the food. One relative said, "The food looks to be ok; people seem to like it." Another relative said, "The food is really good."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection we have rated this key question requires improvement.

This meant people's needs were not always met.

Planning personalised care; End of life care and support
- People did not always receive personalised care.
- Care records lacked detail about people's needs and preferences. Improvement was needed to ensure these were detailed and person-centred documents.
- Improvements were needed to ensure people's end of life documents were more detailed and person centred.
- The end-of-life care plans we reviewed related to a different service. Therefore, the guidance available to staff and people's wishes were no longer appropriate.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
- 1 person at the home did not speak English. There was no communication care plan in place to guide staff how to effectively communicate with this person. The provider had not explored alternatives such as producing information in different languages or pictorial cards. Another person did not always communicate verbally. Staff demonstrated they knew how to communicate with this person; however, this was not outlined in the care plan.

Supporting people to develop and maintain relationships and to avoid social isolation; Support to follow interests and take part in activities that are socially and culturally relevant
- People were not supported to engage in activities or hobbies. During the inspection we did not observe any activities taking place. We received mixed feedback from staff about people having enough to do. We asked 1 person what their plan was for the day, and they informed us, "don't know, nothing is on". When asked what activities happen, they told us, "We have a hairdresser come in."

Improving care quality in response to complaints or concerns
- Relatives told us they knew how to raise concerns. One relative said, "If I have any issues I will speak to the senior on duty or the manager during the week." Another relative told us, "I know how to complain but I've never had to. "Did the provider have a complaints procedure in place? Did we see that complaints are recorded?

Inadequate

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 we have rated this key question inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection we found more robust governance processes were required to monitor the safety of the service. This was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the provider remained in breach of regulations.

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

- We were not assured the registered manager, or the nominated individual were clear about their roles and regulatory requirements. However, the nominated individual was open and honest during the inspection process and showed enthusiasm to implement new systems and processes and become compliant.
- At the previous inspection we found the provider had failed to ensure there were effective governance systems in place to identify concerns and drive timely improvements. At this inspection, we found no improvements had been made. There were no audits in place to monitor the quality of the service or identify areas where improvements were needed.
- There were no systems or processes in place to monitor the daily care people received. This included audits and oversight of medicines, health monitoring charts and daily notes.
- The provider did not always work in line with their own policies. For example, the fire policy. Following the inspection, the provider sent over evidence to demonstrate action had been taken.
- Reviews of PEEPs were inconsistent. There was no system in place to monitor and update PEEPs when people's needs changed. We identified PEEPs did not clearly instruct staff on evacuating people safely. PEEPs also assumed people would be based in one area of the house during the day, we observed for 1 person they were not in the room as stated in their PEEPs.
- There was no system in place to monitor how long it took staff to respond to call bells. We did not identify any impact as a result of this.
- We identified missing signatures on the cleaning schedule and a two-week period where records stated the domestic staff were off sick. The provider had not identified this issue. We also raised concerns there were no domestic staff on duty of a weekend. We discussed this with domestic staff who did not provide assurances that adequate cleaning took place during the period the domestic staff were off sick and during weekends. Following the inspection, the provider told us they planned to employ another domestic staff member to cover weekends.
- There was no staffing dependency tool in place to enable the provider to accurately assess the number of

staff needed to meet people's needs.
● There was no DoLS tracker in place to provide oversight of people's DoLS applications or expiration dates.
● The provider had no oversight of recruitment. There was no recruitment audit in place to enable the provider to identify when staff files contained missing information.

We found no evidence people had been harmed. However, more robust governance processes were required to monitor the safety of the service. For example, to maintain building safety, and monitor people's day to day care. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care
● The provider did not promote a positive culture.
● There were some systems in place to ensure information about people's needs was shared with staff. Handovers took place daily and there were regular staff meeting. However, we identified 1 person was consistently not included in handover records despite moving in to the home several weeks prior to the inspection. We raised this with the provider, and this was rectified following the inspection.
● There was not a culture of continuous learning. A number of issues that had been identified at the previous inspection had still not been rectified. When incidents and accidents occurred there were no lessons learned.

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 understood their responsibilities towards the duty of candour. However, this was not always acted upon as notifiable incidents were not always reported to the relevant agencies.
● Relatives told us they were generally informed when things went wrong. One relative said, "They will contact me if there's any problems." Another relative told us "The staff have usually informed us of falls after a few hours delay".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider engaged with people using the service, however, improvements were needed to ensure people's feedback was acted upon.
● Surveys had been completed by people and their relatives. However, there were no records to evidence comments had been followed up on and actioned to drive improvements.

Working in partnership with others
● The provider worked with external professionals; however improvements were needed to ensure a consistent approach to this.
● One relative told us, "When [person] is not very well, they contact the doctors and nurses". Another relative said, "They do contact the doctor when needed".

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Failed to provide care and treat with the consent of the relevant person and failed to follow the mental capacity act

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way.

The enforcement action we took:

Issue an urgent notice of decision to impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not always protected from abuse and improper treatment

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not always established and operated effectively.

The enforcement action we took:

Issue an urgent notice of decision to impose conditions

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Failed to implement robust recruitment processes

The enforcement action we took:

Warning Notice