Heathfield Care Homes Limited

Tudor Lodge Nursing Home

Inspection report

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Date of inspection visit:
29 June 2016
30 June 2016

Date of publication:
03 August 2016

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?	Requires Improvement

Summary of findings

Overall summary

This comprehensive inspection took place on 29 and 30 June 2016 and was unannounced.

Tudor Lodge Nursing Home provides accommodation, support and nursing care for up to 56 people, some of whom live with dementia. There were 54 people living in the home at the time of our visit. The home is built on three levels and there is a lift between the floors. There are three communal areas on the ground floor where people can socialise and eat their meals if they wish.

A registered manager was in place. 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.

People told us they felt safe in the home and we saw staff had a good awareness of their needs and any risks associated with these. Staff awareness of safeguarding adults at risk was good and they said they were confident the manager and provider would respond appropriately to any concerns. Safe recruitment practices were in place. Medicines were managed safely. Suitable numbers of staff were available to meet people's needs.

People were cared for by staff who were supported in their work and encouraged to develop their own skills and knowledge. Staff demonstrated an understanding of the Mental Capacity Act 2005 (MCA), however the records of the application of the Act were not clear. CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. The registered manager and staff understood their responsibilities with DoLs. Some DoLS had been approved for people and staff were aware of the people who had a DoLs in place. We made a recommendation about the recording of MCA and DoLS.

People's needs were assessed to ensure they were met. People and their representatives were encouraged to participate in care planning and review. People were able to express their views of the care they received and they were acted upon. People told us they were supported by kind and attentive staff who treated them as individuals and respected their privacy and dignity.

Staff spoke positively of the home and felt the registered manager was open, transparent and approachable. They knew the provider and felt able to approach them if needed. Feedback was sought from people and action taken to address any complaints. We have made a recommendation about recording the outcome and closure of a complaint. Systems were in place to monitor the quality of the service and drive improvement. However, records were not always accurate and clear.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 home was safe.

People felt safe. Medicines were managed safely and staff were knowledgeable of the risks associated with people's care and the action they should take if they were concerned.

New staff only started work after satisfactory recruitment checks had been completed. People were supported by sufficient numbers of staff.

Is the service effective?

Good

The service was effective.

People were cared for by staff who were trained and well supported.

Staff knew the importance of consent and demonstrated a best interests approach when needed. However, it was recommended the provider review the recording of mental capacity assessments and include details of any DoLS and staff actions in care plans.

People's dietary and hydration needs were met. People had access to other health and social care professionals as needed.

Is the service caring?

Good

The service was caring.

People told us they were very happy with the care and support they received. They described Tudor Lodge as home, supported by kind and caring staff.

Staff had a good understanding of people's needs and knew them well. People were involved in making decisions about their care and staff took account of their individual needs and preferences.

People's privacy and dignity was respected by staff.

Is the service responsive?

Good

The home service was responsive.

People were involved in the care planning.

Staff provided care and support which met people's individual, specific and changing needs.

Complaints were managed well, although we recommended the registered manager clearly record the complainants satisfaction with the outcome.

Is the service well-led?

Requires Improvement

The service was not always well led.

Records of people's care and support were not always clear, accurate and up to date. The registered manager had taken some action to make improvements to care records.

The registered manager and provider promoted an open and inclusive culture where people came first. There was a system of audit in place which meant the quality of the service was regularly monitored.

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.

This inspection took place on 29 and 30 June 2016 and was unannounced.

The inspection team consisted of one inspector, a specialist advisor in the nursing care of older people and an expert by experience in the care of older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed previous inspection reports and information we held about the service including notifications. A notification is information about important events which the service is required to tell us about by law. This Information helped us to identify and address potential areas of concern.

During the inspection we spoke with 12 people and 6 relatives. To help us understand the experience of people who could not talk with us we spent time observing interactions between staff and people who lived in the home. We spoke to the registered manager, deputy manager and the provider. We spoke to 10 staff including nurses, care staff and kitchen staff. We also spoke with the staff of an external activities company that provide support to the home.

We looked at the care records for nine people and the medicines administration records for everyone. We looked in detail at four staff members' recruitment records. We looked at staff supervision records for 12 staff, the training matrix and the staff duty rota for the past four weeks. We also looked at a range of records relating to the management of the service such as accidents, complaints, quality audits and policies and procedures.

Prior to the inspection we gained feedback from a social care professional.

Good

Is the service safe?

Our findings

People told us they felt secure and if they had any worries they would tell the manager. One person said "[they] would come up with an answer."

Prior to our inspection we had received concerns the staffing levels provided were not sufficient to meet people's needs. People said they felt staff responded quickly if they needed them and they would use call alarms to alert staff. Some people wore pendant alarms (these are worn around the neck). The registered manager confirmed a dependency tool was not used to assess the number of staff required to meet people's needs but they discussed this regularly to ensure there were plenty of staff available. The provider also confirmed they were purchasing an addition to the call alarm system that would enable them to monitor more accurately the response times to people's call alarms. Rotas seen reflected a consistent level of staff was provided. Observations demonstrated staff responded quickly to people's needs and requests, and had time to spend with people.

The provider took steps to protect people from risks including those of avoidable harm and abuse. The manager and staff were aware of the types of abuse, what to look for and how to report them if they had any concerns. Staff were confident any concerns would be reported by the manager to the appropriate external authorities but were confident to do this themselves if needed. Training was in place to maintain staff's knowledge about safeguarding. Suitable procedures and policies were in place for staff to refer to, including a whistle blowing policy, which staff told us the registered manager and provider reinforced.. The registered manager held records of any safeguarding matters which demonstrated they investigated these and took appropriate action where needed.

Staff had a good knowledge of the people they supported. Risks to people's safety and wellbeing were known by staff who could describe how these were managed. For example; for one person who had a diagnosis of diabetes, staff were able to talk to us about how this was managed. Records showed they were visited by other professionals who assisted to ensure any physical risks associated with this condition were minimised. A second person was a high risk of falls. A falls risk assessment and mobility care plan were in place which staff were knowledgeable of. An alarm mat was in place to alert staff when this person moved. Accidents were being monitored and the nurse told us they had requested a follow up visit from other professionals and were considering the need for a referral to the falls clinic. Staff advised that following previous incidents, hip protectors were tried however the person removed these, saying they were uncomfortable. A third person was at risk of skin breakdown, their care records contained information about how this risk could be minimised, using specialised equipment, creams and regular repositioning. We saw their pressure relieving mattress was set correctly and was monitored daily by staff. Staff were knowledgeable of this person's needs. They were able to tell us that the person only liked to lie on their right and backside. Records of their positional changes were up to date and we saw that hydrating creams and barrier creams were being used to ensure help prevent any skin breakdown.

Medicines were stored safely in a locked area. Medicines Administration Records (MAR) were up to date with no unexplained gaps or errors. The MAR held information regarding allergies, date of birth and a

photographic identification of people. Storage of medicines was safe. Records were kept of room and fridge temperatures. Liquid and topical medicines which had been opened were dated with the date of opening.. Observation showed the safe administration of medicines by staff. People were prescribed when required (PRN) medicines and protocols to guide staff on when these medicines may be required, their use and possible issues associated with using the medicine were in place. Where medicine errors had occurred, the registered manager had reported these appropriately. Immediate action had been taken to ensure the safety of people and learning from these incidents were shared across the staff team.

Recruitment records for staff contained all of the required information including references, an application form, identification and Disclosure and Barring Service (DBS) checks. These checks help employers make safer recruitment decisions and help prevent unsuitable people from working with people who use care and support services. People could be confident that they were being supported by staff who were safe to work with adults at risk.

Good

Is the service effective?

Our findings

People spoke highly of staff. They felt they were well supported by staff who were knowledgeable. They described the food positively and consistently told us how they were able to make their own decisions.

Staff were supported to obtain and maintain the skills needed to provide care and support to the standard required. They said they received relevant and timely training and had supervision meetings, which they described as helpful to their role. We saw records of staff supervisions which enabled staff to talk about any concerns they may have and receive feedback from the registered manager. The registered manager told us not all staff supervisions had taken place but they had plans in place to complete these. They also advised annual appraisals had not been completed but they intended to complete these by December 2016. Staff confirmed they felt comfortable to make suggestions, felt well supported during supervisions and were able to approach any member of the management team at any time. Regular training was provided in mandatory areas including safeguarding, mental capacity, moving and handling and fire training. New staff who did not have a health and social care qualification were supported to undertake the care certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Staff told us there was always "loads" of training and they just had to ask if they wanted anything extra.

The Care Quality Commission monitors the operation of Deprivation of Liberty Safeguards (DoLS). 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.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At this inspection we checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff demonstrated an understanding of the need for consent. They had a basic understanding of the Mental Capacity Act 2005 and were able to tell us how this related to people's ability to make decisions. People's ability to make decisions and provide consent was understood by staff. Staff supported decision making and undertook a best interest process but the records were not clear.

Where they were able to some people had provided either verbal or written consent to the sharing of information and the use of photographs. They had also either confirmed verbally or signed to their involvement and agreement of their care plans. However, where people were able to provide this consent verbally but not able to sign, a relative had also signed the consent form. Whilst the records appeared to

show a family member providing consent, we observed this person was completely involved in making decisions about their care and support. Staff used alternative methods of communicating with the person and respected the decisions they made.

Where an application for a DoLS had been submitted an initial assessment of capacity had been undertaken. However, the registered manager confirmed when they resubmitted these applications because they had expired, they had not recorded a further capacity assessment had been undertaken.

Other capacity assessments had been undertaken for people but these were quite general and not specific to a particular decision. For example, they covered all aspects of care and treatment. They also did not record any best interest discussion and agreement to care planning. However, people and their relatives were very clear that they were involved in decisions about their care and treatment. They advised their decisions were respected and where required, included in the care plans. Staff told us they always listened to what people wanted and allowed them to make their own decisions. Care staff said if they were concerned about the decisions people were making they would discuss this with nursing staff, who would then talk to other relevant people, including relatives.

The registered manager and staff understood their responsibilities of the Deprivation of Liberty Safeguards. Applications had been made to the supervisory body for some people. Where these had been authorised it was clearly documented on the staff handover sheets and staff knew about these. However the records of these were held in a file separate to the care file. The care files did not contain information about the DoLS, what this meant and the actions staff should take. Some DoLS had been approved and staff knew these people.

We recommend the provider review the recording of mental capacity assessments and include details of any DoLS and staff actions in care plans.

People told us they enjoyed the food. Comments included "There's plenty of it and it's well cooked", "It's excellent", "It's very good." Everyone we spoke with told us there was plenty of choices and alternatives. One person said that if they didn't want the meal in the middle of the day they could ask for an alternative later on. Lunch was served quickly and efficiently. The atmosphere was friendly and relaxed. Where needed staff provided support to people to eat their meals but people were also supported to maintain their independence. For example, one person was given a deeper plate with a rim to help them eat their meal. Staff supported people in a friendly manner and encouraged them to eat. Tables were already laid with fabric cloths and serviettes. Wine was available and also water or squash with tea and coffee being offered at the end of the meal.

People had care plans in place regarding their nutrition and hydration needs. These detailed preferences and needs. For example, if a person required a fortified diet, or a soft diet. Staff told us how they checked people's weight monthly and if they were concerned they would do this more frequently. Where there were concerns staff made referrals to the appropriate professionals, including GP's, dieticians and speech and language therapist.

Staff told us how they would access the GP if needed for people. People had access to a variety of health and social care services as required. This included social workers, GPs, dieticians, speech and language therapists, dentists, chiropodists and other specialist nurses. For one person with a particular health condition they were working with an external organisation to ensure the person was receiving the support they needed.

Good

Is the service caring?

Our findings

People spoke highly of the service they received and of the staff. They described staff as kind, caring and respectful. One person said, "It's a very pleasant atmosphere, everyone's very polite, the best home I've stayed in." A second told us, "they [staff] are like little gold nuggets, nothings too much trouble....if I had to leave here it would kill me, it really is my home." A relative told us, "They are caring and friendly and aware of the need for stimulation. They are well geared up for entertainment."

People were treated with kindness, compassion and respect. We saw many positive interactions and people enjoyed talking to the staff in the home. Observations showed staff had a caring attitude towards people. Staff used people's preferred form of address, showing them kindness, patience and respect, often asking if they were OK as they passed by the lounge or called in. When speaking to people staff got down to the same level as people and maintained eye contact. Staff spoke clearly and repeated things so people understood what was being said to them.

Staff were knowledgeable of people's needs and described how they knew peoples preferences, likes and history which enabled them to ensure care was delivered in a way that people wanted . People's preferences were recorded in their care plans and we saw these were respected. For example, one person's care records described how it was important to them to have their windows open. We saw this on both days and the person and their relative confirmed that staff knew them well and ensured their preferences were met.

Everyone told us they were able to express their views and were involved in making decisions about their care. They said staff always asked them before helping and gave them choices. They all said they felt listened to by staff, the manager and provider. One person told us, "they always find time to come and talk to us." People were aware of their care plan and recalled being asked how they liked to be supported. One person talked to us about how they had been included in a discussion about their needs and preferences and said that staff would discuss this with them as their needs changed. The registered manager confirmed formal resident meetings did not take place but they and the provider regularly sat with people and had less formal chats. They and people told us of a discussion with people that had led to arranging a trip. Records were available which reflected the discussions both the registered manager and provider had with people and relatives. Actions were developed where needed. Communication systems were considered to support people to communicate. Staff facilitated communication with one person by use of an alphabet chart and asking lots of close ended questions.

Our observations saw staff consistently demonstrating respect for people's privacy and dignity. Most people told us they chose to leave their doors open but said that if they wanted to be private and close the door staff would knock on the door and call out before entering. One person said they found it easier to call out to staff through an open door than to use their call button.

People said they were able to make a choice about the staff that supported them and that this was respected. Staff confirmed and our observations showed they respected people's privacy and dignity by ensuring they listened to them and acted on what people said and wanted.

People's religious and spiritual needs were recognised and respected. One person's care records clearly outlined this need and informed staff of the need for this to be supported and respected.

Staff understood the need to respect people's confidentiality and understood not to discuss issues in public or disclose information to people who did not need to know. Any information that needed to be passed on about people was placed in the handover records and discussed at staff handovers which were conducted in private.

We observed staff supporting people in the communal areas of the home and they interacted well with people. Staff explained what they were doing and gave people time to decide if they wanted staff involvement or support.

People were encouraged to remain as independent as possible and people confirmed this. One person who was confused and at a high risk of falls, was encouraged to wash and dress them self independently while staff monitored them discreetly to promote and maintain their independence.

Relatives and friends were able to visit at any time. One relative told us "they look after me as well as they do my [relative]".

Good

Is the service responsive?

Our findings

People spoke of their confidence in staff's knowledge of them and how to meet their needs. They were confident staff would respond if they had any concerns or if their care needs changed. They said they got the help they needed and were able to see a doctor promptly if required.

People and their relatives consistently told us how they were involved in their care planning. One person told us they were given as much control over their care as possible. Their relative confirmed this. The person said they were consulted about the care that was given. Staff knew the people they cared for and the support they needed. They described the care they provided for people which reflected a person centred approach.

Records showed people had been consulted about their needs, wants and wishes which meant their needs were considered in a holistic way. Care plans recognised the need to ensure people were making their own decisions and choices. For example, for one person with a complex health condition, their care records recognised the advantage of using a thickener in their drinks and dietary supplements. However, the records informed staff that this was the person's choice to make. The person had tried the supplements but didn't like these. Staff had tried an alternative which they also didn't like. The person had agreed to drink one a day and staff recorded this.

Care plans were personalised in including the person's likes, preferences and dislikes and we saw these being respected and followed. For example, what people liked to eat and drink, when they chose to get up and go to bed. One person detailed the liquid they liked to take certain medicines with. Another person detailed the outings they enjoyed and other social activities.

Care plans reflected people's needs and we were told by the manager that these were reviewed monthly or sooner if necessary. However sometimes the care plans had not been updated in a timely way to reflect changes in planned care. For example, for one person their care plans regarding their ability to swallow had not been updated. However we saw staff maintained a very detailed handover which was updated as soon as a person's needs changed. These were available to all staff and staff's knowledge of individual's requirements was very good. Staff knew the support this person needed and we observed this being delivered. The detailed handover ensured people received care and support which met their changing needs.

The provider used external activity providers twice a day who engaged with people on a group and individual basis. They spent time with people in communal areas and in their rooms. They spoke to us about how they tried to ensure activities were based around what people wanted to do.
People told us there was always something to do if they wanted to join in. As the activities were undertaken by an external activity provider, records of people's level of engagement and participation were not held at the home. However the activity staff told us they were exploring this.

The service had a complaints procedure. People knew who to talk to if they had a complaint and said they

felt comfortable and confident to do so. No one we spoke with had any concerns. Staff knew how to support people to make a complaint and said they felt confident the registered manager and provider would listen and act on these. Records demonstrated that where the service had received complaints, these were investigated and where required appropriate action was taken.

We recommend the registered manager clearly record the complainants satisfaction with the outcome of their complaint investigation.

Requires Improvement

Is the service well-led?

Our findings

People were complimentary about the attitude of the staff team and the way they all worked together. The service was managed by the registered manager who was supported by a deputy manager, nurses and care staff. The manager and staff team were clear about their roles and responsibilities. The provider was based at the service, visited people regularly and attended staff meetings.

During our inspection we identified a number of concerns regarding the records maintained for people, including poor recording of mental capacity assessments and best interests decisions, timely updates of care plans. and at times risks for people, whilst known by staff were not clearly recorded. For example, people with diabetes had care plans in place but these did not always provide detail about normal blood sugar ranges, signs of complications to look for and action to take to prevent and/or manage complications.

Staff skills and knowledge of people reduced any risk the lack of clear records may have on people, however as the provider was recruiting new staff there was a risk that people may not always receive the appropriate care because the records were not always clear. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a range of information about the home that the provider displayed in the main hallway. The provider displayed a document which identified staff members and their relatives who had been supported at Tudor Lodge. This included a family member of the providers. The provider told us they wanted this to help reassure people that they felt the service met the 'mums test'. To help CQC ensure the right regulatory approach when an inspection is completed CQC consider if a service is good enough for our family. This has been termed the 'mums test'.

A range of audits to monitor the quality of the service were undertaken, including medicines audits. Where these identified any discrepancies, records of the action taken were held and staff described how the learning from these was shared and showed us how things had changed to make improvements following an error.

Systems were effective in driving improvements. Care plans were audited monthly at random to ensure their accuracy. Where actions were identified these were documented and given to the allocated nurse to make the necessary changes. Timescales were also provided. For one person we saw the actions were required to be completed by 4 July 2016. At the time of our visit, some of these had been completed.

The registered manager and deputy manager described how learning from training was taken forward and shared with staff. They told us how they had recognised concerns with their recording of consent following some recent training. As a result they had made changes to consent forms and would be rolling these out. They also talked to us about learning shared from recent care planning training. This had been discussed with staff during May 2016 meetings and tips had been provided to staff. In addition a key worker system had been introduced which encouraged care staff to work with nursing staff to ensure care plans were kept

up to date.

During our observations we saw that the registered manager and provider took an active role in the daily running of the service and had a 'hands on' approach to supporting people who used the service and the staff. Staff confirmed the registered manager and deputy manager were always available if they needed to speak to them. They also told us how they could contact the provider if needed. Staff and people described the management team as approachable, supportive and people who listened to them. All staff felt able to make suggestions. They told us during staff meetings they discussed any changes that were required. They said staff meetings gave them a formal opportunity to make suggestions. Records confirmed this. The registered manager had recognised that some staff may not feel comfortable to open up and make suggestions or raise concerns during the formal staff meetings with the provider present. As a result they had arranged informal drop in sessions for staff which would be held on a monthly basis. These had only just commenced but staff felt positive about these. This approach was positive and enabled the views of people, their relatives and all the staff to be heard, resulting in an atmosphere which was friendly, familiar and person-centred.

The registered manager and staff consistently described the ethos of the home as supporting people to remain as independent as possible and live their life as they chose. It was clear that people were at the forefront of the registered manager and staff's thoughts.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered person had not ensured records were always up to date, accurate and clear. Regulation 17(2)(c)