Tudor Lodge Care Home Limited

Tudor Lodge

Inspection report

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27 November 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection was carried out on 23 November 2017. The inspection was a focused inspection because of concerns received about the service. We looked at Safe and Well Led domains during this visit. We decided to go back to the service on 27 November 2017 to get a full picture and inspected the Effective, Caring and Responsive domains which turned the inspection into a full comprehensive inspection.

At the last inspection on 12 October 2017 the service was overall rated as Good.

At this inspection we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also made two recommendations in relation to good practice. You can see what action we told the provider to take at the back of the full version of this report.

Tudor Lodge is a 'care home'. People in this care home receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Tudor Lodge accommodates up to 44 older people some of whom are living with dementia. There were 40 people living at the service when we inspected.

The service was run by a registered manager and they were present on the days of our visit. '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 and their relatives told us staff were kind and caring and made people feel safe. They said staff had the necessary skills to respond to people's needs, monitored their health and that people enjoyed their meals.

Staff sought and received people's consent to the support they provided and in line with the principles of the Mental Capacity Act 2005. CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The service had made DoLS applications, to ensure that people were only deprived of their liberty, when it had been assessed as lawful to do so

People's needs were assessed and a plan of care was developed which included their choices and preferences, but was not always person centred and accurate.

There was inconsistency in staff practice which meant that people's dignity was not always respected.

People's health needs were assessed and monitored and the service worked in partnership with healthcare professionals to ensure people received appropriate care and treatment. However, there were examples where the provider had not effectively managed and responded to risk.

Medicines were managed safely and people received them as prescribed.

Recruitment practices were robust in ensuring only suitable staff were employed at the service.

Staff training was on-going and plans were in place to ensure they received relevant training for their role. Staff felt well supported both informally and through formal processes such as staff meetings and supervisions.

Management systems were in use to minimise the risks from the spread of infection and keep the service clean, although records did not always support this.

We have made recommendations about the deployment of staff to ensure they are available in suitable numbers to meet the needs of people living with dementia; adaptation to the environment to support independence of people living with dementia; and promoting activities and stimulation to meet the needs of all the people at the service.

Systems to monitor the quality of care were not effective. Potential risks were not always accurately monitored and recorded and records were not always accurate which could result in people receiving inappropriate staff support.

The views of people and their relatives were sought through meetings and an annual survey.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people and the environment were not always assessed and plans not put in place to give staff the guidance to minimise them.

Potential risks to people's health and welfare were not always acted on, or guidance in place followed to ensure people's safety.

Checks were in place so only suitable staff were employed.

People were supported by staff who had received training and understood their responsibilities in relation to safeguarding.

People's medicines were administered by trained competent staff.

Is the service effective?

Requires Improvement

The service was not always effective.

People's nutrition was monitored but they did not always receive the support they required at mealtimes.

People gave verbal consent to care and support. Staff supported people in line with the principles of the Mental Capacity Act 2005 and the requirements of the Deprivation of Liberty Safeguards.

Staff felt well supported and the service was working towards ensuring staff had the skills and knowledge they required for their role.

People had a choice of foods which supported them to stay healthy.

People were supported to access health care as needed.

The design and layout of the service did not always take into consideration the needs of people living with dementia.

Is the service caring?

Requires Improvement

The service was not always caring.

Some staff had built positive and caring relationships with people but this was not consistent throughout the service.

People were not always treated respectfully or supported in a way that was caring and upheld their dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive

People's needs were assessed; the plans of care did not always give accurate guidance to staff about how to provide their care.

There were inconsistencies in people's experiences of being offered meaningful activities.

Any concerns raised by people were responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a lack of oversight of quality which resulted in people receiving inconsistent care.

Quality assurance systems were not always effective in highlighting areas where improvement was needed.

Records did not always accurately reflect people's care and treatment and were not all easily accessible.

The views of people and relatives were sought and acted on.

Tudor Lodge

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 checked 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 was prompted in part by notifications of incidents following which three people using the service sustained serious injury. The information shared with CQC about the incidents indicated potential concerns about the management of risk of falls.

The inspection was carried out on 23 and 27 November 2017. The inspection was a focused inspection because of concerns received about the service. We decided to go back to the service on the 27 November 2017, which turned the inspection into a full comprehensive inspection.

The inspection was carried out by two 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. The expert by experience on this inspection had experience of caring for elderly people living with dementia.

Before our inspection we looked at records that were sent to us by the registered manager and the local authority to inform us of significant changes and events. We also reviewed our previous inspection report. We looked at notifications about important events that had taken place in the service, which the provider is required to tell us by law. We used all this information to decide which areas to focus on during our inspection.

Some people's ability to verbally communicate was limited, so we were unable to talk with everyone. We observed staff interactions with people and observed care and support in communal areas. We spoke with 16 people who used the service and four relatives to gain their feedback of the service. We spoke with thirteen staff, including the operational manager, registered manager, deputy manager, a senior carer, eight care staff and the activities person.

We looked at the provider's records. These included eight people's care records, which included care plans,

health records, risk assessments and daily care records. We also looked at medicines administration records. We looked at the one staff file of a person that had been employed since the last inspection in October 2017, a sample of audits, satisfaction surveys, staff rotas, and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People and their relatives all told us that they felt safe at the service. They said that they felt reassured as there was consistency in staffing and staff knew them and their relatives well. People said, "I feel safe because I know that there is always someone to help not too far away and if I really need help they will come to my aid", "I think I am safe here, but I do worry sometimes that no one will come to me at night. I suppose it is my age as I know there are staff here at night, but sometimes they are not around when I need them", "I have everything I need up here and I can use the call bell if I am worried about anything, that's always a reassurance that I am safe. The staff try to come as quick as they can and if they can't get to me they will check in with me and explain that they will get to me as soon as possible".

People's plan of care contained individual risk assessments in which risks to their safety were identified, such as their risk of falling, when moving around the service, of developing pressure areas, nutrition and continence. However, not all care plans contained all appropriate risk assessments that people needed. For example, for one person who had sustained a number of falls, the risk assessment had not been updated. There was no risk assessment in relation to information that a person liked to take things apart, and no risk assessment in relation to a person harming themselves if they had a razor. For another person there was no risk assessment in place for epilepsy and no information as to what their seizures were like.

Guidance about the action staff needed to take to make sure people were protected from harm was included in some risk assessments. However, there was inconsistency in how any guidance was followed and how effectively people's safety was monitored and managed.

The provider had failed to effectively manage and respond to risks to ensure people received safe care. This was a breach of Regulation 12, (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service's safeguarding policy set out the definitions of different types of abuse, staff's responsibilities and how to report any concerns. Staff had received training in safeguarding and knew how to follow the service's policy to ensure people's safety. All the staff we spoke with were able to tell us about the different types of abuse they may encounter, signs they may see if people were being abused and what they would do about any concerns. Staff told us, "I would go and tell the manager". The registered manager was aware of their safeguarding responsibilities. Referrals had been made to the local safeguarding authority when required and action had been taken to reduce the risks of incidents happening again. One Commissioning Officer from a local authority stated in November 2017, "I feel that they have responded appropriately and have put in further checks/guidelines for staff".

Most people and their relatives said there were sufficient numbers of staff available. They said that there were times when staff were busy and people had to wait a bit longer for their needs to be met, but staff responded as soon as they could. We observed interactions with the staff that were caring but sometimes hurried, for example when transferring a person from their chair to a wheelchair and wheeling the person away before securing their feet on the footrests.

The registered manager told us a specialist dependency tool was used to assess the staffing levels required to meet the needs of people living at the service. On admission each person's needs were rated according to if they were high, medium or low, so staffing could be adjusted accordingly. We found that the dependency tool scores that we looked at in the care plans did not always reflect the needs of the person. For example the overall score was stated as low, but the information in the care plan and what we observed, indicated that the person's needs were higher. The dependency assessment did not take into account the persons medical diagnosis. This was discussed with the registered manager, and on the second day of the visit a dependency score for one person had changed from low to high. The registered manager is currently updating all the dependency assessments, as they had already identified that they did not have enough staff on duty at night.

Most people and their relatives said there were sufficient numbers of staff available. Any shortfall in staff due to holidays or sickness were covered by staff at the service or from one of the providers other local services. On the first day of the inspection there were five staff on duty in the morning and five staff on duty in the afternoon. On the second day of the inspection there were six care staff on duty in the morning and five care staff on duty in the afternoon. We have since been told that the current staffing levels are six care staff in the morning and five care staff in the afternoon. There were three night staff on duty each night; however the registered manager told us that action had been taken following the investigation and outcome of incidents that had led to the night staffing level being increased to four staff each night. We were told that four staff working at night will remain in place until completion of the dependency assessment tool scores and review of staffing levels. The provider told us that they had the option to borrow staff from other services if there was sickness or absence that required covering. However, the rota showed that this had not always happened. On one day in November there were only four staff deployed on shift. Records showed that the registered manager attended for approximately four and a half hours to help staff out, but this level of staff deployment still fell below the staffing levels we had been told about.

We recommend that the provider seeks advice and guidance from a reputable source about effective dependency assessment and subsequent effective deployment of staff.

People were supported to have their medicines safely and in the way they preferred. Medicines were only administered by staff who had been trained and assessed as competent to do so. Medicines were stored in a dedicated room which was organised and clean. We noted on the first day of the inspection that there were cupboards in the room that contained medicines that did not have a lock on the door. The registered manager took immediate action to address this issue, and locks were purchased and fitted by the second day of the inspection.

Records relating to the management of medicines were completed fully and accurately. Alongside people's medicines administration record there was information about how they liked to take their medicines. For example, if a person could take a long time to take each tablet. Staff understood this information and took it into account when planning the order they would give out medicines and how much time they would need. When people had medicines which were given 'as and
when required' (PRN) there were protocols in place. Each PRN protocol gave staff guidance about what the medicine was for, how to know the person needed it, how often it could be taken and the maximum number of doses in 24 hours.

Staff involved in the management of medicines received training at the start of their employment but they were assessed annually to ensure they were competent in the safe handling and administration of medicines as recommended by national guidelines.

Some people were living with diabetes and some of the staff in the service had completed training and competencies with a community nurse to administer people's insulin. We observed a member of staff going to administer insulin medicine to a person. Before they reached the person, they stopped to help another person who was following a recent fall, at risk of falling again. In doing so they put down the medicine on a table in the lounge area. This was discussed with the registered manager who later said that she had ordered red tabards to be worn by staff when giving out medicine in order that the staff person was not to be disturbed during this time. This was to ensure that people received their medicine safely.

The medicine policy had not been updated since January 2016, and the operational manager and registered manager started to update this policy during the inspection. Action was also taken to contact GP's in relation to having homely remedies in the service should a person have a headache and request pain relief, but were not on prescribed pain relief medicine.

Staff had been recruited safely following the provider's policy and procedure. Written references were obtained and checks were carried out to make sure staff were of good character and were suitable to work with people. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Were told that DBS rechecks were not carried out and the registered manager said that she would review and address this issue. There was no evidence in one staff file that the gaps in employment had been explored. The registered manager said the information should be in the file and said she would address this issue.

People and their relatives were satisfied with the cleanliness of the service. Housekeeping staff cleaned surfaces and vacuumed throughout the day. Weekly and monthly cleaning schedules were in place for the communal areas of the service and people's bedrooms. These however had not always been fully completed, and did not provide evidence that rooms were cleaned daily.

Accidents and incidents continued to be recorded and monitored by the registered manager to ensure hazards were identified and reduced. However, not all falls had been recorded in the person's care plan and the associated risk assessment not updated. Appropriate action was taken in response to risks to individual's safety and wellbeing, but not always recorded.

Checks on the premises and equipment were carried out to ensure the service was safe for people and staff. There was a refurbishment plan that detailed work to be undertaken on the lower ground floor in the near future. The registered manager continued to ensure that the environment was safe for people. The premises had been assessed to identify risks and action taken to minimise these. The building had been made accessible for people with mobility difficulties. There was a lift to the upper floors and handrails fitted around the service. The bathrooms were equipped with aids to ensure people's safety. People moved around independently or with assistance from staff. The garden was accessible and secure for people to use safely.

Each person had a personal emergency evacuation plan (PEEP.) Each PEEP gave details about the support a person would need emotionally and physically in the event of an emergency such as a fire. The fire system was tested on a regular basis and regular fire drills were carried out. The registered manager said she had only recorded the names of staff that had attended the fire drills, but would update the form to record what had taken place and any lessons learned. Fire systems were being checked by an external contractor on the day of the inspection, no concerns were identified. The registered manager completed regular audits of the service related to health and safety and infection control. The safety of the water supply and temperature of the hot water was checked weekly. Additional health and safety audits were completed by an external

consultant annually.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us the staff team had the skills and knowledge they required to meet their needs. One person said, "They (the staff) seem to know what they are doing they do get trained you know". People commented about the quality of food and choices available saying, "Breakfast is good, I like the porridge, and then we can have toast as well", "Lunch can be a bit hit and miss, it's warm and it fills you up. Can't complain", "The food is very good I enjoy it, sometimes I have to eat in a hurry but not every day. I don't know why but I think they like to get us in and out to get going with things", and "We have a choice of what we would like to eat for lunch then we have a light meal in the evening, something like a sandwich. I do get hungry when I am in bed at night because we eat early".

People's experiences at mealtimes were inconsistent throughout the service. For some people mealtimes were a positive experience. By contrast some people were not adequately supported at mealtimes. For example, one person was taken from the table half way through their lunch to go to the lavatory. While they were away another person was brought in and put in their place where the person proceeded to use the previous person's cutlery and drink from their cup. When the person returned to the table they were put back in their place with the same now nearly empty drink.

There was a pictorial menu on the wall in the dining room showing the food on offer that day, although this did not show clearly what was on offer for example, the choice of chocolate sponge and chocolate custard seen served at lunchtime was depicted on the pictorial menu as a piece of chocolate cake. It was observed that people were given a choice of two meals for lunch and asked what they would like from a typed list with no photographs or plated examples of what was on offer. Three people we observed being asked did not understand the options and basically the choice was made for them by staff. This meant that people were not being supported to make their preferred choice of food.

When people needed support to eat staff were patient and chatted to people as they helped them to eat. Some people chatted to each other and staff throughout the meal. However, it was reported on the first day of the inspection visit that in one dining area the expert by experience reported 'Lunch was quite a hurried affair and was served, eaten and over almost within half an hour'. This meant that mealtime experience may not have been relaxed and enjoyable for some people.

Staff encouraged people to drink throughout the day offering them a variety of drinks to choose from. When people were at risk of losing weight staff recorded their food and fluid intake each day. Each person had a target amount to aim for and records showed that staff had taken action when people consistently failed to reach their target. Referrals had been made to dieticians and the local speech and language team as required. When advice had been given this was recorded in people's care plans and risk assessments.

The provider had failed to make sure that people's support needs were met at mealtimes. This was a breach of Regulation 9, (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were assessed before they moved into the service. The registered manager met with people and/or their relatives to talk about what support they needed and if the service could provide that level of support. People's assessments were very detailed and contained information about their preferred routines. The information gathered during the assessment was then used to form the basis of the person's care plan. We found in one care plan that the information provided to the service before the person was admitted stated 'history of falls', however this information had not been transferred into the care plan documentation, and it was recorded that the person had since had a several falls.

People's care plans were not always person centred. The registered manager showed to us a revised care plan on the second day of the inspection that was clearly written in the first person and told staff what support the person required. The care plans included details about what people could do for themselves, what support they needed and how they liked that support to be offered. Care plans gave staff guidance about the best ways to support people and details such as the fact that it was important for some people to always wear their make up or have their bag with them were included. When people were living with dementia care plans showed the type of dementia they had and how it impacted on their lives. People had a 'This is me' document in place. This gave information about their life history, favourite smells, tastes, places and music. This information had been used to develop guidance for staff about how to support people when they became upset or agitated. People's care plan gave details about what could make people upset and the best ways for staff to reassure, distract or redirect people. All the components for a person centred care plan were in place, however not all of the information had been completed, and some of the information see did not accurately reflect the current support needs of the person. There were areas within the care plan documentation for people to sign consent, but again these forms had not always been completed. In one care plan there were no consent forms signed in relation to care, photos or social media. The registered manager is currently updating the care plan format that is being used.

People were supported by staff who had the training and support they needed to carry out their role. When staff began working at the service they completed an induction which included training, competency assessments and the Care Certificate. The Care Certificate is a nationally recognised set of standards for care staff. Some staff in the service and the provider's other services had completed additional training in order to be able to deliver training to their colleagues. Training could then be delivered to staff in their induction and the trainer completed a competency assessment before staff worked with people independently.

There was an on-going training programme which included core subjects such as first aid, fire safety and safeguarding. There was an update of the safeguarding training taking place in the service on the first day of the inspection. Staff also completed additional training related to the needs of the people at the service for example, dementia, end of life care and skin viability. Staff told us they felt well supported and that they had access to lots of training. One staff member said, "I think the training we have really helps us to do a good job. It helps us to empathise and understand how things like dementia or diabetes can affect people." Staff had regular team meetings, staff told us they could make suggestions or give ideas at any time. Staff had regular one to one meetings with their line manager. This helped staff to deliver care effectively to people at the expected standard.

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. Staff attended training in the MCA and understood its main principles and how to put them into practice. They understood that people had the capacity to make daily choices and decisions in relation to their personal care and independence, but sometimes they were not able to do so and so made these in

their best interests. Care plans contained assessments with regards to people's capacity to make choices and decisions and indicated when staff may need to act in people's best interests. A record had been made of best interest meetings and decisions. Staff gained people's verbal consent and explained how they were going to support people before giving them their medicines and assisting them to move around the service.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Applications had been made for people who may be restricted in their freedom and these were incorporated into people's plans of care.

The registered manager and staff had a good understanding of the MCA and how it impacted how they supported people. One staff member said, "You have to assume people have capacity, you always have to consider if I explained it in a different way would it make more sense to the person. If people don't understand we know that decisions have to be made in their best interest with people who know them well." The registered manager had applied for DoLS authorisations when required. Staff asked people for consent before supporting them and encouraged people to make decisions for themselves.

People's wellbeing was promoted by regular visits from healthcare professionals. People's social, physical and mental health needs were assessed and developed into a care plan. The service made referrals and sought advice from other professionals, such as a person's GP, district nurse, speech and language therapist, tissue viability nurse and dietician when required, but these were not always followed up.

People living with dementia benefit from an environment which has signage, memory aids and tactile features to help orientate and stimulate them. These needs had not always been taken into consideration in the adaption of the environment. There was a lack of information to help orientate people. There were no distinguishing signs that would assist a person to locate their bedroom, only a small name label and door number that a person may not recognise. There was signage to orientate people to bathrooms and toilets and other communal rooms. The menu and activity timetable were written in words, pictures and photographs, however the picture on the menus did not always reflect the items on offer, therefore some people may be confused about their options. The registered manager told us there had been some intensive refurbishment carried out that included walls being stripped and plastered, new ceilings and new floors laid. There were plans in place to make the corridors dementia friendly, for bedrooms doors to be painted in colours with names and picture boards attached to them so that individuals could easily identify their room. The bottom lounge was in the process of being changed into a team room/library area with the bottom corridor being changed to reflect an outdoor theme leading into the new tea room. This planned work had been started but was not complete at the time of the inspection.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us that the staff were kind and compassionate and they said they felt well cared for. People said, "They (the staff) are all very kind and caring here, every single one of them", "The staff are usually very friendly and helpful", "Someone will always come up here to my room to check on me and will sometimes stop for a chat if they have time. They are all so busy I can't expect them to sit and natter, but it would be nice occasionally when I feel a bit down".

People were supported by staff who knew them well and understood how they liked to be supported. They used that knowledge to anticipate people's needs and encouraged them to do what they could for themselves. As staff introduced us to people they often spoke about the person's previous career or hobbies and interests. People smiled in response and some people began talking about their family and what they enjoyed doing. Staff called people by their preferred names and tailored their interactions to each person. For example, some people enjoyed laughing and joking with staff and others preferred a gentler approach. Staff adapted to each person's needs. Some people chose to stay in their rooms. Staff would wave to people as they passed their door, people smiled and some waved back. Staff engaged with people as they walked through communal areas, asking if people were ok and if they were looking forward to the afternoon activities.

People were mainly treated with dignity and respect. Staff explained to people what was happening and offered reassurance when needed. Staff knocked on people's doors and waited to be invited in when possible. One person said, "This is my home and the staff all respect it as such They will always knock before entering and never enter until I have answered, unless I leave my door open and then they know they are always welcome". However, some people were not treated in a way which respected their dignity. For example, one person spilt food down their clothes, staff did not offer any cover to protect the clothes, and did not offer for them to change their clothes after they had finished their dinner. There were further examples of this. One being in relation to personal care of people's teeth that was discussed with the registered manager; a person talking with the inspector and carer whilst their clothes were not covering the midriff part of their body. The carer did eventually take action to address this, however action should have been taken immediately in order to protect the person's dignity. One relative told us, that mum was dressed in ways that she would never have chosen, although dressed in her own clothes. The relative also mentioned that there were a couple of clothing items in the wardrobe that did not belong to mum. Another relative commented on facial hair, and said that mum was always very particular. It was pointed out by one relative and we observed that some of the linen on the beds was in need of replacement. The registered manager confirmed before the end of the inspection that new sheets had been ordered.

The provider had failed to make sure that people's privacy and dignity was respected at all times. This was a breach of Regulation 10, (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people benefitted from staff that showed concern for their well-being and responded in a caring and meaningful way. People were involved in decisions about their day to day lives and their care. People and

their representatives had regular and formal involvement in care planning and risk assessment if they wished, but again records had not been completed and consent from the person or their representative had not been obtained. Staff promoted people's independence and encouraged people verbally to do as much as possible for themselves. Staff mainly took care to provide care and support at an appropriate pace to meet people's needs, although observation at times showed that the pace was hurried.

Some people who were living with dementia could become distressed. Staff worked together to think of ways they could support people. For example, one person would show behaviours when they were upset which could cause them to harm themselves or make themselves uncomfortable. Staff had introduced a hairdressing mannequin which the person used to express their emotions. This reduced the level of harm and discomfort the person was causing to themselves.

The registered manager had ensured that people's religious and cultural preferences were catered for. Care plans identified if a person followed a certain religion and how they would like to practice. Links had been made with local churches and church groups to support people in following their chosen religion.

Information about people was kept securely in the office and the access was restricted to senior staff. Staff understood their responsibility to maintain people's confidentiality.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives said staff were responsive to people's needs. People said, I really enjoy doing crafts, my fingers won't really do what I tell them, but he (activities co-ordinator) helps me get it done and now I have made this sparkly Christmas card with a little help", "I do get bored and that makes me quite despondent sometimes", "I like activities , it makes the day pass quicker", "The staff are all very approachable and there is always someone I can talk to if I have any concerns", and I cannot complain about the care at all, if I did have a problem with it I wouldn't be here and I would tell someone".

The service provided care for a large number of people living with dementia. Staff knew people well and what was important to them. This was evidenced by the knowledge and understanding they displayed about people's needs, preferences and wishes. The staff were able to tell us how they provided people with care that was flexible and met their needs. For example, they told us how they assisted people with physical care needs, emotional needs and their nutritional needs. They said they also supported people to be able to take part in activities in the community. The staff showed in discussion with us they understood people's dementia and how this impacted on their life.

The service provided a variety of social opportunities for people. There was an activities coordinator at the service. In the morning they spent time with people making cards and chatting. People were engaged, smiling, laughing and encouraging each other to do well. However, our observations showed that during the morning of the first day of inspection only five people participated fully when the activity was making cards. On the second day of the inspection a visiting entertainer provided musical entertainment. People had been talking to staff about the entertainer and how much they enjoyed them singing. People were singing along and got up with staff to dance to the music. People told us it was 'great fun.' The registered manager told us there was a visit planned from one of the local churches on the 7 December and also a carol service was being held before Christmas.

The activities coordinator knew all the people they spoke with by name and knew their likes and dislikes. People were pleased to welcome them when they arrived and they were very kind and caring in the way they spoke with each of them. They said that they also spent time visiting and chatting to people who stayed in their room, on a one to one basis.

However, there was inconsistency in people's experiences of how they were supported to follow their interests. One relative told us that they would like to see a wider variety of activities and stimulation. Our observations showed that staff were caring but task orientated, and people were quite rushed in the task at hand, therefore did not have time to support people with additional activities.

We recommend that the provider reviews the way it provides activities and stimulation so it meets the needs of all people at the service.

Staff continued to help people to stay in touch with their family and friends. For example, we observed relatives freely coming into the service to visit their family member throughout the day. Staff maintained an

open and welcoming environment and family and friends continued to be encouraged to visit the home. Feedback was that people were encouraged and supported to maintain relationships with people who were important to them. Family members said the service was good at communicating with them and keeping them informed of any changes in a person's care.

People told us they felt confident to raise any concerns and felt the registered manager would take them seriously. One person said, "I am fully confident that I can raise any concern whenever it should arise but I can honestly say I have never had to". People and relatives told us they knew how to complain and who to speak to. There was an easy read version of the complaint policy displayed on the notice board and people were encouraged to raise any issues in residents meetings. When complaints had been received, they were responded to appropriately, the outcome was recorded and reviewed for any learning.

People and their family members were asked about any future decisions and choices with regards to their care. This included if they had any religious or spiritual beliefs, choices about where they wanted to be cared for at the end of their life and there was a staff prompt to complete an advance care plan as appropriate. Advance care plans were part of the care plan documentation of the recently admitted people that used the service, but had not as yet been completed. Advance care plans set out what is important to a person in the future, when they may be unable to make their views known.

Requires Improvement

Is the service well-led?

Our findings

The people knew who the registered manager was and called her by her first name. People told us that she was approachable and listened to them. People said, "She (the manager) will help if at all possible", "She (the manager) is genuinely interested in what we want and what we would like", "She (the manager) really does listen and she really does care that is what I like about her. She will nine times out of ten come up with a solution too", "I can speak to the manager or any member of staff whenever I wish to, I just have to pick up the phone or call down and she will come up for a chat and a discussion about my problems or dilemma", and "My husband had too many falls and the decision to move him was not taken lightly and they listened to my views before making a decision".

People, relatives, staff and other professionals were asked for their views about the service. This was done through surveys and meetings. The results of any feedback and changes made as a result was displayed on the notice board. Feedback from the inspection in October 2017 surveys, included, 'We are very happy with the care you give our relative. We are relieved they are so happy and safe,' and 'You take care of people's needs to such a high standard. Your staff are friendly and attentive. My loved one's quality of life has improved immensely since they have lived at Tudor Lodge.' When any issues were raised the registered manager met with people individually to resolve any concerns. People attended regular residents meetings in which they were given information about changes at the service or planned events. They were also given opportunities to suggest any activities they would like and any changes to the menu.

Audits and checks were carried out by the registered manager and the operations manager. For example, the operations manager carried out a monthly check of the service which included, speaking with people and their relatives, checking the premises and equipment, checking records such as accidents/incidents, care plans, risk assessments, medicines, policies and procedures, health and safety and staff training. An action plan was produced following each audit which the registered manager worked through to ensure improvements were made. The actions had been completed in a timely manner. The last audit undertaken by the operations manager was 11 September 2017. The operations manager told us that as CQC had inspected the service in October 2017, they had not completed their own audit. The registered manager carried out a number of checks of the service. They reported the findings to the operations manager on a monthly basis. The operations manager carried out monitoring and checks of all of the services and provided a short report to the provider on a weekly basis to ensure they had some oversight of the service.

Despite the quality monitoring systems in place further improvements were required to drive the service forward to ensure people were receiving safe, effective, caring, responsive and well led care, as we found that some records were not accurate, up to date and consistent in relation to cleaning records, care plans, risk assessments, daily records, and charts etc.

Quality assurance processes had not been successful in recognising all of the issues we identified in this inspection; such as management of risk; person centred care; records in respect of people's care and treatment not always being accurate; staffing levels; monitoring the support people needed at mealtimes; maintaining people's privacy and dignity and adaptation to the environment to promote independence for

people with dementia. The provider had acted in a reactive manner to concerns and issues within the service and amended process, procedures and policies quickly when they had been informed by external parties (such as the local authority and CQC). However, acting in this way showed that the provider was not proactive. They were not carrying out sufficient monitoring and checks of their own to have sufficient oversight of the service and were not considering good practice guidance to inform how the service continuously improves. Therefore, although the service was inspected six weeks ago, the provider had not sustained compliance.

The registered provider failed to operate an effective quality assurance system to ensure the quality and safety of the services provided. Records were not always accurate and complete. This was a breach of Regulation 17, (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had worked at the service for many years. They worked closely with the provider, operations manager and registered managers of the provider's other services. Regular management meetings were held to provide support and opportunities to share learning and good practice. The registered manager also attended local registered manager forums and training provided by the local nursing team. They told us this support and training helped them to look for ways to continually improve the service they offered people. Information from the forums was shared in staff meetings and staff training sessions.

The provider, registered manager and staff team had a shared vision of the service. Their focus was on giving people the life they wanted whilst continually improving the service they offered. Staff told us, "We all work well as a team". Staff said that management team had an open door policy that they felt well supported and their views were listened to. Staff told us they felt valued and appreciated. The provider held an awards ceremony each year where staff could be rewarded for their work and commitment to the service. This year they had included a new 'Putting People First' award which is for a member of staff who had thought of an innovative way to support people or gone the extra mile. There were regular staff meetings where staff had the opportunity to put forward their ideas or concerns.

The registered manager was proactive in keeping staff informed on equality and diversity issues. They discussed wellbeing, equality and diversity issues with the staff team regularly. We observed that the staff group were diverse from various ethnic backgrounds. Staff told us that they all worked well together as a team.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had submitted notifications to CQC in an appropriate and timely manner and in line with guidance.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had conspicuously displayed their rating.

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 9 HSCA RA Regulations 2014 Person-centred care People were not always supported appropriately at mealtimes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated in a dignified or respectful manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to effectively manage and respond to risks to ensure people received safe care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place for assessing, monitoring and improving the service were not robust. People's care and treatment records were not all accurate, or accessible to ensure people received the care they required.