Mrs S C Joyce

Tudor Cottage

Inspection report

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Date of inspection visit:
07 February 2017

Date of publication:
02 May 2017

Ratings

Overall rating for this service	Good

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We completed an unannounced inspection on 7 February 2017 in response to receiving information of concern about the standard of care provided to people at the home. The concerns primarily related to three staff and an agency worker, who had previously worked at the home. This report only covers our findings in relation to these concerns.

We previously carried out a comprehensive inspection at the service on the 17 and 18 December 2015. At that inspection, we found no breaches of regulations. The service was rated 'Good' overall and in each of the safe, effective, caring, responsive and well led domains. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Tudor Cottage on our website at www.cqc.org.uk

Tudor Cottage is registered to provide accommodation with personal care for up to 19 older people, who have become frail, are living with dementia or who require respite or palliative care.

The service has a registered manager. 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.

On 30 January 2017, concerns were first raised to the Care Quality Commission (CQC). They included allegations about poor standards of practice, about attitudes of three staff working at the home and about an agency worker who had previously worked at the home. The person who had contacted us was concerned about the safety and wellbeing of eight people in particular. We raised a safeguarding alert to the local authority safeguarding team about those people. We also contacted the district nursing team who visited the home regularly for feedback, who had no current concerns about the service. Following this, a second person contacted CQC and the local authority safeguarding team with similar concerns. As the concerns included allegations the manager failed to take appropriate action in response to some specific concerns, the safeguarding team contacted the provider and asked them to investigate the concerns.

Most people said they were happy living at the home and felt safe living there and we had no concerns about staff interactions with people when we visited. However, one person we spoke with raised some concerns. The person had told the provider about this, which they confirmed they were aware of.

People knew how to raise concerns and were confident any concerns would be listened and responded to. Staff were knowledgeable about people's care needs, although some areas for improvement were identified in relation to one person's risk assessments and care plans. Staff were aware of signs of abuse and knew how to report concerns.

The provider undertook a detailed investigation and provided a written report to the CQC and the local

authority safeguarding team. They interviewed people who lived at the home and some relatives and staff working at the home including the registered manager. The provider's report showed the investigation was hampered because there was a lack of information about dates and time certain incidents were alleged to have taken place, and a lack of records related to them.

The provider's report showed most people were happy living at the home and had no major concerns. Most staff were also happy working at the home and felt well supported. Most of the allegations could not be proven. Some concerns about an agency worker who previously worked at the home were upheld and had already been reported to the agency that employed them for further action. The report also confirmed a person did not receive breakfast on one occasion. It also identified some misunderstandings and miscommunication within the staff team about practice, which the provider planned to address.

The report showed the provider took the concerns seriously and was committed to learning lessons and making further improvements in response.They planned to meet with staff to discuss the findings of their investigation, and remind them about professional boundaries. They also planned to reiterate the home's safeguarding and whistleblowing policies, through which concerns should be raised. The provider undertook to increase observations of staff practice including their communication and interactions with people. They also planned to offer further staff training and supervision where needed. Other planned improvements included changes to people's individual care records and record keeping systems and strengthening monitoring arrangements.

The local authority safeguarding team have arranged for care managers to visit the home to review the care of some people who live there. Representatives of the local authority quality monitoring team will visit the home and work with staff to support the improvements needed. The local authority safeguarding team confirmed they were satisfied with the actions taken by the provider and have closed the safeguarding investigation.

Although no breaches of regulations were found at this inspection, some areas for improvement were identified. We will carry out a comprehensive inspection at this home within six months to check the improvements have been made and to check on the safety and quality of care people receive.

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

Some aspects of the service were not safe.

Some people's risk assessments did not identify all risks, and did not adequately assess and manage how people's individual behaviours might impact on their safety and wellbeing and that of staff.

People's risk of abuse was reduced because staff knew how to recognise signs of abuse and how to report abuse.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

People were not fully protected because an investigation into concerns highlighted improvements needed in record keeping and in team working.

Most people, relatives and staff expressed confidence in the leadership and management of the home.

Tudor Cottage

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.

An unannounced focused inspection took place on 7 February 2017. An adult social care inspector visited the service. On the day we visited, the provider was also at the home undertaking their investigation.

Prior to the inspection, we reviewed information we held about the home, such as the previous inspection report, and notifications we received from the service. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We met with eight people using the service. We looked at three people's care records and at people's daily records in their room. A number of people living at the service were unable to communicate their experience of living at the home in detail as they were living with dementia. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people, who could not comment directly on their experience.

We spoke with four staff, the registered manager and the provider. We also looked at staffing rotas, and staff meeting minutes. We sought feedback from district nursing services that visited the home regularly and received a response from them.

Requires Improvement

Is the service safe?

Our findings

In response to the concerns we received, we raised a safeguarding alert to the local authority safeguarding team. They contacted the provider and asked them to undertake a full investigation and send a copy of the report to the safeguarding team and the Care Quality Commission. We contacted the district nursing team and spoke to the lead nurse for the home who visited regularly. They said they had not identified any concerns about how staff interacted with people during their regular visits to the home.

Most people we spoke with were happy living at the home. People seemed happy and relaxed around staff who were caring and compassionate. When we asked people, "Do you feel safe here?" responses included; "I feel safe here;" "Oh yes, it's fine, I joke with them all;" and "All extremely good." One person said they had what they needed and that staff came quickly in response to the call bell. When we asked people "Are staff kind?" their responses included; "Very good" and "I don't know anybody unkind here." However, one person raised some concerns which they had told the provider about, and they confirmed they were following up. When people were asked who they would raise concerns with, their replies included the registered manager, provider and any of the other staff.

When we asked the person who contacted CQC whether the issues had previously been raised with the registered manager, they said, "There is no point." They explained this was because they did not think the registered manager would take any action, as they did not think concerns previously raised were taken seriously. They alleged that some staff were concerned about the welfare of people living at the home, but were unwilling to raise their concerns, in case of repercussions.

Staff demonstrated an understanding of what constituted abuse and knew who to contact and what to do if they suspected or witnessed abuse or poor practice. There were safeguarding and whistleblowing policies in place, which gave staff details about how to raise concerns and contact numbers. Under the Public Disclosure Act 2005, whistleblowing policies encourage staff to raise concerns in good faith, without fear of recriminations, and should protect their anonymity. Staff had received safeguarding adults training and one staff said, "Yes, all staff do this about once a year and there is a booklet (questionnaire) when you start at the home."

Two of four staff said they had no concerns about staff practice. One said, "Residents get good care here." However, a staff member highlighted some concerns about how another staff member approached one person who lived at the home. A second staff member said sometimes residents were not always given the opportunity to make all the informed choices they were capable of. For example, that a member of staff was sometimes quite insistent a person had a shower. They said they had raised this issue with the registered manager in supervision, who disputed this. In response to their investigation, the provider made arrangements to work more closely with several staff and deal with any practice issues through increased supervision and training.

We followed up allegations that some people were forced to do things they didn't want to. Staff told us how a person wanted to stay in bed some days. They said, "We keep going in and ask her, try to encourage her. If

she is adamant there is nothing you can do, just pass the information on." Staff also spoke about another person whose behaviours they sometimes found challenging. One said, "It's a case of encouraging him. He was lovely, no problems today. He can be verbally aggressive. You just have to back off; a different face, a different time." Another person's care plan said: 'Staff to persuade (person) to walk a little and often as if she does not this will result in [name] becoming bed bound.' The person's care plan also included a lot of detail about meeting the person's personal care needs, skin care and weight loss. These examples demonstrated staff understood the need to balance people's care needs and risks with their individual wishes.

People had individual risk assessments and care plans instructed staff how to minimise any risks identified. For example, a person had a care plan to guide staff about their emotional wellbeing and anxiety following a recent bereavement. However one person's care record showed they had diabetes, which was not highlighted in their risk assessment, although staff were aware of this risk. We fed this back to the provider for further action.

The provider's report confirmed the registered manager and provider were already aware of practice concerns about an agency worker who previously worked at the home and had taken positive action to address those concerns through further support and training. However, following a further incident, they were no longer employed to work at the home. The provider had also reported their concerns to the agency so further action could be taken.

The report showed most staff were also happy working at the home and felt well supported. Most of the allegations could not be proven. Some concerns about an agency worker who previously worked at the home were upheld and had already been reported to the agency that employed them for further action. The report confirmed a person did not receive breakfast on one occasion. It also identified some misunderstandings and miscommunication within the staff team about practice, which the provider planned to address.

The provider's report showed a person had sustained bruising in the past related to an accident in the bath which was reported and documented at the time and shared with family. However, they said current marks on the person's skin were related to a skin condition. The provider identified the person did not have a risk assessment in place about bathing them although there were behavioural risks and they had equipment needs. They arranged for a risk assessment and care plan to be completed about this. The report highlighted records of bruising and wounds were written in people's daily records, which made it difficult to track them. In response to this, a new 'body map' form was introduced at the service to report, record and monitor any marks/skin tears/ abrasions/ wounds found, so these can be followed up further. This system was already being developed before the concerns were raised, as part of wider ongoing improvements about people's pressure area care and skin integrity.

The provider's investigation did not uphold the concerns about a person's access to their call bell. This was because the discussion to move the person's chair was a 'best interest' decision made with their relative and the person had a pendant call bell. This meant they could call for help from the new chair location.

The provider's report suggested the concerns about shouting at people were related to two people. For one person, this was about managing a person's behaviour that challenged the service sometimes. The provider explained staff had undertaken Managing Challenging Behaviour training, with an emphasis on positive behaviour support. One intervention they were taught to use was a loud voice to raise a person's awareness their behaviour was unacceptable, a technique staff sometimes used with this person. On another occasion staff had been taught a technique to prevent people with behaviours that challenged staff from hitting out. The provider thought this may have been misinterpreted as slapping the person.For a second person, the

provider found staff sometimes raised their voices because the person was hard of hearing, which was dependent on whether they were wearing their hearing aid or not.

Requires Improvement

Is the service well-led?

Our findings

Most people and staff said they had confidence in the provider and registered manager. The provider also spoke with relatives as part of their investigation. The report showed they had no concerns and complimented the high standard of care delivered by staff.

We asked staff about the culture of the home. One said "Team work is generally good." Another said, "I am happy here." When we asked staff what was good about the home, staff said the standard of care was good. One said, "They get good care here." When we asked whether there were any areas for improvement, one staff member suggested the service replaced the activity co-coordinator who had recently left.

The provider said they had an "open door policy." They promoted a culture of being fair, respectful, open, trustworthy, honest and using humour. They encouraged tolerance and a 'no blame' environment and were committed to ensuring this continued. They visited the home each week and spoke to people and any staff on duty. Outside these times staff were able to telephone and e-mail the provider at home which the provider said did sometimes occur. They said, "I try to make it easy for staff to raise a concern at the appropriate level."

The provider worked closely with the registered manager and said they were experienced and they had a high level of confidence in them. They had discussed and reflected on the concerns with the registered manager and on their management style. They said the registered manager was passionate about their role and was keen to improve in response to the concerns raised.

Staff had a daily handover so essential information about each person's care and any changes could be communicated within the staff team. They also kept daily records of each person's care so staff would know what care each person had received. Regular staff meetings were held and minutes showed these were used to discuss people care needs and any concerns.

The provider's investigation identified the service had failed to keep adequate records about certain incidents. Also that individual staff had failed to report a person's missed meal to the registered manager, which they were following up. The report also highlighted a number of areas where record keeping needed to be improved. In response, the registered manager had redesigned the care records in use and staff were in the process of swopping all existing care plans to a new format. They were arranging workshops to introduce staff to new care needs and risk assessment paperwork.

The investigation also highlighted some tensions within the staff team. We followed this up with the provider to ask how these would be taken forward with the registered manager and staff. They said staff enjoyed working at Tudor Cottage but had recently been through a difficult period with changes in the staff team. Some staff acknowledged they got caught up in destructive behaviours within the team and had learnt lessons. The provider planned to do more work with the team to emphasise the importance of staff respecting one another, even if they disagree about issues.

Other improvements planned included starting a 'monthly surgery' by a trainer from another home in the provider group. This will provide staff with other opportunities to raise concerns in confidence. The provider said surgeries would be advertised on the staff noticeboard and would become a regular feature. This practice was already implemented in another home and was working well.

The provider and registered manager planned to meet with staff to feedback their findings and stress the positive outcomes of the investigation. For example, that it had prompted the service to review their systems and make them more robust. The management team were committed to making further improvements and getting staff to work together to get it right. Other development proposals included asking staff to run the staff meetings with support from a representative of the provider external to the home. This showed the concerns were taken seriously and there was a commitment to learning lessons and making further improvements. We will follow these improvements up further at the next inspection.

The provider's report confirmed the registered manager and provider were already aware of concerns about an agency worker who previously worked at the home. They had taken positive action to address those concerns through further support and training. However, following a further incident, the agency worker was no longer employed to work at the home. The provider had also reported their concerns to the agency so further action could be taken.

The service failed to inform the Care Quality Commission and the local authority safeguarding team about a police incident and safeguarding concerns at the home. We have since requested and received a retrospective notification about this.

The local authority safeguarding team confirmed they were satisfied with the actions taken by the provider and have closed the safeguarding investigation. They had arranged for care managers to visit the home to review the care of some people living there. The provider and registered manager have agreed representatives of the local authority quality monitoring team will visit the home and work with staff to support the improvements needed in record keeping and quality monitoring.