Regulation of Care Act 2013

Adult Care Home

Tudor Lodge

Announced Inspection

6 July 2021

Contents

Part 1 - Service Information for Registered Service

Name of Service:
Tudor Lodge Residential Care Home

Telephone No:
676841

Care Service Number:
ROCA/P/0133A

Conditions of Registration:
The number of persons for whom care and accommodation is provided at any one time shall not exceed sixteen (16)

Registered company name:
Emerald Assisted Living Limited

Name of Responsible Person:
Gary Sherwood

Name of Registered Manager:
Mary Callaghan

Manager Registration number:
ROCA/M/0013

Date of latest registration certificate:
23 January 2014

Date of any additional regulatory action in the last inspection year (i.e. improvement measures or additional monitoring):
Monitoring visit – 11 June 2021

Date of previous inspection:
Desktop inspection – 31 March 2021

Person in charge at the time of the inspection:
Mary Callaghan

Name of Inspector(s):
Kevin West

Part 2 - Descriptors of Performance against Standards

Inspection reports will describe how a service has performed in each of the standards inspected. Compliance statements by inspectors will follow the framework as set out below.

Compliant
Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken. In most situations this will result in an area of good practice being identified and comment being made.

Substantially compliant
Arrangements for compliance were demonstrated during the inspection yet some criteria were not yet in place. In most situations this will result in a requirement being made.

Partially compliant
Compliance could not be demonstrated by the date of the inspection. Appropriate systems for regular monitoring, review and revision were not yet in place. However, the service could demonstrate acknowledgement of this and a convincing plan for full compliance. In most situations this will result in requirements being made.

Non-compliant
Compliance could not be demonstrated by the date of the inspection. This will result in a requirement being made.

Not assessed
Assessment could not be carried out during the inspection due to certain factors not being available.

Recommendations based on best practice, relevant research or recognised sources may be made by the inspector. They promote current good practice and when adopted by the registered person will serve to enhance quality and service delivery.

Part 3 - Inspection information

The Inspection report is based on the information provided as part of the pre inspection desk top analysis and the findings of the inspection visit.

The purpose of this inspection is to check the service against the service specific minimum standards – Section 37 of The Regulation of Care Act 2013 and The Regulation of Care (Care Services) Regulations 2013 part 3, regulation 9.

Inspections concentrate on specific areas on a rotational basis and for most services are unannounced.

The inspector is looking to ensure that the service is well led, effective and safe.

Summary from the last inspection

Number of requirements from last inspection:
Six

Number met:
Four

Number not met:
Two carried over

All requirements not met will be addressed within this inspection report

Please note that any requirement carried forward for three consecutive inspections will lead to the service being served an improvement notice.

Overview of this inspection

Due to COVID 19 the inspection process has altered slightly. More information and evidence has been sought from providers electronically. The inspection team have desktop assessed this information and a service visit has then been undertaken to verify the evidence provided.

Tudor Lodge was inspected on the 6 July 2021 by one inspector from the Registration and Inspection Team.

The inspection was announced and was the home's annual statutory inspection.

Tudor Lodge can accommodate up to sixteen people, aged eighteen to seventy-five.

The Home aims to provide a service for people with past or present mental health issues or learning disabilities. Tudor Lodge provides respite care and post-operative convalescence to this client group in order to successfully return home.

Care / support is provided over three floors.

Both the manager and the deputy manager assisted the inspector throughout the inspection.

A tour of the home was conducted and the previous inspection requirements were gone through.

The inspector examined the following as part of this year's inspection:

- Four residents' care records, including care plans, risk assessments
- Medication records
- Fire records
- Infection control
- Staff training records
- Staff pre-employment checks
- Electrical safety
- Water temperatures / Legionella
- Central heating / boiler maintenance
- Resident dependency
- Staffing levels

Two staff members were spoken to. The inspector spoke in general to residents while having a tour of the home.

Feedback was given to management throughout the inspection.

Part 4 - Inspection Outcomes, Evidence and Requirements

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 1 – Introduction, Assessment and Admission
People are confident that the home's information reflects the services practice and that written information is accurate and current. The registered provider is able to clearly establish that the home's facilities and staff can meet the individual's specific needs and requirements. The admission process is planned and people are clear on the terms and conditions surrounding their residency.
1.1, 1.2

Our Decision:
Substantially compliant

Reasons for our decision:
The home's statement of purpose had been reviewed in June 2021. The information described the overall purpose of the service provision and included all of the information set out in Schedule 3 of the registration regulations.

A copy of the statement of purpose was available by the front door of the home.

Four residents' pre-admission assessments were examined. Particular attention was paid to individual's mental health needs in the assessments. As far as possible these were completed in detail by the home. Not all of the pre-admission assessments evidenced involvement of the person being accommodated and a requirement has been made.

Evidence Source:

Observation	✓	Records	✓	Feedback		Discussion	✓

Requirements:
One

Recommendations:
None

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 2 - Daily Living
People are supported to set and carry out their activities and routines in suitable surroundings. The environment is conducive to people's well-being and safety. People live in a home that is safe, warm clean and comfortable. People have access to the aids, equipment and facilities they need.
2.7, 2.10

Our Decision:
Partially compliant

Reasons for our decision:
A call bell system was installed throughout the home. The manager said that the call system had been serviced but the home did not have any paperwork to evidence this check. This was a previous requirement re servicing. Aids and equipment appropriate to the needs of the residents were provided.

If transport is provided by the home then maintenance records must be kept. The manager provided transport for residents in her own vehicle. There was no record of maintenance checks for this vehicle and a requirement has been made. Annual driving licence checks were recorded and motor vehicle insurance was in place.

Four residents' care records were looked at in detail. Individual's going to bed routines were recorded but not their getting up routines. People were able to choose the gender of the person helping them with their personal care and this was recorded. More information was required in one person's care plan regarding prompting to have a shower. Where and when a person liked to eat their meals was not recorded in all the care plans examined. A requirement has been made.

Staff spoken to on the inspection believed that residents were able set their own daily living routines.

Evidence Source:

Observation	✓	Records	✓	Feedback	✓	Discussion	✓

Requirements:
Three

Recommendations:
None

Regulation of Care Act 2013 Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 3 – Daily Support
People are confident that the staff will support them to maintain their health and to support their social and welfare requirements.
3.1, 3.3, 3.6, 3.9, 3.11, 3.16, 3.19, 3.22, 3.23, 3.24, 3.25, 3.26,

Our Decision:
Partially compliant

Reasons for our decision:
Care plans had been written, based on individual's pre-admission assessments. The care plans examined on inspection did not evidence consultation with the resident, or their representative and a requirement has been made.

Individual's medical conditions were recorded in their care plans along with how to support/maintain/improve the condition.

Social, cultural and emotional wellbeing must be factored into the care plans. One resident's care plan lacked information on any social/cultural aspects and a requirement has been made.

One resident required a care plan on behaviour that challenges. This identified any potential behaviours as well as the staff responses to deal with the behaviour.

Not all staff had received training on challenging behaviour and a requirement has been made.
Leisure interests and hobbies must be identified in a person's care plan along with how contact with friends and relatives can be maintained. This information was not consistent across all of the care plans examined. One care plan contained no information on hobbies/interests or maintaining family contact, even though these had been identified on their initial assessment. The other care plans examined contained information on leisure interests but not family contact. A requirement has been made.

Care plans must be reviewed as required, but at least every six months. The care plans seen on inspection had all been regularly reviewed. A new assessment of needs must take place at the same time as the care plan review. Not all of the care records that were examined showed that there had been a new assessment of needs completed. One resident had been identified as being at risk of pressure sores, but this did not feature in their assessment of needs.

The home must also evidence involvement of the resident / their representative when the care plan is reviewed.

Resident risk assessments were examined. Some residents had numerous risk assessments on identified areas of need. One resident had been identified as being at risk of going out alone, but no specific risk assessment had been written on this. Another resident had a medication risk assessment, but the information in this contradicted with the information written in their medication care plan. The home must also evidence consultation and agreement with the resident when risk assessments are written. Risk assessments must be reviewed when a person's needs change or at least every six months. One resident's risk assessments had not been reviewed since November 2020.

Residents' medication was reviewed at least annually. Some mental health professionals reviewed medication each time they saw a resident.

Each resident must have a medication self-administration risk assessment completed to determine if they can manage and administer their own medication. In the care records examined, only one resident had this in place and a requirement has been made.

In the records seen, one resident was administering their own medication. Systems were in place for staff to monitor that the person managed their medication safely and effectively.

Care plans on how a resident was supported to take their medication was in place for some residents, but one person had nothing specific written as to how they took their medication and the support required.

Medication was administered following prescription instructions. Patient information leaflets were kept on all medication used in the home.

Medication was administered by trained staff. Training was completed via eLearning.

Staff competency to administer medication was assessed annually.

The home's medication policy was reviewed in February 2021.

Medication Administration Record (MAR) sheets were examined. These were kept in a file along with a recent photo of each resident. There were no gaps on the MAR sheets. This indicated to the inspector that medication had been dispensed and then signed for by a member of staff when the medication was taken by the resident. Medication stock checks took place each week.

A Pharmaceutical Advisor visit to the home had taken place in May 2021. A report was then written which was shared with the inspector prior to this inspection.

Evidence Source:

Observation	✓	Records	✓	Feedback		Discussion	✓

Requirements:
Eight

Recommendations:
None

Regulation of Care Act 2013 Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 4 - Environmental and Personal Safety and Comfort
Systems, checks, policies, procedures and staff training ensure that people's dignity, well-being and safety is promoted and protected.
4.10, 4.12, 4.16, 4.17, 4.18, 4.19

Our Decision:

Substantially compliant

Reasons for our decision:
A fire risk assessment had been completed / reviewed by the manager in November 2020. An external fire risk consultant had also completed a fire risk assessment.

Staff members had received fire safety training via eLearning. Training must be renewed annually. The manager's fire training had gone past that frequency and a requirement has been made.

Fire alarm maintenance had been carried out on the 27 July 2020. All fire safety checks had been carried out at the required frequency. This also included an annual service of the fire extinguishers, which had taken place on the 18 September 2020.

Two fire drills had taken place in 2020, but none so far in 2021. Fire drills must take place twice per annum. A discussion was had with the manager for a fire drill to take place as soon as possible and for another before the end of the year.

Staff members had received training on infection control.

Records examined by the inspector showed that a cleaning programme was carried out by both day and night staff. This included mattresses being cleaned and checked after each weekly linen change.

Residents' curtains were scheduled to be cleaned every six months.

The home had an infection control policy for staff to follow.

An electrical installation condition report, dated 27 January 2018, evidenced that the home's electrical installations were compliant with standards. Portable Electrical Appliance Tests (PAT) had been carried out on the 29 April 2021.

The home had a Legionella risk assessment which had been reviewed on the 1 March 2021. Water sample testing, to check for Legionella bacteria, had also taken place on this date. No bacteria was detected. Monthly water temperature checks were being carried out. Showerheads were being bleached / cleaned monthly. A sprinkler system was in situ but was no longer used. A recommendation has been made for the manager to check to see if the non-used sprinkler system is a risk of Legionella bacteria.

The Thermostatic Mixer Valves (TMV's) had been serviced on the 2 July 2021.

The inspector, using an infrared thermometer, tested water temperatures throughout the home. A sink located by the back door had water being discharged at considerably above the permitted 41°c. The manager said that two TMV's were still to be fitted and this sink was on one of the locations. A requirement has been made for the home to ensure that water being discharged from washbasins does not exceed 41°c.

The gas boiler had been serviced on 12 March 2021.

The home had public liability insurance valid from 28 February 2021.

Evidence Source:

Observation	✓	Records	✓	Feedback		Discussion	✓

Requirements:
Two

Recommendations:
One

Regulation of Care Act 2013 Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 6 - Staffing
Staff are recruited following a rigorous and robust recruitment programme. There are sufficient numbers of trained competent staff (including ancillary staff) to meet the needs of the people at the home. There are robust policies in place to ensure effective supervision and continuous professional development.
6.3, 6.20, 6.23

Our Decision:
Substantially compliant

Reasons for our decision:
The pre-employment checks for four people who had started at Tudor Lodge in the previous year were examined.

These records did not evidence that identity checks were being carried out and a requirement has been made. All other required pre-employment checks had taken place.

The records of staff members' Disclosure and Barring Service (DBS) checks were examined. For one staff member there was no DBS number or date recorded, whilst for two other staff members their DBS had expired. A requirement has been made.

On the day of the inspection, two staff were on duty from 09.00-19.00, with two waking night staff on duty from 19.00-09.00. The manager also helped out on shift when required. The staff members spoken to on inspection both believed that the staffing levels were adequate.

Dependency assessments of residents' needs were completed every four months or when an individual's needs changed. On the day of the inspection, fifteen residents were identified as being low dependency with one resident identified as medium dependency.

Staffing rotas appeared accurate and reflective of the actual people and hours worked. The staff member responsible for dispensing medication / senior lead, was identified on the rota.

Evidence Source:

Observation	✓	Records	✓	Feedback	✓	Discussion	✓

Requirements:
One

Recommendations:
None

Regulation of Care Act 2013 Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 7 – Management Quality and Improvement
People have confidence that the systems in place support the smooth running of the home. The registered manager is qualified and competent to manage the home. People are consulted about how the home is run and their opinions are taken into account. The home has an annual development plan that makes provision for the home to develop and improve.
7.14

Our Decision:
Non-compliant

Reasons for our decision:
The manager said that a provider roundup summary was carried out weekly via a conference call with the providers clinical governance. A report, completed by the manager, highlighted actions to be completed and the progress.

Twice yearly visits to the home, as part of the provider's quality assessment process, were not taking place and a report was not being written.

The COVID pandemic has prevented the home's responsible person from coming to the island as frequently as pre-pandemic. Whilst sympathetic to the situation, the minimum standard does state that the responsible person or agreed nominee can carry out these visits. A requirement has been made.

Evidence Source:

Observation		Records	✓	Feedback		Discussion	✓

Requirements:
One

Recommendations:
None

Other areas identified during this inspection

Standard 2.1
Part of the carpet in the lounge was frayed and needed to be repaired / replaced.

Toilet seats were missing from two toilets. These need to be replaced.

Standard 3.7
In one resident's pre-admission assessment it noted that the person practiced their religion. There was no associated care plan that enabled this person to follow their chosen faith.

Evidence Source:

Observation	✓	Records		Feedback		Discussion	✓

Requirements:
Two

Recommendations:
None

Previous requirements which have not been met.

Standard 7.9
The annual report must contain a development / improvement plan, based on the home's quality assurance systems.

Evidence Source:

Observation		Records	✓	Feedback		Discussion	✓

Requirements:
One

Recommendations:
None

The inspector would like to thank the management, staff and service users for their co-operation with this inspection.

If you would like to discuss any of the issues mentioned in this report or have identified any inaccuracies, please do not hesitate to contact the Registration and Inspection Team.

Inspector: Kevin West **Date:** 2 August 2021

Provider's Response

From: Tudor Lodge

I / we have read the inspection report for the inspection carried out on **6 July 2021** at the establishment known as **Tudor Lodge**, and confirm that there are no factual inaccuracies in this report.
☒

I/we agree to comply with the requirements/recommendations within the timescales as stated in this report.
☐

Or

I/we am/are unable to confirm that the contents of this report are a fair and accurate representation of the facts relating to the inspection conducted on the above date(s) ☐

Signed
Responsible Person Click here to enter text.
Date Click here to enter text.

Signed Mary Callaghan
Registered Manager
Date 10/08/2021