Care Quality Commission

Coseley Systems Limited

Meadow Lodge Care Home

Inspection report

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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?	**Inadequate**

Overall summary

We inspected this home on 4 and 7 November 2014. This was an unannounced inspection.

Meadow Lodge Care Home provides accommodation for a maximum of up to 22 people. There were 18 people living at the home when we inspected it.

The home had 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.

At our previous inspection of this care home in April 2014 the provider was not meeting the requirements of the law in relation to welfare and safety, medication, suitability of the premises and how the quality assurance of the service was being monitored. Following this inspection

Summary of findings

the provider sent us an action plan to tell us the improvements they were going to make. During this inspection in November 2014 we looked to see if these improvements had been made.

People told us contradictory things about the service they received. While some people were very happy at the home, others were not. In addition, our own observations and the records we looked at did not always match the positive descriptions some people had given us.

People's safety was being compromised in a number of areas. This included how well medicines were administered and the support for people who could become agitated or distressed and how the garden and care home was maintained.

The provider did not understand the requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). People who used the service had their movements restricted and staff did not understand how to support them to stay safe and meet these legal requirements.

People living at the home and their relatives told us that the staff were kind, considerate and caring. However, people were not always involved in deciding of what level of care and support they needed. People had regular access to a range of health care professionals which included general practitioners, dentists, chiropodists and opticians.

People's care records were not always up to date but staff could support them because the information was shared through regular handover meetings. Staff had knowledge and understanding of people's care needs but did not always know their preferences and personal histories to be able to support them in the way they wanted.

Throughout the duration of our inspection, we noted that most of the communal rooms including the rear dining room smelt strongly of an offensive odour. Some people we observed during our inspection were wearing clothing with food spills/stains on and were not assisted to change. Some had not had their hair brushed or combed or their finger nails cut. This indicated that some people were not always receiving appropriate care and support.

People who lived at the home told us that activities at the home were limited and people were not always able to participate in hobbies and interests of their choice.

Records showed that the provider had failed to record and deal with two complaints that had been made in accordance with the home's complaints policy.

The provider did not have an effective system in place to monitor and assess the quality of the service.

We have made recommendations about the management of complaints and the improvement of people's involvement in hobbies and interests.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

People's needs were not always met in a timely way because there was not enough staff to help them. Staff understood how they should protect people from harm and abuse. People's care records were not completed with enough detail to guide staff and make sure that risks were managed. People's medicines were administered safely but recording systems needed to improved.

Requires Improvement

Is the service effective?
The service was not always effective.

People's rights were not protected by the provider because they did not fully understand how to comply with the MCA and DoLS. Care records were not kept to date and staff training did not always cover the specialist needs of people using the service. People were not involved in the planning and preparation of meals and told us this could be improved upon.

Requires Improvement

Is the service caring?
The service was not consistently caring.

People who lived at the home told us that they were supported by kind and attentive staff. However we found that people were not always involved in planning their care and care plans did not contain relevant information regarding their life history and personal preferences.

It was apparent that some people were not always receiving appropriate personalised care and support according to their needs.

Requires Improvement

Is the service responsive?
The service was not always responsive to the needs of the people.

People were not supported to lead independent lives, the provider needed to take further action to demonstrate how they supported people to pursue their hobbies and interests. Improvements were needed to the way in which the provider dealt with people's complaints about the service.

Requires Improvement

Is the service well-led?
The service was not well led.

The management lacked understanding of the principles of good quality assurance and leadership. Current best practice was not always recognised or developed to move the service forward and improve outcomes for people.

Inadequate

Meadow Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was undertaken 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 service.

We visited the home on 4 and 7 November 2014 and spoke with ten people who lived there, six of their friends and relatives, five members of staff, registered manager and the provider (owner of the care home).

Providers are required to notify us about events and incidents that happen at the service including unexpected deaths, injuries to people receiving care including safeguarding matters. We refer to these as notifications. Before our inspection we reviewed the notifications the provider had sent us and any other information we held on the service to plan what areas we were going to focus on during our inspection.

We observed how care and support was delivered by care staff. We looked at records including six people's care plans and training records for members of staff. We sampled records from staff meetings, staff supervision, meetings with people who lived at the home and accidents and incidents records. We reviewed several of the provider's policies including, safeguarding and complaints. We looked at the provider's quality assurance records which were used to check and monitor the quality of the service being provided at the home.

Requires Improvement

Is the service safe?

Our findings

When we inspected this service in April 2014 the provider was not meeting the requirements of the law in relation to the maintenance of the premises. We asked the provider to send us an action plan outlining how they would make improvements. They told us the improvements needed in the home environment would be completed by July 2014.

At this inspection we found that some improvements had been made since our last inspection. We spoke with relatives of people who lived at the home about the maintenance and safety of the care home. They told us, "The décor in the home left a lot to be desired and the garden was badly neglected", "The home was dark, not very well furnished and often smelt of urine" and "Some of my relatives and family will not visit this home because of the smell and the standards of furniture. The carpets look awful and the place needs a major refurbishment." One person added, "The room was appalling really, it was very smelly we couldn't put any of [relative's name] personal belongings in there because it was so small" and "There were no knobs on the drawers so she couldn't open the drawers to put her clothes in." Another person told us, "My family won't come here they think it's a hostel not a care home."

We noted that some refurbishment had taken place since our last inspection but worn carpets had not been replaced and some rooms were still in need of redecoration and refurbishment. We saw that the tiles in the toilets (on the ground floor) were dirty and damaged. One toilet door could not be locked and the door was sticking making it difficult to open and close. In one ground floor toilet, the top of a tap was missing leaving a sharp edge which could cause an injury to a person.

There were continued problems with the heating in the home. People told us, "It hot in some rooms but cold elsewhere". At lunchtime we saw people eating their meal with several layers of clothing on, including their coats. One person told us, "The radiator in my room only comes on once a day in the morning."

We found that the garden had not improved as had been planned. It had remained untidy, unwelcoming, poorly maintained and dangerous in places. We saw that there were wet leaves all over the paved area in the garden; this represented a health risk to people who used the garden as there was a high likelihood of someone slipping and harming themselves. Large parts of the paving area (at the top of the garden) were crumbling and broken which made navigation particularly difficult for those who had mobility problems.

The failure by the provider to rectify the concerns we had previously identified demonstrated a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected this service in April 2014 the provider was not meeting the requirements of the law in relation to the storage and supervision of medication at the home. We asked the provider to send us an action plan outlining how they would make improvements. The provider told us they would make the required improvements by May 2014.

At this inspection we found there were still concerns with the management and storage of people's medicines. Following a check of one person's medication records we found that there should have been 27 tablets remaining in store, but when we checked there were 28. This indicated that one medicine tablet had been signed for by staff but had not given to the person it had been prescribed to. We also found that some controlled drugs received at the home had been incorrectly recorded indicating that there were 120 tablets in stock when in fact there were only 60. We spoke to the senior care worker who was administering medicines on the day of our inspection and discussed the recording errors we had found. The senior care worker agreed that errors had been made and told us that they would benefit from further refresher training in the management of medication.

We spoke to people who lived at the home about their medication. Most confirmed that they received their medication when they needed it and hadn't experienced any problems. However one person commented, "Sometimes they put pills on the table and leave me before I have taken them."

Through our observations and discussions with people, we found that there was not enough staff to meet the needs of people living at the home. We spoke with ten people living there and most of them told us that staffing numbers were insufficient and staff did not always have time to talk to them. One person told us, "There are not enough staff, they

Requires Improvement

Is the service safe?

need another two or three, sometimes the staff talk to me briefly. Mostly though they don't talk or listen, I feel so alone." A second person told us, "The staff don't sit and talk to us sometimes because they're all too busy" and third person commented, "I really want to go to the shops, but I am not allowed as the staff are too busy to take me."

We saw that staff were not always visible and available in the communal areas of the home to support people. We saw a person walking in the garden area unsupervised and unsupported when it stated in their care plan that they should be supervised and escorted due to their walking difficulties. We saw that some people were left alone for long periods. We spoke with care staff and were told that they were sometimes very busy and it was difficult to stop and talk to people as often as they would like. One staff member commented, "I think that we should have five members of staff on duty during the day, not three as we currently have." On the first day of our inspection there were two staff on duty, the manager told us that three people should have been on duty but one was off sick. There had been no attempt to cover this reduction in staff until our intervention. We spoke with the manager about staffing levels. They told us the staffing numbers were determined by the needs of the people who lived at the home and that the numbers on duty were appropriate.

We found that following an incident, appropriate preventative measures were not always taken to keep people safe. Staff told us that there had been an incident recently involving a person who lived at the home and their behaviour had been challenging. The GP had been called to prescribe some medication to "calm them down". We found the person had been prescribed a sedative medication on an 'as required' basis. There were no instructions for staff to follow about when they should give this medication or how to monitor its effectiveness. We checked this person's care records and there was nothing on file regarding the potentially challenging behaviour or any management plans to ensure that this person and other people living in the home were kept safe. Staff we spoke with told us they would leave the person and go back to them later. This showed us the manager had failed to make sure people were protected because records were incomplete and staff were unaware of the actions they should take to support people.

We found that staff were suitable to work with adults because the provider followed safe recruitment practices. We checked records and saw that all new employees were appropriately checked through recruitment processes which included obtaining character references, confirming identification and checking people with the Disclosure and Barring Service (a criminal records check) to identify if they posed a risk to people living at the home.

We spoke with people who lived at the home. They told us they felt safe, trusted the staff who supported them and were able to raise any concerns they had. Comments included, "I feel safe here" and "Yes I'm safe here, thanks." We spoke with relatives of people who lived at the home. Comments included, "The home is very secure, you can't get in or out without the staff helping you." We spoke with members of staff who worked at the home. They told us that people were well cared for and kept safe. Staff comments included, "We always do our best to keep people safe and secure" and "Yes I think people are safe here." Staff were also able to tell us about how they would protect people from abuse or harm. They told us they had had some training in safeguarding adults.

Requires Improvement

Is the service effective?

Our findings

The manager told us that no one living at the home was being deprived of their liberty. However, one person was being denied the opportunity to leave the home and spend time with their friends. The home had recorded that this person had the capacity to make decisions about their own welfare and independence but despite this had prevented this person from leaving the home or allowing their friends to take them out. We spoke with members of staff about these restrictions and were told that they would not allow anyone to leave the home without the permission of the manager. People who used the service told us they would like to go out but were prevented from doing so by staff who asked them to stay in the home. Information in some people's care records showed that they were under constant supervision and staff told us they would not let the person leave the home. This could potentially have been a restriction of a person's liberty that was not recognised by the staff or the manager.

We spoke with the manager and the provider of the home about restricting people's liberty and found that they did not fully understand the requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). This meant that not all the people living at the home could be as independent as they wished, staff did not always understand the difference between lawful and unlawful restrictive practices. Appropriate procedures had not been followed to minimise restrictions on people's freedom, choice and control.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with people who lived at the home and their relatives about the ability and knowledge of the staff employed at the home. Comments included, "The staff seem to know what they are doing" and "The staff are well trained and knowledgeable." The staff we spoke with told us that they were trained and had the skills and knowledge to undertake all the tasks required of them. However, they told us that although training was available it did not reflect the needs of the people who used the service. They told us they had not received training in specific health conditions such as dementia or diabetes and found it hard to understand the care needs of people using the service as a result. One person told us that they had no instruction of how to manage the needs of people with behaviour that challenged them. We looked at how the manager supported the staff group with supervision. We were told by staff that supervision sessions did not happen regularly and when they did they were observational. For example they told us they were observed by the manager making cups of tea but they did not have the opportunity to have regular one to one meetings. This meant they had limited opportunity to discuss their career development or training needs on an individual basis with the manager.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us that they enjoyed their meals at the care home and they were sufficient, others were less complimentary. One person told us, "Yes, the food is okay," A second person commented, "I enjoy the meals thank you, but we get our tea at about 5 o'clock and it's a long time to wait until breakfast next day" and a third person told us, "We always have one cheese sandwich with salad for tea with a drink, as the week goes by, the bread gets staler." We spoke with relatives and friends of people who lived at the home about meals and nutrition. Comments included, "[name] has never told me that she is dissatisfied with the meals", "I think the meals are okay" and "We received a phone call in the evening from [relative's name] asking us to buy some fish and chips as [relative's name] felt so hungry."

We saw that mealtimes were calm and relaxed and that people were not hurried or rushed when they were eating. Staff were patient, considerate and respectful. Meals were hot and accompanied by a drink of choice. We noted that people were not given napkins, and salt and pepper was not put on the table until lunch was nearly over. People told us they enjoyed their lunch and commented, "We were all surprised to have turkey today, we normally only have shepherd's pie or corn beef hash" and "I enjoyed my meal thanks."

We saw drinks were brought round by staff at specified times throughout the day and people

were offered a choice. We spoke to the manager and provider about meals and nutrition. We were told that people could have their meals when they liked and have

Requires Improvement

Is the service effective?

snacks if they wished. They did accept however that people were not routinely offered supper during the evening and had no facilities to prepare snacks for themselves. The provider agreed to address this issue as a priority.

Records showed that people's eating and drinking needs were assessed and recorded. We saw that people who lived at the home were assessed using a Malnutrition Universal Screening Tool (MUST). This tool enabled staff to assess the risk to people and monitor and manage their weight. We saw that people were weighed regularly. Records showed that people had regular access to healthcare professionals, such as GPs, physiotherapists, chiropodists, opticians and dentists and had attended regular appointments about their health needs.

Requires Improvement

Is the service caring?

Our findings

We spoke with people who lived at the home about their involvement in planning their care and support. Comments included, “I have not seen or been involved with my care plan” and “I asked if I could help with hoovering, washing up and dusting but the staff said no.”

We spoke with people’s relatives and friends about their involvement in planning care and support. One person told us, “We were not involved in any way regarding the decision making process about [person’s name] care.” A second person told us, “I sent the home some useful information about [person’s name] but they didn’t do anything with it, they just gave excuses why they couldn’t.”

People we spoke with who lived at the home told us differing things about the service they received. While some people were content and comfortable, others were not. In addition, our own observations and the records we looked at did not always match the positive descriptions some people had given us. One person told us, “I smoke in the smoking room. It’s cold in there. I have to be pushed in my wheelchair into the room and sometimes they forget that I am there. So after about two hours I had to ring my son to ask him to ring the home to get the staff to get me out. The staff are sometimes upset with me for ringing my son” and “The staff come into the lounge and turn the television to another channel and the staff watch it. They don’t always ask us if it’s okay to change it.” Some people we spoke with were complimentary about the care and support they received from staff. They told us the staff were caring and friendly and understood their needs. Comments included, “The staff are very nice” and “The staff are very caring and helpful.”

We spoke with relatives and friends of people who lived at the home. They were complimentary about the standards of care being delivered and the kindness shown by the staff employed there. Comments included, “The staff were good, compassionate and caring. I think they were well meaning” and “The staff were lovely, really caring.” We observed several instances of staff speaking to people with patience, warmth and affection and we saw some good interactions between staff and people who lived at the home.

We noted that most of the communal rooms including the rear dining room smelt strongly of an offensive odour. We saw some people were sitting on chairs that smelt unpleasant and they had their meals in a room that had an offensive odour. This was disrespectful to people using the service and had a significant effect on their comfort and quality of life. Whilst talking to a relative of a person who lived at the home, they commented, “Some of my relatives and family will not visit this home because of the smell and the standards of furniture. The carpets look awful and the place needs a major refurbishment.”

Some people we observed during our inspection were wearing clothing with food spills/stains on and were not assisted to change. Some had not had their hair brushed or combed or their finger nails cut. One person smelt strongly of an offensive odour. This indicated that some people were not always receiving appropriate care.

We spoke with the manager about these concerns and were told that some people preferred not to change their clothing or receive regular personal care and it had been difficult to persuade them to do so. We checked records and saw that no plans had been formulated by the provider to address these issues of concern.

Requires Improvement

Is the service responsive?

Our findings

When we inspected the service in April 2014, we were concerned about the lack of hobbies and interests available to people who lived at the home. This was a breach of Regulation 9. We asked the provider to send us an action plan outlining how they would make improvements. They told us they would ask people who used the service what they would like to do and support them to do this.

At the inspection we found that very few people at the care home were participating or being supported to participate in hobbies or interests of their choice. For example, the people we spoke with who lived at the home told us that activities were limited. One person told us, "There are no activities taking place." A second person commented, "There was Bingo about three or four weeks ago but nothing else." A third person told us, "I wish there was a library system available here."

Records showed that people had recently been asked what type of hobbies and interests they would like to participate in. We noted that several people had responded expressing an interest in activities such as going shopping, outside visits, attending a day centre etc. However, we found that the information obtained by the provider had not been acted upon and people had not been supported to participate in hobbies, interests and pastimes of their choice. We found that some people had indicated a wish to attend a day centre but they had not been supported to do so.

We spoke with the manager and provider about these concerns and were told that some people preferred not to engage in the activities offered and it had been difficult persuading them to participate. However, they accepted that some people had not been supported to participate in the interests and hobbies of their choice in particular those which had been identified following the survey earlier in the year.

We spoke to staff about the people they were supporting. We found that staff had a good knowledge and understanding of people's care needs but did not always know their preferences and personal histories. Care records included health and risk-based information but did not always contain detailed pen pictures and life histories of the people who lived at the home. These plans contained limited reference to the person as an individual. There was little information on file to say what people liked or disliked and what their individual preferences were. This indicated that the provider had not taken the time to obtain and record proper information on people's likes, dislikes and preferences so individualised care could be provided. This meant that some staff were not always able to provide 'personalised' care that met people's individual needs and preferences.

We found that the provider did not always listen to people who lived at the home. We looked at records and saw that group meetings and discussions were held with people to obtain feedback about the quality of care and support being provided. This showed that people were encouraged to 'have a voice' and express their views about topics and issues that were important to them. However there was no evidence to show any of the issues or suggestions raised by people using the service had been acted upon.

People commented, "We know who to speak to if we have a problem" and "I would talk to staff if I had a complaint. We noted that the provider had a policy in relation to dealing with complaints. This document set out how the provider would respond and deal with complaints and concerns. We checked the complaints records and found that the provider had not recorded two recent complaints that had been made by relatives and friends of people who lived at the home. This meant that the provider had not dealt with and supervised the complaints in accordance with the home's policy. We spoke with the provider about these concerns and they accepted that these complaints had not been recorded and dealt with in accordance with the home's policy. This meant that concerns and complaints were not used as an opportunity for learning and improvement or to deal with concerns promptly.

We recommend that the service seek advice and guidance from a reputable source, about the management of and learning from complaints.

We recommend that the provider seek advice and guidance from a reputable source, about supporting people in the pursuit of their hobbies and interests.

Inadequate

Is the service well-led?

Our findings

We have highlighted throughout this report that some improvements had been made but many more were needed. People's health and welfare were being put at risk due to the lack of action by the manager and the provider in addressing these issues.

When we inspected the service in April 2014, we found the provider was in breach of four Regulations. At this inspection we found the provider remained in breach of two of these Regulations. The monitoring and checking systems in the home were still not effective because they had failed to highlight and address the issues raised in this report.

We identified medication recording errors that had not been picked up by the provider's own audit system. Records showed that the manager had undertaken regular internal audits on medication, risk assessments and care plans but had not been identified and dealt with prior to our visit.

Some improvements in the home had been made in relation to the décor but they had not been completed as the provider had told us they would in their action plan. Records showed that where issues or improvements had been identified, appropriate action had not always been taken to address these.

Accident records showed that a person living at the home had fallen on a number of occasions in recent months. A check of this person's care plan showed that a risk assessment had been completed regarding their risk of falling. However, we noted that the assessment, despite being recently reviewed by the manager, had not been amended or updated to show that this person had fallen several times and was at a high risk of injuring themselves. The provider had not conducted effective analysis to identify risks and minimise and prevent further occurrences.

We found that management lacked understanding of the principles of good quality assurance which meant best practice was not always recognised or developed to move the service forward and improve outcomes for people. All of the above evidence demonstrated that this was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed comments about the service and how it was managed and led. Some people who lived at the home told us that they saw the manager regularly and felt they could talk to her at any time they wished. However some relatives and visitors to the home told us that the home was not well managed and concerns were not always acted upon. Comments included, "I don't think the home is very well run but we don't want to say too much just in case we make it bad for [person's name]" and "The manager was not very responsive to us or as helpful as she could have been."

We spoke with care staff about the supervision and support they received at the home by the manager. The staff members we spoke with told us that the manager was supportive, fair and approachable at all times. However they also told us that they had not had any recent one to one supervision meetings with their manager (or senior supervisor) or received annual appraisals. We were told that there were occasional team meetings.

Staff had been observed on a number of occasions by the manager to check they were delivering safe and effective care. However staff told us they had not been given the opportunity to discuss issues of concerns with the manager or provider including training, staffing levels and personal development.

We spoke to the manager about staff supervision and she confirmed that staff had not always received regular supervision meetings and given the opportunity to discuss issues of concerns and their personal development. This meant that staff were not always supported and encouraged to question practice and bring about improvements at the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The monitoring and checking systems in the home are insufficient and do not highlight areas the service does well or could do better.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The current training provision and supervision does not support staff and does not support the growth of knowledge and skills required for their work.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The current training provision and supervision does not support staff and does not support the growth of knowledge and skills required for their work.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider has limited systems in place to make sure that people's consent is sought in a legal way and necessary deprivations of their liberty are lawfully applied.