MACC Care Limited

Meadow Rose Nursing Home

Inspection report

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Date of inspection visit:
23 June 2020
24 June 2020

Date of publication:
08 September 2020

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Meadow Rose Nursing Home is a care home providing personal and nursing care for up to 56 people. Meadow Rose is a purpose-built accommodation with three floors, each floor has a communal area and there is also access to a garden.

People's experience of using this service and what we found
Risks in relation to restraint had not been adequately assessed, monitored and reviewed and staff had not received the appropriate training. Staff had knowledge of safeguarding, but some staff had failed to recognise and report a safeguarding incident. Some recruitment records required improvement.

At our last inspection we found the provider's governance system required improvement. This remained a concern at this inspection and systems to monitor the quality and safety of the service had not identified the areas for improvement found at this inspection.

People and relatives told us they were safe. There were sufficient staff to meet people's needs. Some people felt call bells could be responded to more quickly. Our observations were people did not wait to receive care and there was ongoing monitoring of call bells response times by the registered manager. Medicines were managed safely and infection control procedures were in place and followed by staff.

People, relatives and staff spoke positively about the management at the service and staff felt supported. The registered manager was open to feedback and following the inspection took action to address the concerns raised.

Rating at last inspection and update:
The last rating for this service was requires improvement (published 03 October 2019) and there was a breach of regulation 17, good governance. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to the safety and care provided to people in relation to the use of restraint. As a result, we undertook a focused inspection to review the key questions of safe and well- led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. The overall rating for the service remains the same. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see safe and well-led

sections of this report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Meadow Rose Nursing Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to regulation 12, safe care and treatment and regulation 17, good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Meadow Rose Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Meadow Rose Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service a short notice of the inspection the day before. This was because we wanted to discuss any current impact of Covid-19 in the service.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and clinical commissioning group who commission care from the provider. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan

to make. This information helps support our inspections. We used information we gathered through our Emergency Support Framework (ESF) Call. We have used the ESF framework to gather information from health and social care settings registered with CQC during the COVID-10 pandemic. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and six relatives about their experience of the care provided. We spoke with nine members of staff including the registered manager, nurse, senior care workers and care workers.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at audits and handover records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse

● Risks to people who may require the use of restraint were not adequately assessed by a relevantly trained and competent person. Staff had not received training in how to safely use restraint techniques and care plans did not contain sufficient guidance for staff to follow. There were inconsistent accounts from staff of how they carried out the restraint technique. This meant there was a lack of assurance that any restraint was being used in a safe way based on the person's individual needs.

● Records were being kept when any restraint techniques were used. The recordings however, were inconsistent and there was a lack of detail to demonstrate how the restraint was carried out and the impact on the person. Staff were able to explain other approaches they would try prior to using the technique but this was not evidenced in the records. This meant it was not clear that the person had been supported in a safe consistent way that was least restrictive.

● On one occasion staff had not recognised when unsafe care had been provided and needed escalation as a safeguarding issue. One person had been supported in an unsafe way that was not in line with their care plan. Although this information had been shared with other staff, no one had raised this as a concern or a safeguarding issue until an injury became apparent the next day.

We were not assured that all reasonable steps had been taken to reduce risks associated with people's care which placed people at risk of harm. This constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

The registered manager responded and acted upon all the above concerns following the inspection.

● At the last inspection, it was identified that prescribed thickeners for drinks, were not stored securely in some bedrooms. At this inspection we saw improvements had been made and thickeners were stored in lockable cabinets.

● People and relatives told us they felt safe. One relative said, "He is safe, that is the biggest thing for me, knowing they care for him almost as much as I could."

● Staff had received safeguarding training and the provider had safeguarding procedures in place. We saw the registered manager had carried out robust safeguarding investigations when required to do so by the Local Authority. However, despite the training some staff had failed to recognise a safeguarding incident. The registered manager had identified this and taken steps to address the concerns with staff.

Staffing and recruitment

● At the last inspection it had been identified that improvement was required to ensure a full employment history was obtained. At this inspection we found this was still an ongoing concern with a lack of recording in some staff files. The registered manager advised that it was usual practice to gather a full employment history and following inspection we were advised an extra level of monitoring had been put in place.
● Most people and relatives told us there were enough staff. One person said, "Yes they come to the call bell within two to three minutes." Our observations were there were enough staff to meet people's needs and people were not waiting to receive care.
● Staff told us there were enough staff to meet peoples' needs. The provider had a tool to assess the number of staff required based on peoples' needs and regularly monitored the call bell response time.

Using medicines safely
● People were supported with their medicines safely and told us they were happy with how medicines were being administered.
● When people required medicines to be administered on an 'as and when required' basis there was guidance in place for staff to know when to give the medicine. The medicine records we viewed showed this guidance was being followed correctly and clear records were being kept.
● Medicines were stored, administered and disposed of by trained staff and regular audits took place.

Preventing and controlling infection
● The environment was clean and tidy and people told us their bedrooms were kept clean. One person told us, "They clean my room every day."
● During the COVID-19 pandemic, the provider had updated their infection control practices in line with current guidance. This included a risk assessment for all essential visitors to the service, regular temperatures being taken and enhanced cleaning throughout the service.
● Staff were wearing personal protective equipment appropriately such as masks, aprons and gloves.

Learning lessons when things go wrong
● The registered manager shared learning from incidents with staff. We saw evidence that recent safeguarding concerns had been shared in a team meeting to ensure the incident did not happen again.
● The call bell audit had identified a high number of calls from some people. More frequent staff calls were put in place to support them and this had been successful in reducing the time people were waiting.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection we found the auditing of the service had not always been effective. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This inspection found further improvement was required and the service remains in breach of regulations.

● There were ineffective systems in place to ensure when staff were using restraint, the risks were adequately assessed, monitored and reviewed. Although there was oversight in place, there was a failure to ensure staff were appropriately trained and competent. This increased the risk of people receiving unsafe care.
● Systems had not identified where there were gaps in employment history in some staff files. After the inspection the provider advised that due to COVID-19 the usual audits of staff files had not been able to take place which could have impacted on this.
● Systems to assess staff's competency and knowledge of safeguarding had not always been effective. This meant there was a delay in reporting a safeguarding incident and a lack of monitoring in place of the person.
● Auditing of care plans were taking place, but they had not been effective in identifying the lack of robust recording in response to distressed behaviours and the lack of detailed guidance for staff to follow. The lack of guidance increases the risk of inconsistent care.

The provider's failure to ensure that effective systems were in place was a continuing breach of a Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 Good governance.

Following the inspection the registered manager took steps to address the concerns raised.

● At the last inspection, concerns were raised about response to call bells and there was no system in place to monitor this. At this inspection we found auditing of call bell response times were routinely taking place and improvements had been made to reduce the times people were waiting.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● We found a mixed picture about the person-centred care received. One person told us, "I like to get up

early, sometimes I don't get to choose the time." However, a relative told us, "They have found out what [person] likes and been very person centred."
● The service had a dignity champion and audits were undertaken to ensure care was given in a dignified way. Each person had a life history record in their care plan however, some staff we spoke to were unable to give any person-centred information about a person they supported.
● People and relatives knew who the registered manager was and spoke very positively about them. One person said, "They're marvellous," and another, "They've been really good."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care
● The management team were open and transparent during the inspection and demonstrated a willingness to listen and address any concerns. The registered manager took action in response to our feedback during the inspection to address the concerns raised.
● The provider had systems in place to share learning across their services to improve care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There were regular staff meetings for staff to share their views of the service and discuss any issues. Staff we spoke with spoke positively about management and felt able to raise concerns, and that they would be listened to and addressed.
● People told us the manager came to talk to them on a regular basis to gather their views.
● Relatives told us involvement was good in relation to individual care of people and they felt able to approach the registered manager or care staff with any concerns. They were also involved in meetings and questionnaires to give their views on the service as a whole.

Working in partnership with others
● The service worked in partnership with other professionals and agencies, such as community health services and social workers to ensure that people received the care and support they needed.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Some risks to people had not been adequately assessed, monitored and reviewed and staff had not received the appropriate training to meet all needs.

The enforcement action we took:

A warning notice was issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Some of the providers' systems had been ineffective to assess and monitor risks relating to the health and safety of people using the service.

The enforcement action we took:

A warning notice was issued.