

Meadow Care Homes Ltd

Meadowcare Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Good ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

We carried out a comprehensive inspection of Meadowcare Home on 6 December 2016. At our previous inspection in May 2015, we found the provider had not ensured that medicines were always stored in a safe and suitable environment. Following this inspection, the provider told us what action they had taken to meet the regulation. During this inspection we found that sufficient action had been taken.

Meadowcare Home provides accommodation for nursing and personal care for up to 34 people. The service mainly provides support for older people who are living with dementia. At the time of this inspection in December 2016, there were 32 people living at the service.

There was a registered manager in post. 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.

The service had not complied with the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. The service had not consistently ensured any conditions attached to people's DoLS had been completed. In addition, staff were not fully aware of how the DoLS impacted on their work despite receiving training in the subject. Best interest decisions had not been consistently undertaken in accordance with the Mental Capacity Act 2005. The provider had failed to send DoLS notifications to the Commission as required by law.

People at the service told us they felt safe. People received their medicines on time and medicines were now stored correctly in a safe temperature range. People's risks were assessed and identified risks were managed. There were sufficient staff on duty and we saw that people's care needs were attended to promptly. Recruitment procedures were safe and people were cared for in a clean, hygienic environment. Environmental risks were monitored and an analysis of falls and incidents was completed.

People told us they received effective care and relatives we spoke with were complimentary. People had access to healthcare professionals when needed to ensure their needs were met. People's weights were monitored, and where required they received the required support from staff. The service used a nationally recognised tool to monitor malnutrition and obesity risks and referrals were made when required. Staff received an induction when commencing their employment. Training for staff was provided and staff were supported through a supervision and annual appraisal process.

People and their relatives said they received support from caring staff. We made observations to support this, with staff delivering care in a compassionate and friendly manner demonstrating they knew people well. People could be visited by friends and relatives to avoid social isolation. Staff were responsive to people's care needs and care records demonstrated a person centred approach to care provision. People

had activities to partake in and there were links with the community. The provider had a system to record and respond to complaints.

People and staff told us the service was well-led. People spoke well of the communication they received from the service and staff were happy in their employment. Staff spoke of a good team ethos. There were systems to communicate with people, their relatives and staff. There were systems that monitored the quality of service provided and people's clinical needs were monitored and reviewed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Medicines were stored safely and people received their medicines.

People's risks were assessed and identified risks were managed.

Staffing levels were sufficient and recruitment procedures were safe.

Falls and incidents were monitored to reduce harm to people.

The service was clean and environmental risks were managed.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

The service had not complied with the Deprivation of Liberty Safeguards.

Best interest decisions had not always been completed.

People had access to healthcare professionals when needed.

Staff received training, supervision and appraisal.

People were supported with nutrition and hydration when required.

Is the service caring?

Good ●

The service was caring.

People and their relatives said staff were caring.

We observed positive interactions between people and staff.

People's visitors were welcomed and people had personalised rooms.

Staff understood the needs of the people they cared for.

The provider encouraged feedback about the service.

Is the service responsive?

Good ●

The service was responsive.

People and relatives said the service was responsive.

The service had been responsive when people's health needs had changed.

Care plans were personalised and detailed people's needs.

There was an activities programme for people.

The provider had a complaints procedure for people to use.

Is the service well-led?

Requires Improvement ●

The service was not consistently well-led.

The provider failed to send notifications to the Commission as required.

People and staff felt the service was well-led.

There were systems to communicate with staff and relatives.

Staff spoke of a high level of employment satisfaction.

There were governance systems in operation to monitor service quality.

Meadowcare 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 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.

This inspection was carried out by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

At our previous inspection of Meadowcare Home in May 2015, we found that the provider had not always ensured that medicines were stored in a safe and suitable environment. Following this inspection in May 2015, the provider told us what action they had taken to meet the regulation. During this inspection, we found that sufficient action had been taken.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We also reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

Most people in the home were living with dementia and were not able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home. We also looked at five people's care and support records.

During the inspection, we spoke with six people and three people's relatives. We also spoke with the registered manager, the deputy manager, and four other members of staff who were providing care to people on the day of our inspection.

We looked at records relating to the management of the service such as the staffing rota, policies, incident and accident records, recruitment and training records. We also reviewed information such as meeting minutes and audit reports.

Is the service safe?

Our findings

People appeared at ease with staff and we saw that positive, caring relationships had been formed. People we spoke with and their relatives were positive about their experiences of the service. One person we spoke with told us, "I always feel safe here." A relative we spoke with said, "I feel that my relative is safe." Another comment we received from a relative was, "Since my relative has been here, we have not regretted it."

At the inspection of Meadowcare Home in May 2015, we found that the provider had not ensured that medicines were always stored in a safe and suitable environment. Following that inspection, the provider told us what action they had taken to meet the regulation. During this inspection we found that sufficient action had been taken to meet the regulation.

People received their medicines when they needed them. The service managed medicines and there were systems in place to order, retain, administer and dispose of people's medicines. At the last inspection we found that some medicines were being stored above their recommended safe temperature. The provider had purchased equipment and installed it into the medicines room to reduce the room temperature. From reviewing recent records and the thermometer within the medicines room we saw the equipment was effective and medicines were now stored safely.

Medicines were ordered on a four weekly cycle. In addition, there were systems to return unused or unwanted medicines and we saw the supporting returns register. We reviewed a sample of people's Medicine Administration Records (MARs) and saw they had been completed accurately by staff. The medicines trolley was securely stored when not in use. Where people received 'as required' medicines, for example paracetamol for pain relief, there were protocols in place. The records showed why people may need the 'as required' medicine, the reason they need it, the maximum daily dosage they may have and any possible side effects they may experience.

We reviewed the medicines held by the service that required additional legal storage requirements and these were stored correctly. There was a supporting register that showed current stock balances and we undertook a review of stock with the deputy manager and found the stock levels were correct. There were systems to monitor the stock levels of these medicines weekly. The management at the service also completed regular medicines audits. Staff received training in medicines and their competency was continually assessed.

The service had undertaken an assessment of the risks associated with people's care and risk management care plans had been completed when needed. For example, within people's records we saw that risk assessments had been completed in relation to people's risk of falls, nutrition and skin breakdown. Where a risk was identified there was a plan completed that showed staff how to manage the identified risk. For example, one person was at risk of falling. The person's record stated, 'If appears wobbly, speak with him, reassure and offer a seat or wheelchair.'

Additional risks to people were assessed and risk management plans recorded. For example, people who

had diabetes had an individual care plan for this. This showed the person's assessed needs in relation to their diabetes and the action nursing staff should undertake to meet the person's needs. For example, to record the person's normal blood sugar level range and action to be taken should the person be outside of this range for a prolonged period of time. We saw that where required, staff had followed this guidance.

Staffing levels were appropriate and we made observations to support this. People we spoke with, their relatives and staff did not raise any concerns about the current staffing levels. During the inspection people were well attended to, with staff having time to support people with meals, drinks and to just sit and talk with people. People who required or requested assistance received the support they required promptly and we observed that call bells did not ring for a prolonged period. Staff appeared to communicate well with each other and were not rushing around. When staff numbers were at risk of falling below the required set levels, for example through unplanned sickness, current staff would be used or on rare occasions the service would use agency staff.

The provider had appropriate arrangements to identify and respond to the risk of abuse. There were appropriate policies in place for safeguarding and staff had received training. Staff understood their duties in relation to reporting suspected or actual abuse. They explained how they reported concerns internally to senior management or to external agencies such as the Commission or the local safeguarding team. Staff were confident that concerns would be acted upon by the management team.

Staff understood the concept of whistleblowing and how they could confidentially report any concerns they may have about the service. The provider had appropriate policies in place to support staff should they wish to report concerns through whistleblowing. Although staff knew they could contact the Commission to whistleblow, within the current policy there was an emphasis on reporting the matter internally with a section of the policy entitled, 'Tell us first.' No details of how staff could contact the Commission or any information on any third party agencies were contained in the policy. This information would ensure staff had all available contact numbers to support them should they not wish to report concerns internally.

Safe recruitment processes were completed. Staff had completed an application form prior to their employment and provided information about their employment history. Previous employment or character references had been obtained by the service together with proof of the person's identity for an enhanced Disclosure and Barring Service [DBS] check to be completed. This DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified.

We found the service was clean. Domestic staff were employed to maintain cleanliness standards. There was liquid anti-bacterial gel available at designated points around the building. There was guidance for visitor's in the entrance foyer of the service about them not visiting a care home environment whilst unwell and the risks this presents to people. Staff were observed wearing protective equipment when required which also reduced the risk of cross infection. People and the relatives we spoke with did not raise any concerns about the cleanliness of the service. One person we spoke with said, "It's always kept clean & tidy."

There were systems to complete a monthly review of reported incidents and accidents. This review was to identify any patterns or trends in incidents and accidents and was aimed at preventing or reducing reoccurrence through intervention and support for people. Recent reviews showed no trends in the reported incidents or accidents. The service was included within a recognised falls prevention programme in a scheme supported by the local authority. In 2015 the service was recognised as 'falls champions' for having the lowest number of recorded falls of the programme group, which consisted of 27 other services.

The provider had systems that monitored the environment and the equipment within the service. From

reviewing audit and governance records we saw that the boiler systems, lifting and hoisting equipment, electrical equipment and the call bell systems were serviced when needed. There was a risk assessment for the premises dated May 2016. The folder showed emergency evacuation plans and drills were completed. Supporting records that showed the fire alarms, lighting and firefighting equipment were checked and tested. People had personalised evacuation plans showing the level of assistance they would require in the event of having to leave the service during a fire.

Is the service effective?

Our findings

The service had not always acted in accordance with the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We saw that where required, decisions taken in people's best interests had not always been undertaken and recorded. Within people's records we found the service had some areas of good practice in relation to completing best interest meetings and decisions, however this was not consistent. For example, within some people's files we found that best interest decisions had been made in conjunction with a person's family and GP in relation to matters such as covert medicine administration and receiving one to one care. However, we found examples of where this had not been completed.

Best interest documentation had not been completed when the service was monitoring people's movements for their own safety. For example, within one person's records it showed there had been a previous incident whereby a person had locked themselves in their bedroom. The person's care plan stated that the person was prone to playing with their door handle and water tap. The care record stated that the risk management of this would be for staff to have a master key and to, 'Make her PIR (Passive Infrared Sensor) and door alarm active.' Within the service, all rooms had door alarms and PIR sensors to monitor people's movements. These can be turned on and turned off by staff as needed.

To remotely monitor a person's movements without their consent could potentially impact on their privacy. A decision to monitor the person's movements remotely should be a decision taken in the person's best interest. Within the person's care records, it showed the person's daughter wished to be involved in their care. There was no supporting record to show that the decision to monitor the person taken by the service, using electronic monitoring equipment, had involved the person's family or that it had been taken in the person's best interest with other less restrictive options being considered.

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

People living in care homes can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The application procedure for this is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found the service was not consistently meeting the requirements of the DoLS and staff knowledge of DoLS was poor placing people at risk of inappropriate care. We reviewed the current DoLS file within the service. It was evident there was no current system in operation that allowed the service to quickly review

the current status of DoLS. We requested the registered manager reviewed all current applications.

There were currently five people at the service subject to a DoLS authorisation. There were 25 further applications outstanding with local authorities, some of which dated back 29 months and the registered manager was not clear on the current status of these. For one further person the registered manager was unsure of their application status. Within people's records it was unclear that action had been taken to monitor the progression of the DoLS applications or to review if they were still required.

The service had not met the conditions attached to some people's DoLS. When a DoLS authorisation is granted, some authorisations come with conditions attached. The service is legally required to comply with these conditions. We found that where conditions had been applied to a person's DoLS, there was inconsistency in adhering to them. For example, one person had several conditions with their DoLS. The service had worked alongside relevant healthcare professionals to complete the conditions. However, we found examples of where the service had not adhered to conditions as required.

One person's conditions showed that a condition was to obtain clarity of a person's diagnosis from their GP to resolve current confusion. It stated this was because it may affect treatment options available to the person. The person's DoLS with the condition was authorised on 15 September 2016. We asked to see evidence this condition was met and the service management produced two documents relating to the person's condition. One was dated in June 2012 and the other in September 2014. There was no evidence that showed the condition had been addressed since the DoLS authorisation.

Another person's DoLS was authorised on 14 October 2016. There were two conditions with the DoLS. One was to arrange a review of a specific medicine and the second to arrange an audiology appointment for the person. We discussed this with the registered manager and deputy manager. They told us that all medicines were reviewed by the service's GP in November 2016. From reviewing the person's medicine records, they were still receiving this specific medicine. There was no supporting evidence to show the service had discussed this condition with the reviewing GP to demonstrate compliance with the condition. In addition, the person had not been referred to audiology for an appointment since the DoLS authorisation was granted.

Staff knowledge of DoLS was poor. We spoke with three staff about DoLS. None of the staff were clearly able to demonstrate they understood what the DoLS were and none of the staff knew who in the service had a current DoLS authorisation. This placed people at risk of unsafe or inappropriate care.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt they received effective care from staff. People's relatives were also complimentary of staff. One person we spoke with said, "I like it here, I like the people." Another told us they had, "No worry here at all." A relative we spoke with said, "I can't fault it at all." We asked a relative about the access to external healthcare professionals the person in the service had. They said, "GP brilliant, very committed and its nice for us to have a consistent contact, the GP is flexible and arranged a time that we could meet up to discuss my relative's medication, medication is regularly reviewed."

People received the support they required to access healthcare services when needed. For example, we saw from a review of people's care records that when the service had a concern for people the relevant healthcare professional was called. Records showed that where required, people had been referred to and received visits from their GP and the district nursing team. We saw that where needed, tissue viability nurses

had attended the service and there was regular contact with the dementia wellbeing service. This demonstrated that the service had ensured people's care and treatment needs were addressed.

People received the care and support they needed from staff to ensure they ate and drank sufficient amounts. Where people had received guidance from a healthcare specialist this was followed. People who required modified consistency foods had their needs met and where prescribed, people received their supplementary drinks. People were weighed monthly and a nationally recognised tool was used to identify people at risk of malnutrition or obesity. Where a malnutrition risk was identified, the deputy manager explained how people's weight monitoring frequency increased and relevant food and fluid records were introduced. We reviewed the supporting records that demonstrated this practice was undertaken.

The provider's induction for new staff was aligned to the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers should adhere to when performing their roles and supporting people. The certificate is a modular induction and training process designed to ensure staff are suitably trained to provide a high standard of care and support. The induction within the service for new staff encompassed training, a review of the employee handbook, reviewing policies and procedures and familiarisation of the service.

Staff received training to carry out their roles. Staff felt they received sufficient training and were supported by the registered manager and provider with additional training. We reviewed the training records within the service which showed staff had completed training in key areas to support them in providing effective care to people. This included first aid, moving and handling, safeguarding, infection control and food hygiene. Additional training to meet the needs of the people at the service, for example dementia and challenging behaviour, was also completed. Some staff told us they were completing national qualifications in Health and Social Care. This showed that staff were supported to develop their knowledge and skills to aid them in caring for the people effectively at the service.

Staff told us they were supported through performance supervision. Staff told us they received supervision and the registered manager produced the supporting documents. Supervision sessions focused on recent achievements, what was going well and any areas of challenge, any training the staff member may need and any actions to take forward. Staff also received an annual supervision that focused on their employment role, the yearly goals they had achieved, any training staff felt may benefit them and any changes the staff felt they could make to the service. Staff told us they found supervision and appraisal useful.

Is the service caring?

Our findings

People and their relatives gave very positive responses when asked about the staff at the service and the care they received. All of the feedback we received was positive. One person we spoke with commented, "Staff here really care." Another person told us, "Really nice people here, I really like it here, that's why I live here." A person's relative we spoke with said, "Staff are very friendly and relate well to residents and staff."

We made observations to support the positive feedback we received from people and their relatives. We observed that all of the staff were fully committed, very caring, enthusiastic, very attentive and had a meaningful rapport with the people. Some of the staff were observed comforting and encouraging people. All of the communication we observed, both verbal and non-verbal was good.

We observed a positive attitude from staff and saw people were not kept waiting for help or assistance. We saw that when people may have been distressed or anxious, the person was aided immediately in a calm, good natured and professional manner. We observed the registered manager also spent time on the floor supporting people and staff, as well as attending to the management tasks. People had a choice about what they did. We heard one person say, "I'll have a lie down after lunch, I feel I need to and I can do that here, it's relaxed here."

We observed that over the lunch period the chef also interacted and communicated with people enthusiastically. They plated up each person's lunch according to their individual wishes. A staff member explained that menu choices were given to people the day before and people were supported to choose their meals with the aid of picture cards. There was a selection of drinks offered and taken to people. People we spoke with said that they enjoyed the food. One person told us the, "Cooked breakfast tastes good." Another person commented they were, "Encouraged to eat lunch myself." This demonstrated how the service actively promoted people's independence.

Over the lunch period we observed some sensitive, empathetic interactions between the staff and people. For example, we observed one staff member started supporting a person to eat their meal and whilst doing this began to support and encouraged the person to be independent. We observed that after a short period of time and with the encouragement of staff this person began to eat independently with their knife and fork.

Staff were knowledgeable about people's care needs. Staff understood how to give personalised care and demonstrated this when they told us how different people liked to be cared for. Staff were able to explain people's risks, their behaviours and their personal care preferences. It was evident through our observations between people and staff that there were good, caring relationships and people always appeared relaxed and happy during interactions with staff.

People had personalised rooms with items important to them. We saw within people's rooms that items such as photographs and personal keepsakes were present. This ensured that people had items significant to them to aid in recollection of their family and historical events throughout their lives.

People could be visited by their friends and relatives at any time of day. There were no restrictions on people's relatives or friends visiting the service and relatives were welcomed. This meant that people living in the service were not isolated from those closest to them. During our inspection several visitors came to the service to see people. It was clear that staff knew the visitors well when we heard them speaking with them.

People had a service user guide available to them. This gave people important information about the service. It explained the management structure and the qualifications of different members of staff. There was information about daily programmes and keyworkers, together with information on their contract and fees. Information on how to make a complaint was also available. This meant people received important information about the service.

We reviewed the compliment cards and letters sent to the service. These contained positive feedback reflective of the comments we received and the observations we undertook. Within one card a person's relative wrote, 'I would like to thank you all for the care you have given my Mum over the last three years and your kindness when she passed away.' Another card read, 'Thank you everyone for looking after Mum. She was safe and secure all the time she was here at Meadowcare.' A further comment from a relative was, 'Thank you all so very, very much for all the kindness and care given to Mum.'

The provider also used a nationally recognised website to obtain feedback. A notice in the entrance foyer encouraged people's relatives to comment on the website about the service. The service had received five reviews since our last inspection in May 2015. All of these reviews were positive. One comment received from people's relatives read, 'I was recommended Meadowcare nursing home by the discharge team at Southmead Hospital in Bristol. I went for a viewing. Directly as I walked through the door, there was a lovely ambience. I was greeted by friendly happy faces who were very helpful.'

Is the service responsive?

Our findings

People and their relatives commented positively on the care provided and told us their needs were met. Relatives commented that they felt consulted and involved during care planning and we reviewed records that supported these comments. One person we spoke with said, "If there was a concern I know who to speak to." A relative told us, "The manager is very flexible so that we are able to attend care reviews." Another relative said, "It's easy to speak to the staff and manager if I needed to - about anything."

We observed staff being responsive to people's needs throughout the inspection. Call bells were answered quickly when they rang and people were observed to have the correct mobility equipment to hand. Staff were seen being attentive to people's needs in relation to food and drink provision and supporting people who needed it to walk safely around the service. A relative gave an example of how the service had been responsive. They explained the registered manager and administrator, "Are very supportive to relatives as well as my relative and provide information and are very helpful, they even included an email (in the person's care plan) where I described how my relative likes their hair cut, so that the information is there and shared with hairdressers - it was so helpful and appreciated by us."

We saw examples of where the service had been responsive when a person had become unwell or their behaviour had changed. For example, a person who had diabetes had given two high blood sugar level readings. Staff had followed the guidance within the person's care plan and contacted the person's GP which then resulted in a medication change ultimately resulting in the stabilisation of the person's blood sugars. Records showed that where a person had a suspected urine infection appropriate action was taken and the person's GP was promptly involved. Where people were receiving proactive treatment to avoid a pressure ulcer developing, a tissue viability nurse was involved and a wound care plan was created and regularly updated.

Care plans were clear and concise and contained information relevant and important to the people to whom they related. In addition to risk assessments and risk management guidance, care plans contained personalised information to support staff in providing individual care. We also saw that care plans had been created with the involvement of people's relatives and people at the service where possible. Within one person's records it detailed how they preferred their personal care to be given. It explained how staff should seek the person's consent and then proceed to offer them a shower or hair wash before involving the person in choosing their clothes.

People's care records demonstrated how to communicate with people and how to support them if they displayed behaviour that may be challenging to others. One person's care record stated, 'Can express verbally challenging behaviour which intimidates other people. She can undress herself in the lounge sometimes.' The person's personalised plan showed the different methods staff could use to calm the person and resolve the situation. For example to engage with the person or to take the person out. This demonstrated that the records had been produced based on knowledge and experience of the person.

Care records showed additional information about people's life histories. There was a document within

people's records entitled, 'This is me.' This is a document produced by The Alzheimer's Society to enable the history and social needs of people living with dementia to be communicated to staff and other healthcare professionals. It has information such as a person's life history, for example their employment and current or past interests. It shows any routines that are important to the person and anything that may cause the person to be worried or upset. It records how people communicate and their preferences for personal care. The records we reviewed showed that relatives or friends close to people had been invited by the service to be involved in completing these documents.

Additional communication methods were in operation to ensure people's needs were met. There was a communications book. This meant messages that needed to be communicated to staff were available and staff were required to regularly review the communication book on shift. It contained messages from family members or the person's GP. It detailed information about new records for people. It also communicated key matters for staff, for example to remind them to sign in and out and to only communicate in English when a differing practice had been observed. Additional systems to ensure staff responsiveness were in place, this included a staff allocation sheet for staff roles and a daily handover book detailing people's daily activity and needs.

The service had a complaints procedure and this information was available to people and their relatives. The complaints procedure was clearly displayed within the service and was contained within people's service user guides. The complaints procedure gave guidance on how to make a complaint and the timelines and manner in which the provider would respond. There was information on how to escalate a complaint to the Commission and information about the government ombudsman, should people wish to escalate to this department. Complaints were subject to a monthly review and the complaints we reviewed had been responded to in line with the provider's policy.

Activities were provided over seven days in the service. There were two members of dedicated activities staff employed. We also observed care staff interacting with people and supporting them with Christmas based arts and crafts activities during the inspection. A range of other activities were available for people, these included discussing the news from recent periods, a walk to the local area, nail care, ball and balloon exercises and quizzes and puzzles. The provider also had external activities provided, for example live music. In addition to this, a voice dance physiotherapist attended for a weekly session and other external activity providers attended monthly. There was a community link with the local school and children periodically attended the service and joined people for a painting session.

Is the service well-led?

Our findings

The service had failed to notify the Commission of Deprivation of Liberty Safeguards (DoLS) notifications as required. During our inspection, we established that five people living at Meadowcare Home had been lawfully deprived of their liberty in 2016. The provider had not notified the Commission of these DoLS authorisations as required by law.

The failure to send these notifications was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People we spoke with and their relatives were very positive about the management of the service. All of the comments we received were positive. One person we spoke with told us, "There is a structure here and it works really well." A relative we spoke with said, "Communication is really good and the manager and administrator work well together and complement each other." Another relative when asked about the management of the service told us, "Nothing is too much trouble."

Staff were positive about the leadership of the service and the support and guidance they received from the management team. All of the staff we spoke with told us they felt well supported and valued. One member of staff said they were, "Happy with my job." Another commented the management were, "Good to work for, we can approach them if we need anything and if you need to say anything you can." A staff member also told us, "They (management) are very supportive."

Staff spoke of a strong team ethos and ethic within the service and it was clear they all aimed to provide high standards of care. One member of staff said, "There is teamwork here – all are each other's families. We are very happy to work here." Another staff member commented, "We are here for the people, I can see myself being here a long time. We treat people like our family here." A further comment from staff was, "We are a good strong team, the manager's look after us. It's good for us and we are a healthy team."

There were systems to communicate key messages to staff. Staff meetings were held monthly and staff we spoke with told us they were constructive and informative. We saw from a sample of recent meeting minutes that matters such as people's care needs, communication, teamwork, governance systems, staffing and activities were discussed. In addition to this, we saw that nursing staff meetings were held that discussed people's individual care and treatment needs and handover systems. The registered manager also had a system whereby they had a 'Policy of the month' where they circulated a policy for staff to read and sign to say they had understood the policy.

Meetings were also held with people and their families or relatives. Although relatives we spoke with commented positively on the communication from the service, these meetings ensured that other key messages were communicated. We saw from the minutes of the last meeting that information such as current staffing ratios, staff training and any relevant staff changes was communicated. Also discussed were the activities held within the service, induction standards for staff and any current or future building improvements being undertaken.

The service had systems to monitor the quality of service provided. For example, the registered manager and deputy manager had a regular programme of audits. A meal and nutrition audit was completed to ensure food choice and appearance was satisfactory. This also focused on staff infection control practice and the mealtime experience. A quarterly dignity audit was completed which observed if care and support was delivered in a dignified and caring manner. An audit from Oct 2016 showed that staff were reminded not to use 'controlling' words during care provision. A 'First Impressions' audit of the environment was completed that ensured the environment was safe and well-presented. A further audit that monitored staff recruitment procedures and reviewed relevant recruitment documents was completed.

Auditing and review systems were completed for clinical aspects of the service. For example, an infection control audit was completed monthly and these had recently identified equipment that needed replacing which had been actioned. A medicines audit was completed to ensure the ordering, retention, administration and disposal of medicines was safe. A monthly review of people at risk of developing pressure ulcers was completed to establish if any healthcare intervention was needed. There was a daily checking system that ensured air mattresses were at the correct setting. There were systems that monitored people's monthly observations, for example their weight, blood pressure and risk of malnutrition. A system to review and update people's care plans where necessary was also in operation. Although we found these audit systems were effective, it was identified that the registered manager did not currently have a robust or effective system that ensured Deprivation of Liberty Safeguards (DoLS) applications were effectively monitored. In addition to this, there was no effective systems that monitored if any conditions attached to people's DoLS authorisations had been actioned.

The provider had recently become a member of Care and Support West and the registered management had attended meetings provided by the organisation. The meetings aimed to ensure the registered manager was aware of current guidance, legislation and best practice. The Provider Information Return (PIR) we requested was completed by the registered manager and the PIR was returned within the specified time frame.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The provider had failed to send DoLS notifications to the Commission as required. Regulation 18(4)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider had not ensured the service had consistently acted in accordance with the 2005 Act. Regulation 11(1) and 11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment
Treatment of disease, disorder or injury	The provider had not consistently ensured conditions on DoLS authorisations had been met. Regulation 13(4)(d) and 13(5)