

Aspire Healthcare Limited

Meadowfield

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

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 an inspection of Meadowfield on 19 December 2016 and 12 January 2017. We interviewed a relative of a person using the service on 10 February 2017. The first day of the inspection was unannounced. We last inspected Meadowfield in August 2016 and found the service was not meeting some of the relevant regulations.

Meadowfield provides accommodation and personal care for up to five people with a learning disability and / or mental health needs. There were four people accommodated there on the day of our inspection.

There was no registered manager in post. A manager was appointed and was in the process of applying to register with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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.

People using the service and a relative told us they felt safe and were well cared for. Staff took steps to safeguard vulnerable adults and promoted their human rights. Incidents were dealt with appropriately, which helped to keep people safe. A robust system to account for financial transactions made on behalf of people using the service was not in place. We identified some accounting errors and a bank account managed by the provider was not subject to internal or external audit. We previously made a recommendation about this.

The accommodation provided was suitably adapted for the people who lived there. The building was safe and well maintained. Risks associated with the building and working practices were assessed and steps taken to reduce the likelihood of harm occurring, although a legionella survey of the water system was not available for inspection. Minor maintenance issues were dealt with at the time of the inspection. The home was clean throughout.

We observed staff acted in a courteous, professional and safe manner when supporting people. Staffing levels were sufficient to safely meet people's needs. The provider had a system to ensure new staff were subject to thorough recruitment checks, although none had been recruited since our last comprehensive inspection.

Medicines, including topical medicines (creams applied to the skin) were safely managed. People were supported to manage their own medicines where appropriate.

As Meadowfield is registered as a care home, CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We found appropriate policies and procedures were in place and the manager was familiar with the processes involved in the application for a DoLS. Arrangements were in place to assess people's mental capacity and to identify if decisions needed to

be taken on behalf of a person in their best interests. People's mental capacity was considered through relevant areas of care, such as with decisions about finances, medicines and supervision when outside the home. Where necessary, DoLS had been applied for. Staff discussed proposed interventions before providing care to obtain the person's consent.

Staff had completed safety and care related training relevant to their role and the needs of people using the service. Further training was planned to ensure their skills and knowledge were up to date. Staff were supported by their manager. Staff performance was supervised and assessed.

People's nutritional and hydration (eating and drinking) status was assessed and plans of care put in place where support was needed. People were supported to access health services to ensure their medical needs were met promptly.

Staff displayed an attentive, caring and supportive attitude. We observed staff interacted positively with people. We saw that staff treated people with respect and explained clearly to us how people's privacy, dignity and confidentiality were maintained. Staff were able to communicate effectively with the people living at Meadowfield.

Activities were accessed within the home, independently and via separate day services. Staff worked collaboratively with local day care services. Staff understood the needs of people and we saw care plans and associated documentation were clear and person centred.

People using the service, a relatives and staff spoke well of the manager. Systems were in place to assess and monitor the quality of the service, which included feedback from people receiving care and oversight from an external manager. The manager and staff team had worked to address areas for improvement identified at a previous inspection, although some further work was still required.

The provider had met some of the assurances they had given in their action plan, however one area identified at our last inspection had not been addressed and an additional concern regarding the robustness of financial safeguards was identified. The provider was in breach of the regulation relating to good governance.

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 consistently safe.

People using the service and a relative said they were safe and were well cared for. Staffing levels were sufficient to meet people's needs safely.

Routine checks were undertaken to ensure the service was safe. There were systems in place to manage risks and respond to safeguarding matters. A robust system to check and oversee some finances was not in place.

Medicines were managed safely.

Is the service effective?

Good ●

The service was effective.

People were cared for by staff who were well supported and who received safety and care related training. Further training reflective of people's needs was planned.

The service was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff actively worked with healthcare professionals to promote and improve people's health and well-being. People's needs relating to eating and drinking were assessed and met.

Is the service caring?

Good ●

The service was caring.

Staff displayed a caring and supportive attitude.

People's dignity and privacy were respected.

Staff were aware of people's individual needs, backgrounds and personalities. Staff were able to communicate with people effectively. This helped staff provide personalised care.

Is the service responsive?

Good ●

The service was responsive.

People were satisfied with the care and support provided. They were offered and attended a range of social activities and day care services.

Care plans were person centred and people's abilities and preferences were recorded.

Processes were in place to manage and respond to complaints and concerns. People using the service and relatives were aware of how to make a complaint.

Is the service well-led?

The service was not consistently well-led.

The service had a manager in post. They had applied to become registered with the Care Quality Commission. People, a relative and staff made positive comments about their manager.

There were systems in place to monitor the quality of the service, which included regular audits and feedback from representatives of people using the service and staff. Action had been taken to address identified shortfalls and areas of development. Systems to audit people's finances required further development. Some areas previously highlighted for attention were not fully resolved.

Requires Improvement 

Meadowfield

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider 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 took place on 19 December 2016 and 12 January 2017. We carried out a telephone interview with a relative on 10 February 2017. The first day of the inspection was unannounced. The inspection team consisted of an adult social care inspector.

Before the inspection we reviewed the information we held about the service, including notifications. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We spoke with the local authority commissioning team for their views on the service and contacted the local safeguarding adults team and Health Watch.

During the inspection, we used a number of different methods to help us understand the experiences of people who lived in the home, including observations, speaking with people, interviewing staff and reviewing records. We spoke with four people who used the service. We spoke with one relative. We spoke with three staff, including the manager and two support workers on duty during the inspection.

We looked at a sample of records including three people's care plans and other associated documentation, medicine records, two staff files, which included staff training and supervision records, accident and incident records, meeting notes, risk assessments and audit documents.

Is the service safe?

Our findings

People using the service and a relative we spoke with expressed the view that they and their relative were safe at the home. One person commented to us, "It's cold outside, I'm warm and safe in here." They continued by saying they were clear about who to report concerns to. Another person, as well as a relative, told us they were happy with the way staff had responded to and helped a person who displayed distressed behaviour. The relative said, "The management were brilliant" when referring to this situation. Furthermore, a comment from a person in the provider's quality survey stated, "Staff are there for our safety."

Staff were clear about the procedures they would follow should they suspect abuse. They were able to explain the steps they would take to report such concerns if they arose. They expressed confidence that allegations and concerns would be handled appropriately by the manager. They informed us they had received relevant training. One staff member said, "I've done safeguarding e-learning." Records confirmed staff had undertaken relevant training on identifying and reporting abuse. Procedures were also available to guide staff on handling safeguarding concerns and reporting poor practice (whistle blowing). The manager was aware of when they needed to report concerns to the local safeguarding adult's team and where appropriate to other agencies. We reviewed records and saw safeguarding concerns had been reported and handled appropriately.

People's financial purchases were documented, but required further safeguards to provide assurance they were appropriately handled. People's cash balances were limited to small amounts of money. Checks on cash balances were carried out on each handover, with a designated staff member holding responsibility for people's monies. Staff kept records of transactions, with corresponding receipts retained. Some entries involving multiple purchases made on one occasion were not individually accounted for; rather they were totalled into one entry for that trip out. For example they might include rail fares, beverages, etc. We identified two recording errors which we highlighted to the manager to investigate further.

Where a bank account was managed for a service user there was no record of the bank transactions retained for cross referencing with cash balances, for audit and inspection. This meant we could not cross reference cash withdrawals from the account and cash held at the home on the person's behalf. There was no means to check that withdrawals made were appropriate or confirm the accuracy of financial records. We highlighted this concern to the manager to address with the registered person in liaison with the person's care manager (social worker). The manager informed us that audits of cash balances took place, but these were not clearly documented in a way that demonstrated if errors were identified and resolved. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in August 2015 a breach of legal requirements was found. The breach related to people's safety and the safe use of the premises.

At the time of our last inspection we found when a person sustained a minor injury. Staff were unable to find any plasters, which were not held in stock at the home. Following an incident at home, we examined arrangements for providing basic first aid and monitoring people's health. Basic items to monitor a person's

wellbeing or to deal with a minor injury; such as a thermometer to measure a person's temperature and an appropriately stocked first aid kit, were not available. Formal de-briefing arrangements, or other systems to critically review adverse incidents, were not in place.

At the last inspection we also found domestic chemicals (washing powder) were stored in an unsecured container, allowing for uncontrolled access and risking inappropriate use. Product data sheets, which provided staff with safety information on chemical products, were not available for easy reference. The washing machine had a broken dispenser tray, fixed with a protruding screw, presenting a risk of injury. There was also no blind fitted to the window which did not promote adequate privacy. A copy of the legionella survey, was not forthcoming despite our request for this. Wardrobes in people's bedrooms were not affixed to walls, presenting a risk that they could be toppled over. Two radiators without covers, one directly next to a bed posed a risk of people being exposed to hot surfaces.

On this occasion we found staff undertook checks to identify and deal with potential hazards, such as those relating to the premises and equipment; including monitoring hot water temperatures. Action to ensure a legionella survey was carried out and a record of this made available for inspection, as highlighted at our last comprehensive inspection, had not been actioned at the time of this visit. The manager undertook to arrange for this to be followed up, and forwarded confirmation that this had been carried out shortly after the inspection.

On this occasion we found hazards relating to the premises and furnishings which could cause injury had been minimised. Chemical products had been safely stored and the hazards we previously identified had been resolved. Minor maintenance items identified at this inspection were dealt with in the period between our two visits. First aid stocks had also been refreshed and a first aid thermometer had been obtained. A critical incident analysis format had been drafted, but at this time had not yet been used to review incidents.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

External contractors carried out other safety checks on utility services including electricity and gas safety. These had been carried out within the last year and contractors had confirmed the safety of the gas and electrical installations. Records of these checks were held at the home. Shared areas of the home were free from unpleasant odours and were clean.

The manager and senior staff took steps to identify and manage risks to people using the service, staff and visitors. For example, where concerns were apparent about a person's mobility, behaviour, or general welfare and there was the risk of them being harmed, staff had developed plans of care and risk assessments to ensure a consistent and safe approach was taken. These were designed to inform staff of the area of concern and to ensure a consistent approach was taken to minimise risks. Staff regularly reviewed needs assessments, support plans and risk assessments to keep them up to date and to ensure they accurately reflected people's level of need, and the associated level of risk.

Staff logged accidents and incidents. We advised the manager to document any further action taken as a result of accidents on the related accident report forms to highlight any lessons learnt and revisions to practice. They acknowledged this feedback and undertook to do this in the future.

Staff were present in sufficient numbers to ensure safe levels of observation and to respond to any urgent need for help and assistance. The view of the manager and care staff was that staffing levels were sufficient to ensure people remained safe. During the inspection we saw staff were busy, but not rushed. They had

time to prioritise one to one time with people using the service and provided support appropriate to people's levels of need.

No new staff had been recruited since we last inspected the home. The provider had arrangements to ensure staff were vetted for their suitability to work with vulnerable adults before they were confirmed in post. This included the receipt of an application form which included provision for staff to provide a detailed employment history. Other checks they would carry out included ensuring the receipt of employment references and a Disclosure and Barring Service (DBS) check before an offer of employment was confirmed. A DBS check provides information to employers about an employee's criminal record and confirms if staff have been barred from working with vulnerable adults and/or children. This helps support safe recruitment decisions.

Suitable arrangements were in place to support the safe administration of medicines. Staff confirmed they were trained in the system used. One told us, "We're trained in meds, we do a work book and e-learning." A monitored dosage system (MDS) was used to store and manage medicines. MDS is a storage device designed to simplify the administration of medication by placing the medicines in separate compartments according to the time of day. Medicines records were well presented and organised. All records seen were complete and up to date, with no recording omissions. Hand written entries were countersigned by a second member of staff to verify their accuracy. Our check of stocks corresponded accurately to the medicines records. Creams and liquid medicines, such as eye drops, had been dated upon opening. This ensured they were not used beyond their safe shelf life. Each person had a medicines care plan, which detailed the differing level of support needed by them. Where people managed their own medicines this was subject to a risk assessment kept under regular review. This meant there were measures in place to help ensure medicines were safely managed and administered as prescribed.

Is the service effective?

Our findings

People using the service and a relative we spoke with made positive remarks about the staff team and their ability to do their job effectively. Comments included, "Staff, they're ok" and "I get on with them all (staff)." A relative told us, "The staff are very helpful." Staff made positive comments about their team working approach, the support they received and training attended. One staff member informed us, "The training is very good, very thorough. We've asked for additional areas and epilepsy is pending."

Staff said they felt the supervision they received was helpful. Records confirmed staff attended regular individual supervisions and group meetings. The records of these supervision meetings contained a summary of the discussion and the topics covered were relevant to staff roles, service users' needs and staffs general welfare.

Records showed staff had received safety related training on topics such as first aid, moving and handling, and food hygiene. Topics and learning opportunities relevant to the health and care needs of people using the service were also offered, including mental health awareness and epilepsy awareness. Further training was planned, including refresher training once training was deemed to be out of date. Staff also had access to additional information and learning material relevant to the needs of people living at Meadowfield.

The Mental Capacity Act 2005 (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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions of authorisations to deprive a person of their liberty were being met.

We discussed the requirements of the MCA and the associated DoLS with the manager. They told us people's capacity to make decisions for themselves was considered as part of a formal assessment. We also saw people's decision making capacity and consideration of 'best interests' was documented in relevant care plans and risk assessments. Staff communicated clearly with people to describe care interventions and to ensure people were happy with the intervention proposed. Staff recorded care interventions in daily notes. Most people were assessed as having capacity to make important decisions, but where this wasn't the case relevant DoLS had been applied for. A copy of each authorisation was retained on file so staff were aware of any relevant conditions attached to the authorisation. Staff worked with others to identify what each person's known beliefs and wishes in relation to any best interest decision taken, with the least restrictive options considered.

Staff undertook nutritional assessments and completed relevant care plans. Nobody was identified as being at risk of malnutrition. Where people had risks associated with eating, plans of care were developed. For example a staff member told us, "We are mindful that [Name] will bolt food. We sit with her." A person using the service said, "The staff are good cooks."

One relative said regarding the GP's input "She [staff] got her to the Doctor straight away if anything's wrong." Records showed people were registered with a GP and received care and support from other professionals, such as the chiropodist, dentist and optician. Links with other health care professionals and specialists to help make sure people received appropriate healthcare had been made. Care plans relating to healthcare needs were up to date and completed appropriately. Medical history information was gathered and was available in a 'hospital passport' that could easily be communicated with healthcare staff when someone needed to be admitted to hospital at short notice.

Is the service caring?

Our findings

We saw people's privacy and dignity were promoted. People were well groomed and smartly dressed in well-fitting clothes. A person using the service said to us, "What I want from staff is good manners." They confirmed staff demonstrated this in practice. Staff expressed clarity on the importance of ensuring people's privacy and promoting their dignity when receiving care. This included ensuring practical steps were taken to ensure personal care and confidential discussions were undertaken in private. Staff we spoke with were clear about the need to ensure people's confidentiality; ensuring personal matters were not discussed openly and records were stored securely. Practical measures had been taken to preserve privacy, such as door locks fitted to toilets and bathrooms.

Staff worked to promote positive, caring relationships. We saw people being spoken with considerately and staff were seen to be polite. We observed the people using the service to be relaxed when in the presence of staff. We also observed staff interacted in a caring and respectful manner with people using the service. For example, we observed appropriate humour and warmth from staff towards people using the service. Staff acted with professionalism, good humour and compassion. The atmosphere in the home was calm, friendly, warm and welcoming.

On a tour of the premises, we noted the home was furnished with personalised items. People had brought their own possessions and had been involved in decorating parts of the home. This personalised their space and contributed to a homely atmosphere.

Staff encouraged people to maintain and develop their personal and communications skills. People were encouraged and supported to be independent. For example one person was supported to control their own medicines and some people were seen to come and go from the home as they pleased. Staff encouraged community access and the use of local facilities, including shops and leisure facilities. This meant staff promoted community inclusion and a positive community presence for people. A relative informed us they could visit flexibly. They said, "It's an open house. I can see [my relative] any time I want."

People using the service and a relative told us they were involved in decisions about their care. The relative stated if they had any worries they could approach the staff and they would help. They also informed us that they were kept up to date and involved in important decisions about their relatives care. A staff member was clear about the importance of people, and their relatives where appropriate, being involved in decision making. They said, "People will sign their own care plan – it's taken on board and they're interested in it."

People's beliefs and culturally important aspects of their daily lives were assessed, acknowledged and met in practice. Staff had a good awareness of people's cultural needs, which was reflected in the way aspects of care, such as meal preparation and provision, was carried out. Culturally significant events were respected and celebrated.

The manager was aware of local advocacy services available to support decision making for people should this be needed. Staff told us they were updated about people's needs at 'hand over' and team meetings to

ensure decisions regarding care were implemented in practice. Records confirmed this was the case.

Is the service responsive?

Our findings

People using the service and a relative expressed the view that staff were responsive to their needs. They were happy with the activities offered and were aware that they could complain and to whom. Comments we received included, "I'm going to play bingo" and "I'm going to an art class today." A relative told us, "I get invited for annual reviews and when social services visit." They also said "I have no concerns. If I did I would deal with it." They were clear about the means of raising complaints and external organisation they could also speak to, such as Social Services.

Staff identified and planned for people's specific needs through the care planning and review process. We saw people had individual care plans in place to ensure staff had the correct information to help them maintain their health, well-being and individual identity. People's needs were periodically reassessed to ensure care was tailored to meet their changing needs.

Care plans were sufficiently detailed to guide staffs' care practice. Staff developed care plans with a focus on maintaining people's wellbeing and independence. A relative remarked to us, "Now my relative's speaking out; getting more independent." The outcome of this approach was reflected in the active lifestyles that people maintained and increased involvement in tasks such as cooking. Care plans covered a range of areas including physical health, psychological health, leisure activities, and relationships that were important to people. Care plans were evaluated regularly to ensure they were meaningful. There were updates on the progress made in achieving identified goals, such as helping people to manage distressed behaviour, stay healthy and to promote good mental wellbeing. If new areas of support were identified, or changes had occurred, then care plans were modified to address these changes. Staff also detailed the advice and input of other care professionals within individual care plans so that their guidance could be incorporated into care practice. A member of staff reflected on the positive way they worked with people using the service and said, "I'm proud the way we've helped [name] through a tough time."

Progress records were available for each person. These were individual to each person and written with sufficient detail to record people's daily routine and note significant events. Such records also helped staff to monitor people's health and well-being. Additional monitoring records helped evidence the care and support provided, for example with epilepsy and leisure activities. Areas of concern were recorded and these were escalated appropriately, for example to the General Practitioner (GP), or to community healthcare professionals, such as the community health team.

Staff had a good knowledge of the people living at the home and could clearly explain how they provided support that was important to each person. Staff were readily able to explain people's preferences, such as those relating to health and social care needs, personal preferences and leisure pastimes.

The people living at Meadowfield accessed activities in the service, via a day service and in the community, both independently and with the support of staff. Examples included social events, arts and craft classes and trips to places of interest.

People using the service and a relative were aware of to whom and how to complain. They said they would speak to a member of staff and the registered manager if they had any concerns. There were no complaints recorded within the service during 2016. People's views were proactively sought at user forum meetings and through quality surveys. This meant opportunities were taken to seek people's views before they escalated into complaints.

Is the service well-led?

Our findings

At the time of our inspection there was a manager in place. Following our prompting they had applied to become registered with the Care Quality Commission. The people using the service, a relative and staff told us they were happy with the home and with the leadership there. One person said, "[Name] is very dedicated." A relative told us, "I can ring her [manager] at any time; she's really committed." They continued, "There's no problems with [manager] or the staff."

Staff were complimentary about the manager. They were clear about expected standards of conduct and the ethos of the service. They commented, "[Name] is finding her feet and doing well. I think she's doing a good job."

To ensure a continued awareness of current good practice the manager attended on-going training and had networked with other managers within the provider group. The manager sought the advice and input of her line manager, colleagues and relevant professionals. The manager was able to highlight their priorities for the future of the service and their aim to develop into their new role. The manager assisted us with the inspection and was open to working with us in a co-operative and transparent way. They were aware of the requirements to send the Care Quality Commission notifications for certain events and had done so. The manager knew the people using the service and the staff well and had a visible presence within the service.

Most paper records we requested were produced for us promptly and some documentation was sent to us after the inspection. The legionella report we requested at a previous inspection and again at this one was not forthcoming. The manager and staff carried out checks and audits at the home. A representative from the provider organisation also visited to carry out quality checks on care and staffing issues. The lack of follow-up for the legionella report, lack of recorded finance audit and lack of audit of people's savings meant systems were not as robust as they could be. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service and staff said they were well informed about matters affecting the home. The manager told us there were 'house forum' meetings for people living at the home and separate staff meetings. Records confirmed this was the case. A broad range of topics were discussed and feedback was sought. Team meetings included discussions of care related policy, safety and personnel issues. Feedback from people using the service and those acting on their behalf was also sought by questionnaires. Survey results highlighted expressions of satisfaction with the service. Areas where people felt the service was doing well and specific comments included, "Helping me", "A feeling of staff being there for our safety", "Thank you very much to all the staff especially [manager] for the ongoing support and understanding" and "I'm happy. You all do well."

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 17 HSCA RA Regulations 2014 Good governance The registered person had failed to ensure systems and processes enabled them to assess, monitor and improve the quality and safety of the service provided. Regulation 17(2)(a)