Accredited Care Limited

Meadows Sands Care Home

Inspection report

98 South Parade
Skegness
Lincolnshire
PE25 3HR

Tel: 01754762712
Website: www.meadowssands.co.uk

Date of inspection visit:
09 April 2018
10 April 2018

Date of publication:
13 August 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We undertook a comprehensive inspection on 09 and 10 April 2018. The inspection was unannounced.

Meadow Sands is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 is registered to provide accommodation for up to 26 older people. There were 23 people living in the service during our inspection.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had been appointed to post since our last inspection.

When we inspected the service in January 2017 the service was rated requires improvement and was in breach of regulation 12 safe care and treatment and regulation 17 good governance. We undertook a focussed inspection of the service in August 2017 to find out if the provider had made improvements. The registered manager provided us with an action plan that showed that the required improvements had been made.

On this inspection we found that the service had made and sustained the required improvements, and was now rated good.

Systems and processes were in place to keep people safe from the risk of harm and abuse. People had their medicines administered safely by trained and competent staff. The service was clean and staff adhered to safe infection control practices.

People had their care needs assessed and their care was planned in line with up to date guidance and legislation. There were sufficient staff to care for a person's individual needs and staff were trained appropriately. People were provided with a balanced and nutritious diet and staff sought access to a range of healthcare services. People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

People were cared for by kind, caring and compassionate staff. People and staff had a good relationship and the service had a homely atmosphere. People were cared for as unique individuals and their privacy and dignity were respected.

Staff supported people to spend their time as they wished. People had an advanced care plan to protect their wishes at the end of their life to achieve a comfortable and pain free death.

People spoke highly of the care they received and the attitude of staff. Staff enjoyed working at the service and were proud of their achievements. The provider had a robust approach to monitoring the quality of the care people receive. The registered manager had built a good relationship with key organisations and the local community. The registered manager was proactive and innovative and had introduced improvements to the service.

People who live in the service and staff have a voice and are supported to give their feedback on the service.

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.

Staff were aware of how to keep people safe and safeguard them from abuse.

A robust approach to risk assessments had been introduced to protect people from the risk of harm and accidents.

People received their medicines from staff that were competent to do so.

There were good infection control practices in place.

Is the service effective?

Good

The service was effective

People are cared for by staff who have the knowledge and skills to support their needs.

People are provided with a nutritious and balanced diet.

Staff support people to access healthcare professionals.

Staff obtain consent from people in line with current legislation.

Is the service caring?

Good

The service was caring.

Staff looked after people with kindness, care and compassion.

People are enabled to be involved in decisions about their care.

Staff respect peoples' dignity and privacy.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs.

People were treated as an individual.

People were encouraged to maintain their independence.

People and their relatives had information on how to make a complaint.

Is the service well-led?

Good

The service is well-led.

A robust governance framework had been introduced and sustained.

The service had built a strong relationship within the local community.

People and staff have a voice and are listened to.

There is strong visible leadership in the service.

Meadows Sands Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 comprehensive inspection took place on 09 and 10 April 2018 and was unannounced. The inspection team consisted of 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.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made judgements in this report.

Before the inspection we reviewed any information we held about the service. We reviewed safeguarding alerts and notifications that had been sent to us. A notification is information about important events which the provider is required to send us by law.

During our inspection we spoke with the registered manager, three members of care staff, the cook, the housekeeper and seven people who lived at the service and two visiting relatives. We also observed staff interacting with people in communal areas, providing care and support.

We looked at a range of records related to the running of and the quality of the service. These included two staff recruitment and induction files, staff training information and arrangements for managing complaints. We looked at the quality assurance audits that the registered manager and the provider completed. We also looked at care plans for seven people and medicine administration records for seven people.

Good

Is the service safe?

Our findings

The registered manager kept a log of all safeguarding incidents that occurred in the service. These incidents were fully investigated and actions to reduce a risk of reoccurrence were recorded. Staff had access to safeguarding and whistleblowing policies to help keep people safe from harm. We saw that these documents reflected current best practice guidelines. Staff from all disciplines were aware of how to identify if a person was at risk of abuse and their responsibility to escalate their concerns through the safeguarding route or by whistleblowing. Staff had information on the local authority safeguarding helpline and told us that they would use it if they had to. We saw that the safeguarding and whistleblowing helpline numbers were on the staff notice board.

Systems were in place to identify and reduce the risks to people living in the service. People's care plans included detailed and informative risk assessments. These documents were individualised and provided staff with a clear description of any risks and guidance on the support people needed to manage risk. Staff understood the support people needed to promote their independence and freedom, yet minimise the risks.

The service is in a three story building. The bedrooms on the top floor have access to balconies. We spoke with one person in a top floor bedroom who told us that their balcony door was always locked for safety reasons. Other people we spoke with said they felt safe living in the service. One couple told us, "We feel safer in this place than anywhere else. We don't want to move out because they've taken care of us. We trust them." Relatives told us that they were reassured that their loved ones were safe living in the service and one said, "This place has lifted a weight from the family. It's very secure."

We saw that the provider had up to date certificates to confirm that essential safety checks had been carried out to keep people safe. For example, electrical appliance testing, fire safety and water safety. The business continuity plan identified the action staff must take in an emergency situation to keep people safe. A neighbouring hotel had been identified as a place of safety for people to be taken to if the service needed to be evacuated.

People told us and our observations confirmed that there was enough staff on duty to keep people safe. The registered manager calculated safe staffing levels from the dependency of each person living in the service. The registered manager did not use bank or agency staff, but had a unique way to cover shifts at short notice. They explained that all staff had agreed to sign up to an on-call rota. Staff members took it in turns to be on-call on a day off and if another staff member was unable to come to work, the on call covered their shift. We found that the benefits were two-fold; there was continuity of care as people always received care from staff they knew and staff sickness levels had reduced. We saw that people had access to a call buzzer in their bedroom and told us that they knew how to use it if they required assistance from care staff. One person said, "I ring the buzzer, it doesn't take long, they rush in and ask if you're alright.'

A robust recruitment and selection process was in place and staff had been subject to criminal record checks before starting work at the service. These checks are carried out by the Disclosure and Barring

Service (DBS) and helps employers to make safer recruitment decisions and prevent unsuitable staff being employed.

Robust systems were in place for the safe ordering, storage, administration and disposal of medicines. We found that people's medicines, including controlled drugs were managed consistently and safely by competent staff. The dispensing pharmacy provided care staff with training and competency checks every six months. One person was prescribed a nasal spray and staff were assessed by the district nurse to ensure that they were competent to administer it.

We looked at medicine administration records (MAR) for seven people and found that medicines had been given consistently and there were no gaps in the MAR charts. Each MAR chart had a photograph of the person for identification purposes and any allergies and special instructions were recorded. Where a person did not receive their medicine a standard code was used to identify the reason, such as when a person declined their laxative. Some people were prescribed as required medicine, such as pain relief, and staff had access to protocols to enable them to administer their medicines safely.

We identified that the storage of commode basins did not follow national guidelines. We brought this to the registered manager's attention and our concerns were addressed immediately. The service did not have a sluice and staff emptied and cleaned commode basins in the nearest toilet. We observed staff and saw that they had access to adequate supplies of personal protective equipment and used it when handling bodily fluids.

We met with a housekeeper who was clearly proud of their role and their achievements in maintaining a high standard of cleanliness, all areas of the service were clean. We saw that good infection control practices were adhered to. All staff had attended infection control training, had access to policies and procedures that reflected national guidelines and had access to personal protective equipment. Standards of cleanliness in the home were regularly assessed by a registered manager and the housekeepers completed a daily record of cleaning duties undertaken.

Lessons were learnt and improvements were made when things went wrong. We discussed a recent safeguarding incident that resulted in all staff being retrained in the control of substances hazardous to health (COSHH), and the kitchen door was kept locked at all times, even when the cook was working in the kitchen. The head housekeeper showed us the new locked COSHH cupboard stored in the locked housekeeping room to keep people safe from harm.

Good

Is the service effective?

Our findings

Before a person moved into the service the registered manager undertook a full assessment of their physical, social, psychological, cultural and spiritual needs. Risk assessments and care plans were developed in accordance with their needs and preferences and regularly reviewed. When a person moved into the service for a short term respite stay or as an emergency they also had their needs and preferences assessed. Relatives told us that they had been involved in this process.

Newly appointed staff undertook the Care Certificate, a 12 week national programme that covered all aspects of health and social care. All staff undertook mandatory training such as fire safety and safe infection control practices. In addition, some staff undertook special training to meet the individual needs of people in their care. For example, four members of care staff had been trained and had their competency checked to safely change a urinary catheter drainage bag and follow an aseptic technique.

The registered manager had recently introduced a champion's role. Members of staff had taken on the responsibility of leading other staff in key topics that were of interest to them, relevant to their role and would have a positive impact on the well-being of people who used the service. For example, the housekeeper was the infection control champion and the cook was the lead for healthy eating. They acted as a resource to others and shared their new found knowledge with colleagues.

People were provided with a nutritious and balanced diet. We saw that healthy options were on the menu, including fresh fruit, vegetables and salads. People could have a hot or cold drink whenever they wanted one and there was a bowl of fresh fruit for people to help themselves to in the lounge. The cook told us that they had changed over to the summer menu and people were offered a greater choice of salads and pasta dishes, rather than stews and pies. People at risk of weight loss also had their food fortified with dairy products such as butter and milk. We saw where a person did not want to eat their main course, that staff offered them an alternative and the person had soup.

The cook kept a record of individual likes and dislikes and any allergies or special diets people were on, such as weight reduction and reduced sugar. The cook told us what factors influenced the menu and said, "I sit and chat with a group of them [people who lived in the service] about the menus and the food they miss. We introduce new foods to the menu choice and I get their feedback after a meal to see if it worked out ok and if they enjoyed it." People told us that the food was good, they had a choice and they had plenty to eat. One person said, "There is a menu board, they change it for lunch, we usually get sandwiches for tea time. I'm having fish fingers, chips and beans for lunch. I get a dinner every day, Friday is fish & chip day. The meals are lovely." Another person told us, "We have a good breakfast, dinner and tea."

Staff ensured that people ate their meals with minimal interruptions. The service practiced protected mealtimes and visitors were kept to a minimum to reduce the risk of unnecessary disturbances. Staff told us that this enhanced the dining experience for people and they were more likely to eat well when they were not distracted by visitors.

When we arrived on day one, two ambulance personnel had arrived to take a person to a hospital out patients' appointment. We observed how the care staff and ambulance personnel exchanged information about the person and the person was involved in their conversation. One ambulance personnel told us, "We know the residents and staff as we are a local team. The staff are always ready for us arriving."

The registered manager shared with us the difficulties they had arranging visits from their local GP practices and district nurses (DN). The registered manager had written letters of complaint to the practice manager, but the situation had not improved. The root of the problem was that GPs were reluctant to visit a person when they were normally independent with their mobility. The registered manager did add that people had not come to any harm because of the delays in GPs and DNs visits. However, one person was full of praise for the way the registered manager had supported them and involved several health professionals such as a dietitian, DN and physiotherapist to work together to help them regain their independence.

Care staff ensured that people had access to appropriate healthcare services such as their GP, dentist or optician. A member of care staff told us about a person who had recurrent falls and said, "We were concerned about their falls and asked the GP to come and see them. They've now have an appointment for falls clinic. We encourage their family to go with them, but if they're unable staff will go." Care staff knew what to do if a person became unwell or if they need urgent help. The community defibrillator was located in a neighbouring hotel and staff were trained on how to use it.

We found evidence that the service was undergoing a robust maintenance and refurbishment programme in response to concerns identified at a previous inspection in January 2017. For example a new bathroom had been installed on the first floor. It was designed to make bathing a pleasurable activity; with mood lights and a sound system. We noted that other areas for improvement were planned, such as converting the second floor bathroom into a wet room and the provision of a hand wash sink in the laundry. The people we spoke with told us that they had been involved in decisions about the decoration and furnishings. This meant that people's needs were met and they were enabled to take ownership of changes to their home.

People were encouraged to personalise their bedroom and make it homely. We saw that most people had photographs and ornaments from home and some people had chosen their own bedding. We saw that signage throughout the service met the needs of the people who lived there. People could easily identify their bedroom as they had their name and photograph on their bedroom door.

The service did not have secure grounds that people could access on their own. However, there were seating areas with flower pots to the front of the service. People told us that they could sit there with their family and friends or members of staff.

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. Staff understood the principles of MCA and acknowledged a person's right to make unwise decisions. For example, one person recently admitted to the service would have benefited from surgical intervention; however, staff respected their wish to be treated conservatively with support from their district nurse. When a person had appointed a lasting Power of Attorney (LPA) to act on their behalf when they were no longer able to make decisions for themselves a copy was kept with the person's care file.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The

procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Three people living in the service at the time of our inspection were waiting on relevant assessments for a DoLS authorisation.

Staff were aware of MCA, DoLS procedures and how to obtain consent from a person. One staff member said, "We act in the resident's best interest. We don't take away their freedom or ability to make a decision. Sometimes they need an advocate to be their voice." We saw evidence in care files that people had given their consent to have their photograph taken, to share their information with external agencies such as CQC and if they wanted a key to their bedroom door.

Good

Is the service caring?

Our findings

People were looked after by kind, caring and compassionate staff. For example, we observed a member of care staff administer medicine to a person who had mild memory loss. The staff member sat down beside the person and explained their medicines to them and maintained eye contact with the person throughout. The person was not rushed and when they had taken their medicines the staff member had a little chat with them.

People told us that staff were kind and caring. One person said, "The day staff always pop in to say goodnight before they go home and say 'I'll see you in the morning'. Then the night staff come in to see if I'm ok." Another person said, "Staff seem to do what they can to help if I need help. They are all nice girls." One person's relative said that their loved one was well cared for and said, said, "They treat my grandmother like Royalty. She gets anything she wants."

People had a say in the running of their home. We saw the responses received from a recent quality assurance questionnaire completed by people who lived in the service. One person had said that they would like to see smoked haddock on the menu. The registered manager and cook discussed their preferences with them and they now have kippers for breakfast.

Staff told us that they found talking with people helped them learn more about the person than asking them lots of formal questions. A member of care staff said, "You learn more talking to them, give them quality time and they'll open up to you. It's nice to know what they've lived through and we sympathise with their losses."

Care staff told us that it was important to assist people with their care and gave examples of the assistance they would give to help a person eat, bathe and dress. However, one staff member said, "If you do everything for them, then you keep them from doing it themselves. I give them as much independence as I can. I let them choose the clothes they want to wear." We saw where people wanted to help about the service that staff enabled them to do so. For example we observed one person set the dining table for lunch.

Staff had signed up to a dignity commitment to the people who lived in the service and some staff were dignity champions. Staff told us that they treated people the way they would want their families to be treated and believed that the care people received was good enough for their own parents.

People's records and personal information was treated confidentially and staff complied with the Data Protection Act. The provider had recently introduced an electronic system for record keeping. With the exception of food and fluid intake charts, position change record charts and medicine administration records all records were recorded and stored electronically and could only be accessed by a secure password individual to each staff member. This meant that people's personal information was respected by staff.

People were supported to maintain contact with their family and friends and visitors were frequently popping in and out of the service. Some people were enabled to keep in touch with their relatives who did not live locally through the use of social media or their mobile phone.

Six of the bedrooms were designed as shared occupancy. We found that two couples who lived in the service shared a bedroom, as this had been their custom all of their married life together. We observed staff enabled them to spend quality time together. We spoke with people who shared the other double bedrooms and found that measures had been put in place to respect their individual space and promote their privacy and dignity.

Good

Is the service responsive?

Our findings

People had their care needs assessed and personalised care plans were introduced to outline the care they received. Care was person centred and people and their relatives were involved in planning their care. We saw that individual care plans focussed on supporting people to live well and maintain their optimum level of independence and well-being. People told us that they could spend their time how they wanted to and go to bed and get up at a time that suited them. One person told us, "It's just like your own house. I always come up the stairs at half past five and get undressed to go back down. I come up to watch TV. I bought the TV. My daughter phones every night on my mobile or she texts me."

After lunch several people joined in a sing-along to "Old Time Music". One person's favourite pastime was singing to the radio and we observed that this person was happy sitting at the dining room window waving to passers-by and singing. Three people and a member of staff were playing a board game. We observed a lot of friendly banter and laughter and people and staff were comfortable in each other's company.

Group social events were arranged to reflect people's histories or lifestyle. For example, people had recently been involved in a "Forties" themed day. The entertainment, clothing and menu reflected this era. People had been issued with ration cards and used them in exchange for food from the buffet table.

Most people had previously lived in the local community prior to moving into Meadow Sands. We found evidence where people were supported to maintain their involvement in the community. For example, during the weeks leading up to Christmas the local Rotary club had a shoe box appeal for less fortunate families in Eastern Europe. People bought and wrapped gifts and donated shoeboxes to the appeal. This meant that people achieved a sense of belonging and sharing and felt like they mattered.

People were supported to maintain their cultural and religious beliefs and could choose to attend regular religious services of different persuasions held in the home.

Several people living in the service had mild cognitive problems. The registered manager had researched activities that would enhance and promote their individual wellbeing. They had sought support from family, friends and the local community to fundraise to buy an interactive table specifically designed for people living with reduced cognitive ability. We spoke with one person's relative who had planned a sponsored cycle ride from Skegness to Lincoln Castle and back to raise funds for the table. Several local businesses were involved in fund raising and a fun day had been planned for May bank holiday Monday, with entertainment. Following this event the registered manager informed us that their fundraising events had been successful and had purchased the interactive table. Relatives and members of the local community who had supported the fundraising had been invited to see the table in use. The registered manager shared with us a video of a group of people being supported by staff to use the table. We saw that they were fully engaged in what they were doing and staff encouraged and praised them.

People and their relatives had access to information on how to make a complaint, and told us that they had no reason to complain and could talk with staff at any time. Staff told us that if a person shared a concern

with them they would escalate the concern to the registered manager or the deputy manager. A member of staff told us, "If anyone complained I'd go straight to [name of registered manager]." The registered manager addressed all complaints and we noted that complaints were resolved in a timely manner. Complaints were stored electronically and confidentially.

People and relatives were aware of how to share their concerns. However, one person's relatives said, "I can go to the manager, any of them, they are proactive they phone us. Today one of the staff rang. They keep us informed, anything that's happening they let us know." Another relative said, "We can speak to [name of registered manager] all the time. There's never any hassle they're always interested."

Staff understood the importance of supporting people and helping them prepare for care at the end of their life according to their wishes. People were supported to record their final wishes on an advanced care plan, such as where they wanted to have their funeral. The evening before our visit one person had died unexpectedly. A member of staff told us that it was sad time when a person in the service died and said, "It's a sad loss as you are with them here and then they are gone." We found that the registered manager returned to the service the previous evening when the person had died to give them last offices as a mark of respect for the person who had died.

Good

Is the service well-led?

Our findings

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. There was a registered manager in post at the time of our inspection.

Staff told us that the registered manager was approachable and that they felt respected and valued. One staff member said, "I couldn't ask for a better manager. They are understanding. If I don't understand anything, they help me. I enjoy working here." Another member of staff who had recently been appointed to their post spoke about the positive attitude they had experienced from the registered manager and staff and said, "[Name of registered manager] has gone over everything with me. The support, not just from the manager, but from all the staff had been great. We're like one big family, all have the same thinking. I was made to feel like part of the team on my pre-visit." One staff member summed up the staff culture and said, "It's like family. We are all helpful and can all pull together."

Improvements had been made to the culture of the service since our last inspection. People and their relatives told us that there had been a positive change in the culture since the registered manager took up their post and that they had recommended the Meadow Sands as a good place to live to other people. We received feedback from relatives such as, "It's superb, I can't fault it", "The manager leads from the front, we don't have to sort problems out. We've noticed a change in culture." Staff also spoke about the positive change to the culture of the service since the registered manager was appointed. A member of staff said, "Everything is addressed in a mature manner. If I get something wrong we talk about it."

All staff were invited to regular meetings and had a voice. We looked at the minutes of the last two meetings and found that topics discussed were pertinent to the care and well-being of people who lived at the service. For example, confidentiality, bedroom cleanliness checks and person-centred care.

The registered manager told us that they were well supported by the provider who was in daily telephone contact with the registered manager and visited the service once a week to offer on-going support to make improvements to the quality of care people received. In addition, the registered manager and provider met off-site once a month for a full business development day.

The registered manager always submitted statutory notifications to CQC. A notification is information about important events which the provider is required to send us by law. CQC rating from previous inspection was on display in the main hallway.

People and their relatives were provided with a copy of the statement of purpose (SoP). We saw a copy of a recently revised version and noted that it was relevant to people who lived in the service as it focussed on core values which included dignity and freedom of choice.

All staff were involved in supervision sessions and met with the registered manager every three months to

discuss their progress and performance and jointly identify their learning needs. For example, we saw one person had been put forward to attend a training course in dementia and another person had been identified as a being ready for promotion to a more senior position. The registered manager told us that supervision sessions can happen more frequently if there are urgent matters to discuss. Staff shared their experience of supervisions and appraisals with us. A staff member said, "I had my appraisal with [name of registered manager] last week. She told me to keep doing what I am doing. It was all positive."

The registered manager ensured that people and their relatives were kept up to date with events and news about the service through a quarterly newsletter. Relatives told us that they had been asked for their feedback on the service and had been invited to meetings.

The provider had changed their approach to auditing the service and had introduced more robust audit tools to measure the quality of care people received and the overall effectiveness of the service. When necessary the registered manager developed an action plan to address any areas that required improvement. We discussed the benefits of the new electronic record and reporting system with the registered manager. A major benefit was that the registered manager could access an overall view of assessed risks to people who lived in the service, such as the risk of malnutrition or falls. Another benefit of the electronic system was that when a person moved into the service, staff recorded a summary of their care needs. This flagged up the care plans needed. If any omissions were identified, then the care plans cannot be reviewed until these have been completed.

We found that improvements had been made in the standard of information recorded in food and fluid intake charts and position changing charts. The records were completed at the time care was given and signed by the staff member responsible. This meant that the registered manager had an audit trial of the care provided to people.

The service was member of Lincolnshire Care Association (LinCA). LinCA supports care home staff to keep up to date with current legislation and best practice guidelines. The infection control leads attended the local authority infection prevention control (IPC) forum led by the local authority IPC team. Internal IPC audits were undertaken using the forum's recommended care setting improvement tool to measure the standard cleanliness in the service and prevent the risk of infections and cross contamination. The service had achieved Investors in People award and had scored the maximum rating of five stars at their latest environmental food hygiene assessment.