Meadow Court Limited

Meadow Court Residential Home

Inspection report

Meal Hill Lane
Slaithwaite
Huddersfield
West Yorkshire
HD7 5EL

Date of inspection visit:
08 February 2016

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15 June 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 8 February 2015 and was unannounced. Meadow Court is a care home providing personal care and accommodation for up to thirty seven older people. It is located in Slaithwaite, Huddersfield, West Yorkshire. At the time of the inspection there were 33 people using the service.

The service was inspected in May 2013 and was not meeting one of the standards of the Health and Social Care Act regulations. It was inspected again in October 2013 and was found to be meeting all standards against which it was inspected.

There was a registered manager in place. 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.

Staff were aware of their roles and responsibilities in relation to safeguarding. Staff training in safeguarding was up to date.

Medicines were not administered safely. We could not see the provider had carried out any competency checks on staff who had been trained to administer medicines or completed effective medication audits.

People who used the service and staff we spoke with felt there were enough staff on duty and we observed call bells were answered in a timely manner. However, during the night when staff were busy offering personal care, there was no other staff available within the building to support people.

The accident records showed a high number of un-witnessed falls occurred during the night when there were only two members of staff on duty. Accidents and incidents had been recorded but not analysed. This meant the provider could not to establish any patterns or trends and put in plans to minimise the risk of harm.

There were no personal emergency evacuation plans (PEEPs) in place and fire drills had not been carried out on a regular basis.

We looked at the training matrix for the service and saw gaps in staff training for the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS).The registered provider was meeting the requirements of the MCA 2005 and associated DoLS.

The food looked appetising and people we spoke with told us they enjoyed the food. People had been weighed monthly and the provider had referred people with weight loss to the General Practitioner (GP).

There was a variety of activities on offer for people to take part in. In the care records we looked at we saw the people's social preferences had been recorded.

Staff were aware and knew how to respect people's privacy and dignity.

Management of the service was divided between the registered manager and the providers. However, we found it difficult to establish what the role of the registered manager was when the provider was involved in the day to day management of the home.

We identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take in the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff had received training in safeguarding and understood their roles and responsibilities in reporting their concerns.

People who used the service felt there were enough staff to meet their need in a timely manner.

Medicines had not been administered in line with the recommendations of the manufacturer. There was no protocol in place for the administration of 'as and when' or PRN medicine. The temperature of the drugs fridge was not being recorded.

Risk assessments had not been completed in relation to emergency evacuation. This puts people risk of harm because their support needs in the event of an evacuation had not been identified.

Risk assessments were in place and had been reviewed on a monthly basis.

Is the service effective?

Requires Improvement

The service was not always effective

Not all staff training was up to date. Some staff had limited understanding of mental capacity and how decisions might be made in someone's best interest if they lacked capacity.

The registered provider adhered to the principles of the MCA 2005 and we saw evidence DoLS had been applied for appropriately.

People had access to health care professionals in a timely manner.

People were offered a choice of food at mealtimes. We saw a variety of snacks and hot and cold drinks had been made available to people throughout the day.

Is the service caring?

Good

The service was caring.

We saw staff and people who used the service got on very well together, interaction was warm and respectful.

Staff understood the needs of people who used the service and could recognise changes in people's condition.

People's privacy, dignity and independence was not always respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although the care records were detailed and person centred, there were gaps in the recording of people's information in their care records.

People felt happy with the level of activity which took place within the home.

Information was available letting people know how they could make a complaint. The registered provider did not record informal concerns. This meant feedback was not being monitored to identify patterns or trends.

Is the service well-led?

Requires Improvement

.The service was not always well led

The registered manager was known to people who used the service and staff felt the service was managed very well and they felt supported.

Day to day management of the home was shared between the registered manager and the registered provider.

Whilst there was evidence health and safety audits had been carried out, the registered provider had not carried out audits of accidents, incidents and medicines.

Quality assurance systems were not always efficient in monitoring the effectiveness of the service.

Meadow Court Residential 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 took place on 8 February 2016 and was unannounced.

The inspection team consisted of one adult social care inspector, a bank inspector and a specialist adviser who has a nursing back ground and experience in medicines.

We spoke with four people who used the service, two relatives, three care workers, two senior members of staff, the registered manager, the registered providers, the housekeeper and the kitchen apprentice. We looked at the care records of four people who used the service and we reviewed five staff files. We looked at the staff rota and training matrix. We reviewed the records relating to the safety of the premises and equipment.

Prior to the inspection we contacted the local Health watch office to establish whether they had received any information about the service. Health watch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We did not request a Provider Information Return (PIR) because the inspection was in response to concerns which had been raised. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Inadequate

Is the service safe?

Our findings

One of the people we spoke with told us, "I feel so safe here." Another person told us," Staff have the skills to keep me safe."

Staff we spoke with told us they had received training in safeguarding and had a good understanding of what constituted abuse and how they would report their concerns. The training matrix showed staff had completed training in safeguarding. We asked staff how they would recognise signs of abuse in people who had difficulty communicating. They told us they would be able to tell from people's body language and emotions whether anything was wrong.

We saw staff used equipment such as a hoist in a safe way. One person told us, "I don't like the hoist but they [staff] know what they are doing so I feel okay."

Staff completed electronic risk assessments for each person to assess their level of need in relation to mobility, nutrition and hydration and skin integrity. Staff tracked the outcomes of risk assessments on a monthly basis, which were presented in individual care plans using a graph that enabled staff to quickly identify changes in need. Established risk assessment protocols were used to ensure people's needs were adequately met. For example, staff used the Falls Risk Assessment Score for the Elderly (FRASE) to assess needs relating to mobility and the Malnutrition Universal Screening Tool (MUST) to protect people from malnutrition. 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. It also includes management guidelines which can be used to develop a care plan. This meant care and support was planned and delivered in a way that reduced risks to people's safety and welfare.

We saw a monthly review of each risk assessment had taken place and when any changes in risk had been identified the risk assessment had been updated.

Staff we spoke with told us they were aware of the whistleblowing policy but had never had to use it. A whistle-blowing policy gives guidance and protection to individuals in order to raise any concerns about any alleged wrongdoing (as set out in the Public Interest Disclosure Act 1998), at an early stage and in the right way, without fear or victimisation, subsequent discrimination or disadvantage.

We looked at the accident and incident reports for five people and saw out of 23 falls, 18 of them were unwitnessed. Out of the 18 unwitnessed falls, 11 had occurred during the night shift. We asked the registered provider how often they audited the accident and incident reports. They told us they did not analyse the reports and were not aware of the number of unwitnessed falls that happened during the night shift. The registered provider told us information from accidents forms were recorded in individual's mobility care records and reviewed monthly. In the care records we looked at we did not see any referrals had been made to specialist services such as the falls team for people who were at risk of falls. The lack of analysis of the accident reports showed the registered provider was not able to identify trends or patterns and put in action plans to minimise the risk of harm.

Staff we spoke with told us they had received training moving and handling but not in falls prevention. This showed the provider had not taken steps which ensured had the necessary skills and knowledge to minimise the risk of people having falls.

The registered provider told us they used to monitor the waiting times for call bells but had not been doing this as the home was being refurbished and redecorated. It was difficult for us to establish the amount of time people had to wait for their call bells to be answered during the night. During the day, we heard the call bells answered in a timely manner and people we spoke with told us they did not have to wait long for staff to answer their call bell. The number of people who required two staff to support them varied according to their needs. This meant, during the night, if two staff were supporting one person, there was no other staff available for people when they rang their call bell.

Although staff we spoke with told us they felt the levels of staffing were good, one member of staff told us, "There are enough staff but it is busier in the morning so another pair of hands would help." People who used the service told us, "The staff work very hard, how these girls cope I don't know."

The registered provider told us they did not use a dependency tool to allocate staff but to determine how many staff each person required. On duty during the day there were; three care staff, one registered manager, one activities coordinator, two domestics, one laundry person and two kitchen staff. During the night there were two members of staff on duty. The provider told us only three people required the support of two care staff for specific personal care tasks.

These examples demonstrate a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the registered manager to show us the temperature records for the treatment room and the drug storage fridge. We saw a thermometer in the fridge and asked the registered manager to show us the records of the fridge temperature they told us, "We don't write it down anywhere what the temperatures are, but we look at the thermometer every time we go in the fridge".

We saw topical medicines such as creams and lotions which did not have a date of opening written on the tube or on the box. It was difficult to establish how long these medications had been in use. There was a risk people could receive out of date medicines. One person had been prescribed eye drops but there were no instructions to tell staff which eye the drops were to be placed into or how many drops to administer.

There were no protocols in place for medication prescribed on a PRN or 'as required' basis. PRN protocols inform staff how to administer this medication, the indications of when it should be given and when to omit it. This meant it was not always clear to staff how they should have administered the medicines.

Medication audits were not being undertaken effectively. The provider had attempted to put in place an audit tool, however it was simply a tick box audit, and did not provide meaningful information. There was no action plan attached to the current template meaning that if issues had been identified at the time of audit, there was no means of recording what these were, how they would be rectified and by whom.

These examples demonstrate a breach of Regulation 12 (1) (2) (g) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

In three of the four staff records we looked at a current DBS (Disclosure Barring Service) certificate was in place. The DBS enables organisations make safer recruitment decisions by identifying potential candidates who may be unsuitable for certain work that involve adults. In the fourth record we saw where a delay had occurred in obtaining a DBS; staff had been able to work following a risk assessment and accompanied by a colleague.

The recruitment and selection process was not as robust as it could have been. We looked at the personnel records of four members of staff. We found professional references had been documented inconsistently. For example, in one staff member's record one employment reference was unsigned and undated. In two other staff records friends had supplied references and in another there were no documented references. The showed the provider had not completed a series of pre-employment checks prior to make sure potential candidates were suitable and safe, before they started working with people.

This demonstrates a breach of Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider carried out internal and external health and safety checks. We saw where any issues had been identified through the checks; action had been taken to address them. We saw there was a piece of tape keeping two pieces of carpet together, this could have posed a risk as people walked about the building. The registered provider told us they were in the process of arranging a new carpet to be fitted and this would address the risk of people tripping on the tape. Safety checks had been carried out on the equipment used by the home.

The interior of the building was cluttered with furniture and chests of drawers. Although we saw people walked around the building and staff could manoeuvre wheelchairs along the corridors, there was a risk the clutter could impede an evacuation in an emergency.

There were no Personal Emergency Evacuation Plans (PEEPs) in place. A (PEEP) is a document which details the safety plan, for example the fire exit route, equipment, staff support for a named individual in the event the premises have to be evacuated. This meant there was a risk people's support needs would not be understood in the event if an evacuation of the building. We found fire exit signs were not always clear in the home. For example, one fire exit sign was placed on the floor next to a ground floor exit but was pointing away from the door. This meant it was not clear where people should evacuate to in an emergency. Health and safety records we looked at showed fire drills had not been carried out on a regular basis. The training matrix we looked at showed staff had not received training in fire safety awareness. The providers told us they were aware of the gap in staff training and had plans in place to address this.

These examples demonstrate a breach of Regulation 12 (1) (2) (a) (b) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us they felt staff had the skills and knowledge to carry out their role effectively. One person told us, "They know me and what I need." Relatives we spoke with told us, "They know [relative] and I feel staff have the knowledge and skills to do their job."

During our observations it was clear staff had a good understanding of people's needs. Staff we spoke with told us they had worked at the home for a long time and knew people who lived there very well.

From looking at induction records, we saw staff had been given an introduction to each person who lived in the home. This enabled them to get to know people before having the time to read people's care plans and risk assessments.

Staff we spoke with told us they had supervision every three weeks and found supervision useful to discuss issues. The aim of supervision is to enable staff to reflect and learn from their practice, to discuss professional development and to be given advice and support. Whilst staff told us they had received supervision, when we looked at the supervision records for four members of staff we saw that supervisions had been recorded inconsistently between staff roles and for some individuals. For example, one staff member's supervision record indicated in January 2015 they were to receive a monthly supervision review. In March 2015 this changed to two-monthly but there were no documented entries until August 2015. The member of staff had been given an annual review in October 2015 but this did not explain the discrepancy in more regular supervision. We saw from looking at records that a senior member of care staff had not received supervision since June 2015.

The content of supervisions was not always detailed or constructive. For example, in the supervision record of one member of staff the registered manager had written, 'Discussed various things.' It was not possible to identify how this had been used to support the member of staff or develop their practice.

These examples demonstrate a breach of Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had completed training in areas relevant to their role, including catheter care, pressure ulcer prevention, dementia, First Aid, moving and handling and medicines management. We saw one member of care staff had undergone Common Induction Standards 2010 (CIS). The CIS sets down minimum expectations to the learning outcomes that need to be met so that new workers know all they need to know to work safely and effectively. We saw other care staff had undergone the Care Certificate with Skills for Care training. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers. The CIS has since been superseded by the Care Certificate.

This showed us staff had access to a specialised programme of training based on the best practice of national qualification and certification organisations.

Staff we spoke with told us they enjoyed the training and there was plenty of it. One staff member told us, "The dementia course is good; it gives you an understanding of how to work with people."

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 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 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 and whether any conditions on authorisations to deprive a person of their liberty were being met. 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 2005. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA 2005 and whether any conditions on authorisations to deprive a person of their liberty were being met.

The home had a key pad in place to protect people from leaving the building unsupervised. Some people who used the service were living with dementia and had difficulty recalling information and making decisions. Dementia can impact upon a person's ability to make decisions regarding their health and wellbeing.

In one of the care records we looked at we saw the registered provider had submitted an application to a 'supervisory body' for authority to restrict this person's liberty in line with the principles of the MCA 2005. A best interest meeting had taken place and the opinion of the person's relative had been taken sought. Following this process demonstrated openness and transparency in providing services for people who lack capacity as described in the Mental Capacity Act 2005.

There was a mixed response from staff when we asked them about their understanding of and training in the MCA and DoLS. One staff member had not received training in MCA or DoLS. The only relevance they felt the MCA and DoLS had on their day to day work was asking people for their consent before they carried out any personal care. Other staff we spoke with did have a good understanding of the MCA and DoLS and how they would apply the legislation in their role. This meant there was a risk people's human rights were at risk of not being protected because not all staff had received training in the MCA 2005.

Where people had been assessed as not having the capacity to make decisions or give their consent to care and treatment, the registered provider had asked the relatives to give their consent to care and treatment on behalf of the person. We did not see evidence there was a Lasting Power of Attorney in place giving the relatives the legal authority to do so. A lasting power of attorney (LPA) is a way of giving someone you trust the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future or no longer wish to make decisions for yourself.

In the four care plans we looked at pre-admission consent to care had been documented for each person. This included consent for staff to take photographs of wounds or lesions to assist with medical treatment. Staff we spoke with told us they always asked for people's permission before they carried out any kind of personal care. This meant before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

People we spoke with told us they had access to other health care professionals such as their GP and

chiropodist. The provider made use of a system called Telemed. Telemed is an electronic system which gives staff access to specialist health care advice from nurses or doctors 24 hours a day without people having to leave the building. The provider told us Telemed had proved especially useful at night when it was difficult to access a GP in a timely manner. People we spoke with told us they had access to other health professionals such as their GP, chiropodist and optician. In the care records we looked at we saw people had been referred to health care professionals when there had been concerns about people's health and wellbeing. The provider told us they had a good relationship with their local GP practice and district nurse service.

We saw people's bedrooms had been personalised to reflect their hobbies and interests. We saw people had brought in furniture from their home; there were photographs of their family and friends on walls and on top of chest of drawers. Each of the bedrooms we looked in had been painted or had wall paper which had been chosen by the person. One room we looked in had been decorated with posters and signed photographs of the person's favourite celebrities. Personalising bedrooms helps staff to get to know a person and helps to create a sense of familiarity and make a person feel more comfortable.

We found the registered provider had modified aspects of the environment to meet the individual needs of people. For example, to enable people with reduced mobility to use the outside space safely, the provider had installed non-slip surfacing. The main lift included a pull-down support stool, which helped people with reduced mobility to use the lift comfortably and safely. The provider had created a separate memorial garden for the relatives of people who had died to use for quiet reflection and to plant flowers in their memory.

The environment was not conducive to promoting people's independence. There was a risk people with memory problems or visual difficulties would not be able to find the bathrooms and toilets because they did not have signs on them. Not all bedroom doors had pictures of the person on the front of them. This meant people who had memory problems or who lived with dementia had to rely on staff to find bathrooms, bedrooms and toilets. The registered provider told us some people had chosen not to have their picture on their bedroom door. We did not see any evidence of any consultation about whether people wanted photographs on their doors.

We observed the lunch time experience. We saw the food looked nutritious and people we spoke with told us they enjoyed the food very much. The dining room was large with plenty of space for people to move about between tables. The environment was calm with classical music playing in the background. The tables seated up to four people and this made it easier for people to talk to each other. Each table had been set with napkins and condiments. Some people chose to stay in their rooms to eat their meal and we saw staff covered the plates which ensured food was kept warm and was protected as staff carried the food tray to people's bedroom.

There was a menu on the wall of the dining room telling people what was for lunch on the day. We asked people if they knew what was for lunch and they were able to tell us and showed us where we could find the information.

Care staff told us all staff had MUST training and they felt the kitchen staff had a good understanding of people's nutritional needs. There was a list in the kitchen which detailed who was on specific diets such as soft diets or diabetic diets. Although drink thickener had not been identified as being required by people, the care staff we spoke with understood when and why it would be prescribed. People who used the service had been weighed monthly and we saw any concerns with weight loss had been shared with the GP and the

dietician.

We observed snacks, including a selection of cakes, biscuits and fruit were available for people to eat and hot and cold drinks had been made available to people through the day and with their meals.

Good

Is the service caring?

Our findings

People we spoke with told us they felt staff who supported them were very caring. One person told us, "They [staff] are lovely, they are very good." Another person told us, "I couldn't ask for better people to look after me."

We asked people whether staff spoke with them in a respectful way. One person told us, "They never shout, they are all very patient." One of the relatives we spoke with told us, "The staff here are so good, I chose this home because my friends told me how caring staff were."

We observed staff treated people with respect. They knocked on people's bedroom door before they entered. We saw Interaction between staff and people who used the service was warm and friendly. Visitors we spoke with told us they felt welcome to visit their relative at any time. We saw people had visitors through the day. Visitors to the home told us they felt staff were very caring toward their relatives. People looked well dressed and cared for. This showed staff had taken the time to support people with their personal care in a way which would promote their dignity.

On the day of the inspection, it was one person's birthday and the kitchen staff had made a cake which was presented to the person at lunchtime. All people in the dining room took part in singing 'Happy Birthday' and in the afternoon we saw people had a celebratory drink. One member of staff told us it was important they celebrated people's birthday and the kitchen staff always made a birthday cake when it was some one's birthday.

In each of the care plans we looked at, staff had included details of how people would like their dignity maintained during day-to-day care. For example, one person had stated they would like help to maintain their personal hygiene and generally smart appearance. We found staff had personalised each person's care plan to include consideration of how to ensure the risk of social isolation was reduced whilst ensuring people had the level of privacy they wanted. We saw for one person this was achieved by providing them with a tranquil and calm environment and gently encouraging them to socialise with other people. One person's care plan indicated it was important to them to have well-manicured nails, we saw they had a recent manicure from a member of care staff.

There were no private spaces available for people to meet with their visitors and have conversations in private. One visitor we spoke with told us, "I can go to [relative's] bedroom but it is too far for them to walk so we just meet in the lounge. It would be nice to have a private space to talk to [relative] a bit closer."

One of the people we spoke with told us they attended a 'committee' meeting once a month where they discussed ideas such as future outings, activities and the quality of the food. We observed staff and the activity coordinator asked people if they wanted to take part in the activity of the day. We saw staff ask people where they wanted to sit in the communal lounge and dining room. We saw a service user involvement policy was in place. This showed people were involved in decisions being made.

When people were being transferred from wheelchair to chair, we saw staff explain to people what was happening at each stage.

End of life care records had been completed and reflected people's preferences. We looked at the care record of one person who had been cared for in the home at the end of their life; we found staff had adhered to the wishes the person had expressed in advance and been responsive in calling for emergency out of hours medical help. The training records of three care workers we looked at indicated they had undergone end of life care training.

We did not see any information about how people could access the advocacy service on display. When we spoke with staff and the provider about the MCA and DoLS, only one member of staff mentioned the use of advocacy to support people make decisions when they did not have capacity to do so themselves and when their relatives did not have a LPA in place. An advocate is a person who is able to speak on people's behalf, when they may not be able to do so for themselves.

The provider kept electronic care records access to which was password protected. The provider told us information was updated each night and stored onto a secure server. This showed the provider had taken steps to protect people's confidential information.

We saw staff encouraged people to be as independent as possible. People were encouraged and supported to access local community services such as the local café. We saw one person had been out to meet and have a coffee with their relatives. The care records we looked at had identified personal care tasks people could carry out themselves and tasks which required support from staff. This showed the service had taken steps which ensured people were encouraged to retain skills to maintain their independence.

Requires Improvement

Is the service responsive?

Our findings

None of people we spoke with were aware of their care plan. When we asked one person what they could tell us about their care record, they told us, "I can't remember if have a care plan." This showed the registered provider was not involving people in the creation and review of people's care records.

One of the relatives we spoke with told us. "When my [relative] first came to the home I was involved in their care plan but after that I am happy to trust them [staff] to care."

Prior to moving into the home, the registered manager or the provider carried out an assessment of need. This involved a face to face assessment and a visit to the home where the person would be observed and assessed. The provider told us they felt this way of assessing people ensured the care staff would be able to meet the needs of the individual.

Once the person had moved to the home, an assessment of individual need would be carried out and electronic care plans created to help staff deliver personalised, timely care. The electronic records included an individual diary for each person that staff used to record medical appointments, safety-related incidents, planned social activities and events important to people such as their birthday. This meant staff could provide an overall level of care that was responsive to people's needs because there was an individualised approach to everyone who lived in the home.

At the top of each page of the electronic records, a high-visibility colour-coded system was used to identify important information about each person. This included if a person had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order in place, if they were diabetic or if they had any allergies. Each electronic care plan included space for a personal profile, which staff used to detail of the person's life, likes and dislikes. In two of the care records we looked at we found this section to be detailed and to have been influenced by the person and their relatives. For example, in one care record we found the person had asked staff to call them by their nickname. This helped care staff to know what was important to the people they supported. However two care records we looked at did not contain a personal profile. One of the care records did not have in place a personal profile for the person who visited the home for day care. This meant there was a risk people's needs would not be understood when care was carried out.

Staff completed daily care records for each person and recorded a monthly update in each person's electronic diary that indicated where they needed to pay additional attention. For example where a person appeared to be disinhibited, aggressive or restless. Although we found records to be up to date staff did not always record how changes in behaviour or need were tracked and managed. For example, staff had recorded in daily notes that a person had been distressed, disorientated and shouting out in the night and had demonstrated aggressive behaviour. There was no documented follow up to this and staff had not indicated what action had been taken to ensure the person's needs were met.

These examples demonstrate a breach of Regulation 17 (1) (2) (c) of the Health and Social Care Act 2008

(regulated activities) Regulations 2014.

Each person had a monthly dependency assessment. Staff used this to assess each person's level of need in relation to communication, bathing, washing, dressing, grooming, continence, eating, drinking, moving and handling, pain management and sleep.

Staff had completed personalised monthly risk assessments to meet the individual needs of people. For example, one person was recorded as at risk of reduced mental cognition and associated problems with communication. Staff had spent time with the person and found they could become frustrated when they couldn't hear people talk to them clearly. Staff had addressed this by implementing a more detailed communication care plan. Another person was known to experience high levels of anxiety. We found staff had planned appropriate care by indicating the person should be offered reassurance, offered the choice of quiet activities such as jigsaws and the opportunity to sit and talk whenever they wanted. From looking at care records, we found staff understood the need to interpret non-verbal communication with people who could not verbalise their needs or feelings.

Activities took place on a daily basis and included board games and external entertainers. One person told us," I really enjoy the days when they bring in birds, the last time they brought in an owl." Activities were planned during the residents 'committee' meetings. In one of the communal areas we noticed a computer on a table. One person told us, "I have used the computer to e-mail my relatives. I was very proud of myself being able to do that." During the inspection we noticed the dining room had been decorated with Chinese lanterns to celebrate Chinese New Year.

We saw from looking at the daily notes of people that staff made sure they were aware of the daily activities on offer and encouraged people to join in. We saw the provider had sought the opinion of people who used the service and their relatives about the activities. The responses were positive and people reported the amount of activities was good.

The provider had a 'how to complain' policy in place and information about making a complaint was in the handbook given to people who used the service. People we spoke with told us they would talk to the registered manager if they had any complaints. Relatives we spoke with knew how to make a complaint. One relative told us, "I feel I can approach [registered manager] to talk through any issues so I haven't made any complaints because I feel they listen to me." We looked at the complaints file and saw no formal complaints had been made. The provider told us they had not received any complaints and did not record any informal issues raised by relatives or people who used the service. This meant the provider was not able to analyse feedback about the service to identify patterns or trends.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with told us they knew who the registered manager was. One person told us, "The manager is lovely." One of the relatives we spoke with told us, "I think the home is very well managed."

There was a registered manager in place. The service was managed by both the registered manager and the registered provider. The registered provider had day to day involvement with the service. The registered provider told us they felt the way the service was currently managed worked well because there was a lot of support available for the registered manager and for them as the registered provider. The care staff we spoke with were aware the registered manager had overall responsibility for the day to day management of the home.

We asked the registered provider what they felt their challenges were. They told us they wanted to build on the care records they currently used to make them more person centred. As they had not been involved with the home for very long, the registered provider told us they felt they were still learning.

The Registered Manager had been in post for a long period and stated, "I feel very supported in my role. It was difficult when they [registered providers] took over from their [relatives] because their way is very different to what we are used to but I can see now that we need fresh ideas and fresh eyes. We have clearly got a lot of work to do and caring alone is not enough anymore"
We reviewed the registered provider's policies and procedures. The policies had been purchased from an external company and as a result were generic and not specific to Meadow Court, except for the name and address of the service listed within.

Some of the Health and Safety, Risk Assessment and Administration policies were due to be reviewed in June 2015 however there was no evidence that this had been completed. Reviewing policies enables registered providers to determine if a policy is still effective and relevant or if changes are required to ensure the policy is reflective of current legislation and good practice.
There were seven folders which contained policies relating to care management, care planning, quality assurance, CQC registration, Human Resources, Health and Safety and Administration. We saw a copy of the Mental Capacity Act Code of Practice also.

We had received notifications from the registered manager and registered provider and they had referred incidents to the local safeguarding authority. However, they had used an out of date notification system when sending in notifications to the CQC and we concluded the registered manager had not kept themselves up to date with notifying incidents to the CQC.

The registered manager had not used the updated system of notifications and we had to provide them with the handbook for provider notifications as they acknowledged they were not aware the system had changed

We looked at the most recent quality assurance survey used by the registered provider to seek the views of people who used the service and their relatives. We saw the results were very positive and we saw the

actions the provider had taken to address any issue identified through the survey. For example, the survey highlighted people's concern about the fall in the number of activities and the provider responded by employing a new activity coordinator.

Care staff we spoke with were very positive about the way the home is managed. One care staff told us, "The manager is visible on the floor and they carry out spot checks on our performance." Another member of staff told us, "I feel I could go to the manager about anything." During the inspection we saw the registered manager was visible throughout the building and often interacted with people who used the service.

Staff told us they had a sense of the vision of the home and felt it had changed over the past twelve months and had become more focussed on the future. In the handbook given to people who used the service we saw the registered provider had outlined the aims of the home and how the aims were to be achieved. The aims had also been displayed in the reception area of the building.

The registered manager had two relatives working as care staff and we asked them how they would approach their relative if they had to investigate poor practice or issues of poor performance. They told us they did not have responsibility for the supervision of their relatives, they were supervised by the registered provider. They felt this helped maintain professional boundaries. We spoke with the relatives of the registered manager and they confirmed they had been supervised by the registered provider.

The registered provider had carried out regular health and safety checks which included water temperature checks, electrical safety checks and fire safety checks. The registered provider told us they were in the process of updating and improving the fabric of the building by redecorating and replacing floor coverings. They told us they still had a lot of work to do to improve the look of the home and ensure the safety of people who used the service, for example through replacing floor coverings. As we looked around the building we saw evidence of the changes taking place, we saw rooms had been redecorated and updated.

People who used the service told us they felt the home was changing and felt positive about the changes. However, there was one person who did not approve of the changes that had taken place and they were waiting for their film room to be finished.

We requested the staff meeting minutes for 2015 and we found staff meetings had been held on a regular basis until August 2015 but none had taken place after this date. These meetings were held with the team leaders only and the provider told us, "Ideally we would like to hold these once a month but it is hard with staff needing holidays and people being off sick".

We asked to see minutes of a full staff meeting and was told that as the registered providers lived on site, they saw staff daily and therefore felt there was no need to hold a full staff meeting. However, staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and treatment for people living at the home.

Although the registered provider carried out regular health and safety checks, they did not carry out audits on accidents and incidents and we found incidents had not always been recorded consistently or accurately. The temperature of the drugs fridge had not been recorded. We saw there were inaccurate recording of information in people's care records. For example we saw there was a behavioural incident relating to one person that had been categorised in their care records as 'breathing difficulties.' Whilst staff felt communication was not an issue, no care staff meetings had been held and team leader meetings had been held in frequently. It was evident the audit and quality assurance systems had not identified areas

highlighted as part of the inspection. Complaints had not been recorded and so the registered manager was unable to monitor the type and nature of people's concerns.

The registered manager did not appear to have a role in monitoring the quality of the service and it was difficult for us to establish what their day to day role was in relation to the governance and oversight of the service.

These examples demonstrate a breach of Regulation 17 (1) (2) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users did not always reflect their preferences, was not always appropriate and did not always meet their needs. Regulation 9 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Decisions had been made on behalf of people by relatives who did not have a Lasting Power of Attorney (LPA). Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always administered safely. Regulation 12 (1) (2) (g) The provider had not put in place a system which ensured the health and safety of service users. There were no personal evacuation plans in place which would be used in the event of an evacuation of the home. Regulation 12 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not in place which ensured accurate, complete and contemporaneous records had been maintained. There were gaps in the care records for people on short stay placements. Accidents and incidents had not been analysed Regulation 17 (1) (2) (c) (b) The registered manager did not have in place a system to evaluate and improve their practice. Regulation 17 (1) (2) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures did not operate effectively and people had been employed without the proper references and in one case with no references at all. Regulation 19 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff on duty at night to meet people's needs. There were a high number of un witnessed falls at night. Regulation 18(1) Staff did not receive consistent and regular supervision and there were no records of appraisals having been carried out. Regulation 18 (1) (2) (a)