Veecare Ltd

High Meadow Nursing Home

Inspection report

126-128 Old Dover Road
Canterbury
Kent
CT1 3PF

Tel: 01227760213
Website: www.veecare.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
High Meadow Nursing Home is a 'care home' registered to provide accommodation and nursing care for up to 34 people. At the time of the inspection, the service was supporting 24 people. Most of the people using the service were older people living with dementia. The service is a detached house situated on the outskirts of Canterbury. Accommodation is split over three floors, access to each floor is by lift or stairs.

People's experience of using this service:
There were not always enough staff to provide the care people needed. Staffing was reduced in the afternoon and evenings and people had to wait for the support they needed at times. Some people slept in beds without duvet covers or pillow cases because there were not enough housekeeping staff to do the laundry. These concerns, which would have been evident to staff, were not reported by them or escalated to the extent that they could be investigated or resolved

Some risks to people were not mitigated or well managed because there was no clear guidance for staff to follow. This included how people's hydration should be monitored. Aspects of the environment were not well maintained or designed or adapted to support people living with dementia.

The service was not well-led, this had an impact on the care people received. Feedback about the registered manager and staff was positive, but feedback about the provider was less positive. Concerns about staffing, management and the environment of the home raised with the provider had not been effectively addressed.

People and visitors told us they enjoyed the activities available. There was a daily choice of food which people told us they enjoyed. Medicines were managed safely and people told us they received the right medicine at the right time. People and relatives told us they found the registered manager, nursing and care staff approachable and friendly.

The service did not meet the standard of Good in any key area and there were also three breaches of the regulations.

Rating at last inspection:
At the previous inspection (published on 2 May 2019) the service was rated as Inadequate and placed into special measures.

Why we inspected:
The inspection was prompted in part due to concerns received about the environment of the home, insufficient staffing and a safeguarding matter, together with concerns about the management of the service. A decision was made for us to inspect and examine those risks.

Enforcement:
You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up:

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

High Meadow Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was a responsive inspection following concerns received to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. We only looked at the key questions of safe, effective and well led as this was a focussed inspection.

Inspection team:
This inspection was completed by two inspectors.

Service and service type:
High Meadow Nursing Home 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was on pre-planned leave during the inspection. In their absence, the day to day running of the service was overseen by the deputy manager.

Notice of inspection:
The inspection was unannounced.

What we did:
Before, during and after the inspection we reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as abuse. We sought feedback from the local authority safeguarding team and service commissioners.

Some people were unable to tell us about their experience of care at the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with the deputy manager, the provider, four staff and the nurse on duty. We also spoke with two visitors.

We looked at range of documents including five people's care records, aspects of medicines records and the recruitment records for two members of staff. In addition, we reviewed records relating to the management of the home including audits, policies and processes.

Inadequate

Is the service safe?

Our findings

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

Requires Improvement: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At the last inspection on 12 and 13 March 2018, we asked the provider to take action to make improvements because there were not enough staff to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008. In addition, risks to people and risks from the premises were not always mitigated. Equipment used by the service was not always safe and risks associated with the control of the spread of infection were not managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Despite providing an action plan setting out how improvement would be made, some actions had not been completed and people continued to be at risk.

Staffing and recruitment

- Since the last inspection the provider told us they had increased care staff in the morning from seven to eight members of staff. However, they had also decreased the care staff on duty from 2pm to 8pm from five to four members of staff.
- Care staff arrangements were as the provider had described them; however, we found there were still not enough staff to meet people's needs.
- No new people had been admitted to the service since our last inspection, the number of people receiving support remained unchanged at 24, with 22 people requiring the support of two members of staff. Two people were unable to leave their bed for clinical reasons and a further nine people preferred to receive most of their care in bed.
- People and staff told us there were not enough staff on duty on the afternoon shift. Care staff told us they felt rushed and people told us sometimes they had to wait too long for staff to support them. We spoke with the provider about staffing. They told us the registered manager and deputy manager had recently spoken with them expressing concern about insufficient care staff in the afternoon. Although these concerns had been raised with the provider, they had not yet taken any action to address this.
- No proactive arrangement had been made to cover the absence of laundry staff over their two-week sickness absence. Some people were sleeping in beds without duvet covers or pillow cases because the washing had not been done and there were insufficient stocks of clean bedding. One member of the morning care staff team had been told by the provider to cover the absence of laundry staff. This reduced the morning care staff team from eight to seven.
- People had to wait in dirty beds and were not supported to get up when they preferred. One person told us they preferred to get up earlier, however, at 10:10am a member of staff had just arrived in their room to support them. The person was incontinent, they told the member of staff they needed some help because they felt "messy and sore." The member of staff said they would need to find a second member of staff as two members of staff were required to support them. After 10 minutes, two members of staff arrived to support the person with their personal care and wash and dress them.
- People were left with no drinks or their drinks were out of reach. Two people who were cared for in bed

told us they were thirsty and wanted a drink. One person asked us for a drink three different times because their drink was relatedly left out of reach. The person told us, "I don't get a lot to drink. I am thirsty." One member of staff told us, "It is a struggle in the afternoon. There is not a fifth person to assist people to eat and get them drinks".

● An activity coordinator was employed, however, their duties also included checking the mattresses and air pump settings on pressure relieving equipment as well as checking water temperature to reduce any risks of scalding. They were spending a significant amount of their time undertaking these additional health and safety tasks, this meant they had less time to spend with people on activities.
● After this inspection, the provider wrote to us. They told us they had reviewed and increased staffing levels; there were now eight care staff in the morning and five care staff in the afternoon. There were two domestic staff, whose hours had increased from five to six hours daily. There was a member of staff responsible for the laundry, their hours had also increased from five to six hours daily. The activity coordinator no longer undertook health and safety duties and their hours had increased from five to eight hours daily. We will review the impact of these changes on people at our next inspection.

The provider had failed to ensure that there were sufficient numbers of staff to meet people's needs. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Assessing risk, safety monitoring and management
● Despite risk assessments in place to support people with their mobility, continence, nutrition and hydration; risks were not always well managed. For example, where people were at risk of dehydration, fluid monitoring charts were in place. However, while staff were recording the amount of fluid that people drank, fluid charts were not being appropriately checked to ensure people had enough fluids. Additionally, fluid charts did not set out a target amount for people to drink. This made it difficult for staff to know if people were on target to drink the required amount and, therefore, to know when to encourage people to drink more.
● One person's fluid intake was low and they had a history of ongoing urinary tract infections. During the inspection we found their drink was left out of reach on more than one occasion and they told us they were thirsty. This increased their risk of developing an infection.
● The nurse told us the person sometimes resisted drinking. However, this information was not in their care plan and there was insufficient information for staff on how to mitigate the risk that the person would become dehydrated.
● The person had a catheter in place and staff were not assessing their fluid intake against the fluid output to ensure that they were not retaining fluid, which was a known risk for this person. On some days the person passed less fluid than they had drunk, and staff had not identified this as a concern. There was no strategy to support the person to drink more or introduce other fluids.
● One person told us and staff that their mouth was sore. Staff reported this to the nurse and the GP was called. The nurse told us the person had a history of mouth infections, but no investigation had been carried out to determine why this problem re-occurred and there was no information in the person's care plan about the infection or mitigation in place to prevent it from happening.
● Checks on hoists used to move people were previously out of date. At this inspection appropriate checks had taken place.
● Risks to people from the environment had been managed. People's personal evacuation plans had been updated setting out the support they needed, for example, how to assist people to get down the stairs. Fire drills had taken place.
● Other risks to the environment were assessed and mitigated. For example, the gas and electric systems had been checked to ensure that they were safe.

Preventing and controlling infection

● Some improvement had been made to prevent and control the risk of infection. Further supplies of slings used to support people use the toilet had been purchased. This allowed people not to have to share slings.

● However, a torn commode seat cover exposed the inner foam material which was absorbent of fluids. Additionally, infection control risks were increased without appropriate use of bedding covers i.e. pillows cases and duvet covers.

The provider had failed to take reasonable steps to mitigate known risks to people. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Systems and processes to safeguard people from the risk of abuse

● Before the inspection we received a safeguarding concern about people living at the service. The local authority safeguarding team were still investigating this matter at the time of this inspection; therefore, the outcome had not been established.

● Staff we spoke with told us they knew how to identify concerns and felt confident any concerns raised would be addressed by the registered manager. Staff told us if concerns were not addressed, they would report them to CQC or the local authority.

● However, despite the responses given by staff, we could not be wholly confident that safeguarding matters would be recognised and reported. This was because staff had not reported the concerns received by the local authority safeguarding team. These centred around concerns about the environment, staffing issues and delays in people receiving meals and support; these would have been evident to staff.

The provider had failed to protect service users from abuse and improper treatment because systems and processes were not established and operated effectively to prevent abuse of service users. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Learning lessons when things go wrong

● At our last inspection, incidents and accidents had been recorded and reported as appropriate, however, actions to reduce and prevent further or repeated risk were not always recorded when there were incidents.

● At this inspection improvement had been made. Accidents and incidents were recorded by staff and were now monitored by the registered manager to try to prevent similar incidents being repeated. For example, about falls and behaviour which could become challenging.

Using medicines safely

● Medicines were ordered, stored, and disposed of safely and securely.

● People's medicines were administered as prescribed and staff had information about how people preferred to take their medicines.

● Nursing staff had the information and training they needed to administer medicines safely.

● Where people had 'as and when needed' medicines, known as PRN's, there was information for staff about why, how and when to administer these.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

At the last inspection on 12 and 13 March 2018, we asked the provider to take action to make improvements to adaptations in the premises for people living with dementia. Additionally, the provider had failed to ensure that the building was properly maintained. The provider sent us an action plan setting us out how improvement would be made. At this inspection, some improvement had been made.

Adapting service, design, decoration to meet people's needs

- Holes in the ceilings following the replacement of fire alarm sensors were being repaired and exposed redundant wiring had been removed.
- Improvements had not been made to the environment to support people living with dementia. For example, toilets were white with white seats; best practice guidelines recommend that these are of contrasting colours. People's doors were all the same colour and not personalised beyond having their name on the door in small letters. The use of signage and reference points that would help people living with dementia find their way around was limited.
- Water had been leaking into the building; above the doorway to the conservatory there was staining, flaking and displaced plaster. The water staining was evident around a mains voltage illuminated emergency exit sign.
- The uneven car park had not been resurfaced.
- We discussed these issues with the provider who provided evidence of quotes from contractors to undertake this work. We were assured that this work would be completed by the end of May 2019. We will review the impact of these changes on people at our next inspection, currently they remain areas requiring improvement.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- There were assessments of peoples' cultural and spiritual needs and people had care plans in place for these needs. Relatives were involved in people's assessments.
- Staff used nationally recognised tools on a regular basis to update people's assessments such as the malnutrition universal screening tool (MUST). MUST is a way to identify adults at risk of malnutrition or obesity.

Staff support: induction, training, skills and experience

- Staff training remained up to date. Training and refresher training had taken place when planned and met the provider's policy. This included health and safety, dementia, challenging behaviour, manual handling and medicines. However, training offered did not include equality and diversity and was predominantly DVD based.

● When we spoke with staff most were not positive about the quality of the training provided and did not feel it supported development of best practice. Some staff felt a better quality of training could be delivered as DVD training did not account for different ways of learning and did not prompt discussion between staff to form common understanding. Some training such as fire safety and moving and handling training was delivered face to face.
● People we spoke with felt staff knew how to support them, care and nursing staff were aware of people's needs and how to support them. They recognised that people should be treated equally, but also as individuals. The service did not routinely use agency staff, however, when needed an induction for agency staff was provided.

At the last inspection, we recommend that the provider review the training offered to staff to ensure that it is in line with best practice. This recommendation is reiterated following this inspection.

● Staff induction included training and a period of shadowing
● We observed staff using equipment to move people safely and following guidelines set out in people's care plans.
● There were regular supervision and appraisals for staff. Staff competency in manual handling and medicine administration was assessed and nurses were supported to revalidate their professional competence.

Supporting people to eat and drink enough to maintain a balanced diet
● The cook knew people's preferences well and a picture form menu helped people make informed choices about what they ate.
● People were supported to eat enough to maintain their health. Where people needed softened food to help them to swallow, this was provided.
● Where there were risks to people from eating, such as choking, people were supported appropriately.

Supporting people to live healthier lives, access healthcare services and support
● People were supported to access health care professionals when this was needed. For example, they had access to a GP, dentist, optician and chiropodist.
● People received regular health appointments, including appointments with mental health teams, consultants and specialist nurses. The GP visited the service weekly and when needed.
● Records showed staff usually took timely action when people were ill.
● Wound care management was robust and met with good practice guidelines. Care plans identified the dressings to be applied to affected areas, when they must be changed and nursing staff tracked the progress of healing. People had been appropriately referred to the Tissue Viability Nurse (TVN) when needed, however, the TVN was not involved in direct wound care as these were dressed and cared for by the nursing team. There was evidence of good practice which had resulted in the reduced severity of pressure areas and evidence of good wound care where other conditions such as psoriasis, cellulitis and skin tears had healed or reduced in severity.
● The deputy manager, nurses and staff detailed how they worked closely with healthcare professionals to ensure people's health needs were met. For example, in relation to diabetes management. This was evidenced throughout people's care records.
● Referrals had been made to dieticians and speech and language therapist (SaLT) when people's needs had changed. We observed that advice and guidance given by the dieticians and SaLT was followed. For example, staff all knew the texture and thickness of drinks and food for people who required a different texture to meet their needs.
● When people's needs changed, this was discussed at staff handover and written in the communication

book.
● People and their relatives were positive about the support people had to manage their health.

Staff working with other agencies to provide consistent, effective, timely care
● Information was shared with other health and social care professionals to help ensure people received consistent care and support. Such as specialist nurses to support people with diabetes and the local mental health team.
● The service participated in the NHS red bag scheme. This involved using a red bag when people leave the service to go to hospital and when they come back. The bag is packed with standard information about people's health and care needs as well as people's essential personal possessions such as their glasses. This scheme aims to ensure people's possessions and information are protected and do not get lost. Staff and people we spoke with told us this system had worked well as the right information was to hand when it was needed.

Ensuring consent to care and treatment in line with law and guidance
● 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
● We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. Staff understood the principles of the MCA and were following these guidelines. Where people had restrictions on their liberty DoLS had been applied for in line with MCA guidance.
● Where possible people were supported to make their own decisions, their families and independent advocates were involved when needed. Staff understood the process and requirement for best interest decisions, there were examples of best interest decisions where people had been unable to understand to consent to medical procedures.

Inadequate

Is the service well-led?

Our findings

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

At the last inspection on 12 and 13 March 2018, we asked the provider to take action to make improvements to auditing processes. This was because auditing had not led to improvement; care was not always person centred, risks assessments were not always in place and concerns about the building maintenance were not addressed. In addition, the provider had not notified us of some events they were legally required to.

At this inspection, little improvement was evident.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- The provider, registered manager and key staff completed checks intended to check the quality of the service. These included reviewing care plans, incidents and accidents, medicines, safeguarding, maintenance, room audits and health and safety. Where actions were identified these were recorded and the management team were in the process of completing these. However, the systems to check the quality of the service were not always robust, they had not identified the concerns we raised in relation to risk management, safeguarding and staffing.
- Insufficient improvement had been made. Concerns remained about the care and treatment some people received and the effectiveness of systems intended to monitor and support people.
- These included a failure in oversight to balance people's support needs with the availability of staff to perform basic tasks, such as, ensuring there was clean bedding and effectively monitoring and supporting people's hydration.
- The provider sent us an action plan following our last inspection, however, it contained insufficient detail about how the improvements needed would be made. We returned the action plan to the provider and asked them to provide more information. Nevertheless, aspects of the action plan received, such as the availability of laundry staff, did not reflect what we found during this inspection. Other aspects such as Peeps, wheelchair checks, equipment checks, provision of additional hoisting slings and risk assessments around pressure areas and other health conditions had been addressed.
- The culture of the service was not open and transparent. Staff had not reported concerns which would have been evident to them and impacted in the quality of care and service people received. For example, the lack of laundry staff and resulting lack of clean laundry, together with insufficient staff on the afternoon shifts.
- When the registered manager had previously expressed their concern to the provider about afternoon staffing levels, they had not acted quickly to address this concern.

Continuous learning and improving care

● The provider could not demonstrate continuous learning and improving of care.
● The provider had failed to ensure there were enough staff for the effective management of the laundry and to meet people's care needs when they wanted them to be met. The provider failed to anticipate the impact of the changes they had made to staffing. When it became evident their changes were detrimental to the day to day running of the service, they failed to act quickly to remedy the situation.

The provider had failed to effectively assess, monitor and improve the quality and safety of the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● At this inspection statutory notifications had been made when required.
● It is a legal requirement that the latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The last inspection rating was prominently displayed at the main entrance, as well as being displayed on their website.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider met with people and their families regularly, however, they felt they were not always listened to or the provider did not react to concerns quickly enough. This was demonstrated by concerns we received about the service which had already been raised with the provider particularly in relation to staffing.
● Staff and people told us the registered manager was approachable and knowledgeable. As a registered nurse, they played an active role at the service working alongside staff and providing advice and guidance when needed.
● Meetings took place regularly, this provided staff, people and their relatives the opportunity to have their say about the running of the service. Recent meetings included discussions about the last inspection and how the provider intended to address the shortfalls found.
● The provider had introduced surveys to gain the views of staff, people and visitors about the service, however, they had only recently been sent and the provider was still in the process of gathering responses.

Working in partnership with others
● Staff worked in partnership with other agencies such as care managers and health and social care professionals where this was appropriate.
● Staff told us they were kept informed about engagement and outcomes with health and social care professionals that could result in a change to a person's care, for example, following a visit from a specialist nurse or dietician.