MACC Care Limited

Meadow Rose Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection visit which took place on 19 and 20 July 2017. At the last inspection on 15 and 17 March 2016 we found the provider was not meeting fundamental standards and we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked them to make improvements to their quality assurance processes and the reporting of incidents to CQC. Following the last inspection the service was rated as requires improvement. You can read the report from our previous inspections, by selecting the 'all reports' link for Meadow Rose Nursing Home on our website at www.cqc.org.uk. At this inspection, we found the required improvements had been made and the provider was no longer in breach of the regulations.

Meadow Rose Nursing Home is registered to provide accommodation with nursing and personal care for a maximum of 47 people including people living with dementia and physical disabilities. At the time of our inspection 46 people were living at the home. Accommodation is provided over three floors. There are lounges, rest spaces and dining areas. Every bedroom is equipped with en-suite facilities.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People were cared for and supported by staff that had received training to equip them with the required skills to meet people's needs. Staff received supervision, providing them with appropriate support to carry out their roles. We saw staff treated people as individuals, offering them choices whenever they engaged with people. Staff sought people's consent for care and treatment and ensured people were supported to make as many decisions as possible. Where people lacked the mental capacity to make informed decisions about their care, relatives, friends and relevant professionals were involved in best interest's decision making. However, mental capacity assessments were not always up to date and consistently completed to clearly show what decisions people were being supported or asked to make in relation to their care. Applications had been submitted to deprive people of their liberty, in their best interest; therefore, the provider had acted in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People spoke positively about the choice of food available. Staff supported people who were living with dementia to eat and drink to maintain their health and wellbeing in a caring and sensitive way. People were supported to access health care professionals to ensure that their health care needs would be met, although instructions left by healthcare professionals was not consistently followed.

People who lived at the home were kept safe. Staff were trained to identify signs of abuse and supported by the provider's processes to keep people safe. Potential risks to people had been identified and appropriate measures had been put in place to reduce the risk of harm. People were supported by sufficient numbers of

suitable staff that had been recruited safely. People received their medicines as prescribed.

People and relatives told us that staff were kind, caring and friendly and treated people with dignity and respect. The atmosphere around the home was welcoming. People were relaxed and staff supported people in a dignified way. People and relatives told us they were well supported by staff and the management team and encouraged to maintain relationships that were important to people. People's health care needs were assessed and regularly reviewed. Relatives told us the management team were good at keeping them informed about their family member's care. People were supported by a small, dedicated activities team that provided opportunities to optimise people's social and stimulation requirements. People and their relatives told us they were confident that if they had any concerns or complaints they would be listened to and matters addressed quickly.

The registered manager had introduced new management systems to assess and monitor the quality of the service provided. There were systems to gain feedback from people living at the home, relatives and visitors. This included resident/relative meetings, satisfaction questionnaires and regular reviews. People, their relatives, staff and visiting professionals told us the home had much improved and was now more organised and well-led. We saw the appointment of the new registered manager had had a positive impact on the overall management of the home.

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.

People were kept safe from risk of harm because staff understood their responsibilities to keep people safe and where any risk was identified, appropriate actions were taken by staff.

People were supported by sufficient numbers of staff that were safely recruited.

People were supported to receive their medicines safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Mental capacity assessments did not consistently identify what decisions people were being asked or supported to make in relation to their care.

People were satisfied with the food and drink provided which met their needs and staff supported people to receive medical attention when required, although instructions left by healthcare professionals was not consistently followed.

People received care and support from staff that were trained and knew people's needs.

People were asked for their consent before care and support was provided and any restrictions to people's rights had been authorised in accordance with the law.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect by staff.

Staff were seen to be involved and motivated about the care they provided.

People were supported by staff that knew them well and knew

how people preferred to be supported.

Is the service responsive?

Good

The service was responsive.

People had their care and support needs regularly reviewed.

People received care and support that was personalised, based on their individual needs.

People were supported to engage in social activities they enjoyed.

People and their relatives were confident that any complaints would be listened to and acted upon quickly.

Is the service well-led?

Good

The service was well led.

There were improved systems in place to monitor the quality of the service provided to people living at the home.

People were happy with the service they received and were positive about the registered manager and staff.

Meadow Rose Nursing 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 unannounced inspection took place on 19 July 2017 with a second announced visit on the 20 July 2017. The inspection team consisted of two inspectors, an expert by experience and a specialist advisor on the first day and one inspector on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The specialist advisor was a qualified nurse who had experience of working with older people living with dementia and mental health difficulties.

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. As part of the inspection process we also looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidences which put people at risk of harm. We refer to these as notifications. We reviewed the notifications that the provider had sent us, to plan the areas we wanted to focus on during our inspection. We reviewed regular quality reports sent to us by the local authority to see what information they held about the service. These are reports that tell us if the local authority has concerns about the service they purchase on behalf of people.

We spoke with 12 people, eight relatives, one health care professional, a local councillor, the registered manager, the facilities director and 12 staff members that included nursing, care and domestic staff. Because a number of people were unable to tell us about their experiences of care, we spent time observing interactions between staff and the people that lived there. We used a Short Observational Framework for

Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also looked at records in relation to four people's care and medication records to see how their care and treatment was planned and delivered. Other records we looked at included three staff recruitment files to check staff were recruited safely. The provider's training records to check staff were suitably trained and supported to deliver care to meet people's individual needs. We also looked at records relating to the management of the service along with a selection of the provider's policies and procedures, to ensure people received a quality service.

The service was undergoing some redevelopment at the time of our visit. While we completed our observations of the service, we also checked for any health and safety concerns within the building.

Good

Is the service safe?

Our findings

At the last inspection the service required improvement because identified risks to people were not always managed in a timely way. Staff had not always recognised that certain injuries, sustained from having sore skin, had been reported under the local safeguarding procedures nor had the injuries being managed appropriately by staff at the home. At this inspection we found there had been an improvement.

We found risks to people were assessed and measures were put in place for staff to follow to keep people safe from risk of harm. For example a number of people had been assessed as having a high risk of developing sore skin. We found there were improved systems in place that showed people had been regularly repositioned to alleviate pressure on their skin which had been documented. The risk assessments had been reviewed regularly and the care plans had been updated as peoples' needs changed. We visited one person in their room and found the appropriate measures were in place to protect their skin integrity. For example a pressure relieving mattress and regular visits from Tissue Viability Nurses. We were told by staff, the registered manager and a visiting health care professional, that staff had received training from tissue viability nurses to support with the management of peoples' sore skin. The healthcare professional explained how much the service had improved and told us the staff were working in partnership with them to keep people safe from harm/ to protect people's health'.

Everyone spoken with told us Meadow Rose Nursing Home was a safe environment for people to live in. One person said, "I feel safe because there are lots of people around." Another person told us "The staff come and look around the door asking if I am ok many times during the day which makes me feel safe." A relative told us, "I feel it is safe for mum as there is always somone on reception to monitor people coming in and out." Another relative said, "Mum used to try to climb over the bed rails but there is a crash mat by the bed now and mum doesn't try to climb out of bed, she is calmer and safer now." A visiting professional explained to us they felt the home was a 'safe environment' and confirmed they had not seen anything that would give them cause for concern.

Staff spoken with told us they had received safeguarding training and were clear on what their responsibilities were for reporting any suspicions of abuse. One staff member said, "There are different types of abuse, financial, physical, emotional, institutional, sexual so you have to be alert and watch out for signs like bruising or if the person's behaviour changes in any way, especially if you notice it's around a particular carer or relative." Another staff member explained, "If I saw anything at all that was not right I'd report it straight away to the nurses or manager and to you (Care Quality Commission) if nothing was done about it." The provider's safeguarding procedures provided staff with guidance on their role to ensure people were protected. We looked at records and these confirmed that staff had received up to date safeguarding training. The provider kept people safe because there were appropriate systems and processes in place for recording and reporting safeguarding concerns.

We saw that fire safety checks and general safety check were in place with plans as to what to do in an emergency. Staff spoken with knew what action to take in the event of an emergency, for example if there was a fire or if a person began to choke. One staff member explained, "If we saw anyone choking the first

thing we would do is hit the emergency alarm."

There were sufficiently safe numbers of staff in place to keep people safe during our site visits. Staff confirmed there were sufficient staff to protect people and to meet their basic care needs, but felt they could be more proactive with the provision of person-centred care if they had more staff. For example, at times, particularly in the lounge/dining areas on the lower and ground floors, people were left unattended for short periods of time, while staff were attending to other people. We discussed our observations and the comments made to us with the registered manager and facilities director. It was suggested that staff communication could be clearer. For example, before leaving the dining area, the staff member should ensure there is appropriate cover in place before they leave. The registered manager confirmed staffing levels were calculated based on the number of care hours people received funding for and were sufficient for the current number of people living at the home. The registered manager confirmed to us the management team would review how staff members were deployed around the home.

Staff we spoke with told us they had pre-employment checks completed before they started to work at the home. The provider had a recruitment process in place to make sure they recruited staff with the correct skills and experience. Three staff files we looked at showed all the pre-recruitment checks were completed, including a Disclosure and Barring Service (DBS) check and references. The DBS check helps employers to make safer decisions when recruiting and reduces the risk of employing unsuitable people.

People we spoke with told us they received their medicine as prescribed by their doctor. One person said, "I am given medication regularly and they never forget to give it to me." We looked at four MAR charts, the controlled drugs book and saw these had been completed correctly. We found supporting information for staff to administer 'when required' medicines was available but nursing staff were using a combination of old and new forms. There was person centred information available to support staff to make a decision on when to give the prescribed medicine, however we found that some forms did not contain this information and were not always dated or signed. We discussed this with the clinical lead nurse and they took immediate action while we were on site and replaced the out of date forms with new forms, with the correct information available for staff. Medicines coming into the home had been clearly recorded. Medicines were stored safely and there was an effective stock rotation system in place. We saw that nurses supported people to take their medicines safely and found the provider's processes for managing people's medicines ensured medicines were administered in a safe way.

Requires Improvement

Is the service effective?

Our findings

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 people lack mental capacity to make particular decisions, any made on the person's behalf must be in their best interests and as least restrictive as possible. We checked the provider was working within the principles of the MCA. Staff we spoke with gave us examples of how they would obtain people's consent before supporting them. One staff member said, "Just because somebody can't verbally tell you doesn't mean you don't ask them, you must always ask and the person can let you know by their eyes, or a smile." We saw where people lacked mental capacity to make certain decisions for themselves mental capacity assessments had been completed. However, it was not always clear what decision relating to the person's care and support was being made in the person's best interest. In part, some of the assessments were similar in context; therefore not always individualised to the person's circumstances. For example, we saw there were two assessments completed for individuals who did have mental capacity to consent to their care. We discussed these with the registered manager. They told us the assessments should not have been on the files and they would be removed.

People we spoke with told us they made their own choices, for example when and where they ate, how they spent their time and what social activities they did. One person told us, "I choose what clothes I wear and what time to get up and go to bed." Another person said, "I could drink milk all day, they [staff] know what I like and bring it to me instead of drinks and juices." During our site visits, we saw people were asked for their consent before care was provided.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff we spoke with were aware of their responsibilities to sometimes restrict people from certain activities in order to keep the person safe. One staff member explained, "We have a locked front door so we can safeguard people, it's sad because some people don't feel they need to be here but if they lived at home they wouldn't be able to look after themselves." Another staff member told us, "We are depriving people of their freedom but we only do this in their best interest to keep people safe." We saw applications had been made to authorise restrictions on people's liberty in their best interests in order to keep them safe.

We found people living at the home were supported by suitably trained staff because the provider ensured training, specialist skills, knowledge and support were available to ensure staff could support people effectively. The provider information return (PIR) stated that staff were supported to develop their skills and knowledge based on outcomes from the supervisions and appraisals. New staff were supported in their role and had been through the provider's induction programme that was linked to the care certificate. The care certificate is an identified set of standards that aims to equip health and social care support workers with the knowledge and skills they need to provide safe and compassionate care. We saw there was an on-going training programme of development to make sure that all staff training was up to date. These included

health and safety, fire awareness, moving and handling, emergency first aid, infection control and safeguarding. One staff member told us, "There is a lot of learning we do on our own on the computer which doesn't really suit me but I do my best." Another staff member said, "The training has helped me, I have learnt new techniques." A third staff member said, "The on line learning is ok because you can keep going back to it to refresh yourself." We found staff received one to one supervision from their senior member of staff and on-going support was available from the registered manager.

People living at the home, their relatives and a visiting health care professional we spoke with were all complimentary about the skills of staff working at the home. One person told us, "I think that the staff know what they are doing when they look after me, they involve me in making decisions about my care." Another person said, "I would say staff are well trained." A relative we spoke with explained, "They [staff] do understand my relative's needs very well and I can't fault them". Another relative commented, "The staff have a very hard job and they do it very well."

Everyone we spoke with was complimentary about the quality of the food and people said, they were able to choose their meals and were supported to maintain a healthy diet. One person said, "I prefer my main meal in the evening so the staff made arrangements for my main meal to be in the evening instead of at lunch time like the other residents." Another person told us, "They [staff] tell me what they have to eat and I choose which one I want, we have a good choice." A relative explained, "Mum enjoys the food, it is always served hot." We saw staff reminded people of the choices of lunch available and prompted them to drink fluids. Gravy jugs were placed on tables and people were encouraged to pour the gravy on their meals if they were able to. We found people could choose to eat their meals in their rooms or in the dining rooms and drinks and snacks were made available throughout the day.

The PIR stated that people's nutritional needs were assessed regularly and there was information in people's care plans that detailed their nutritional preferences and needs. The care plans we looked at showed some people were at risk of losing weight and we found plans had been put in place to guide staff in how to support people to gain weight and prevent further weight loss. We found advice was sought from dieticians and catering staff would add additional calories to people's food. One staff member told us who was at risk of weight loss and why added additional calories were added to people's food, for example the use of cream instead of milk. We saw people were also given food supplements to help their weight increase. Additonal support was also sought from speech and language therapists (SALT) where people had difficulty swallowing their food.

People we spoke with told us they were regularly seen by the doctor and health care professionals. One person said, "They do get the doctor in if I need to see them." Relatives we spoke with had no concerns about their family member's health care needs. A relative said, "The staff are very quick if there is a change mum's health and do call the doctor." However, we saw that advice given by clinical professionals was not always followed. For example, we saw the provider had been advised by a clinical professional to ensure one person was encouraged to walk around every hour to relieve pressure on their sore skin. We checked the person's care plan and found this was not being followed. During our site visit, we did not see staff encourage the person to stand and walk around every hour. We discussed this with the registered manager. They explained the person preferred to remain seated in their chair and refused to walk around. It was acknowledged that the person could not be forced, however, it was re-iterated to the registered manager that we had not seen staff try to encourage the person to walk. The registered manager immediately introduced a process for staff to record when they tried to encourage the person to walk. We were also provided with evidence to demonstrate the person's sore skin had improved.

A visiting health care professional explained how the working relationship between the provider and the

community health services had 'significantly' improved. A staff member explained, "We have regular meetings with the local GP practices and a senior nursing practitioner visits regularly and give us lots of support. We also use the 'rapid response' which means GPs will arrange to call in over the weekend if someone is poorly, this has reduced our hospital admissions." The arrangements the provider had in place supported people to maintain their health and wellbeing.

Good

Is the service caring?

Our findings

At the last inspection in June 2016, the service required improvement to ensure people's privacy and dignity was maintained. At this inspection, we found improvements had been made.

People and relatives told us the staff were very caring, friendly and kind. One person told us, "The staff are friendly and down to earth, they cheer me up when I am down." A relative told us, "The staff are marvellous, I can't fault them, they are all very kind and caring to mum." At lunch time, we saw one person became anxious and a staff member used a kind and gentle, reassuring approach to comfort the person. We saw people were relaxed in the company of all the staff, people were treated with kindness and empathy. Staff spoke to people in a sensitive, respectful and caring manner. Staff were able to demonstrate in their responses to us that they knew people's individual needs, their likes and dislikes and this ensured people received individualised support and care.

People we spoke with told us they felt involved in the day to day decisions about their care and support needs. One person said, "I have a shower twice a week that is my choice." Another person explained, "They [staff] encourage you to be independent." Staff were able to explain to us how they encouraged people's independence and supported people who could not always express their wishes. For example, staff said once they got to know people, they could tell by facial expressions and body language, whether the person was comfortable with the level of care being provided. If the person was showing any signs of distress or anxiety when care was being provided, staff told us they would find alternative ways to deliver the care and provide lots of reassurances until the person was more relaxed. Care plans we looked at included information about people's previous lives, their likes and dislikes and their individual preferences. This ensured staff were kept informed of any changes and people were supported to make their own decisions about their care and staff respected people's individual choices. The rooms we were invited into were bright, spacious and very personalised. One person said, "I'm very happy with my room, I have a lovely view of the garden." A relative told us, "[Person's name] room is lovely, we personalised it as best we can with lots of pictures that are important to her."

People we spoke with told us staff respected their privacy and dignity. One person said, "I told them [staff] that I prefer female carers." Another person said, "When my husband comes to visit we close the door for privacy, they [staff] respect our privacy and leave us alone." Another person said, "The staff always knock on my door before they come in." A relative told us, "Staff are very respectful." Staff addressed people by their preferred names and knew the names of visitors to the home, who had come to see their family members. We saw staff knocked on people's bedroom doors and announced themselves before entering. People chose to have their door open or closed and their privacy was respected. People were supported to make sure they were appropriately dressed and that their clothing was arranged to maintain their dignity.

People we spoke with told us there were no restrictions on their family and friends visiting them. The provider supported people living at the home to maintain relationships that were important to them. Relatives we spoke with confirmed there were no restrictions on visiting. A relative told us "We visit all the time and come at different times, they [staff] are always very accommodating and offer us a cup of tea."

There were separate rooms and areas for people to meet with their relatives in private. We found people living at the home were supported to maintain contact with family and friends close to them.

Good

Is the service responsive?

Our findings

At the last inspection in June 2016, the service required improvement to personalise care plans, improve the quality and quantity of social activities offered to people and the provider's complaints process. At this inspection, we found the required improvements had been made?

We found people were supported to receive care and support based on their individual needs. The provider information return (PIR) stated that care plans were updated on a monthly basis or as and when changes in people's individual circumstances changed. One person told us, "We [with staff] have chats and meetings where they [staff] listen to you when you talk to them." A relative told us, "We've been involved in discussing [person name's] care plan." When we asked staff about specific people, they knew what was important to the person. Staff were also knowledgeable about people's care needs and risks and how these were to be met. The care plans we looked at confirmed an assessment of the people's needs had been undertaken at the point of admission and had been regularly reviewed. Any changes to a person's health was identified and recorded in the care plans and showed the involvement of health care professionals when needed.

The PIR explained a new initiative, 'resident of the day' had been introduced by the registered manager. Staff told us how useful they found these discussions to be. The resident of the day would have their care plan reviewed (this was in addition to the routine monitoring of records completed by the provider). The resident's room would also be deep cleaned and any maintenance issues would also be addressed. The registered manager explained the resident of the day was an additional way of ensuring people received more personalised support from the provider. We also found the home environment had been improved to be more effectively designed for people living with dementia. For example, dementia friendly signage was displayed on doors showing pictures that identified where the communal toilets were. The provider was also responsive to people's cultural and spiritual needs. People we spoke with told us they would receive visits from representatives of the local places of worship and prayers were held every Sunday.

We had received some feedback from staff members that 'sometimes' the morning handovers from night staff were 'rushed' and not always 'detailed'. However, day nursing staff told us they too would hold additional daily discussions with the care staff. These discussions were designed to communicate any concerns that had arisen during the previous 24 hours and to talk about any impending issues into the next 24 hours. For example, health professional or hospital visits. Staff told us they found this a good way to communicate 'what was going on in the home' and enabled them to keep up to date with the day to day running of the home and people's changing needs.

Everyone was encouraged to join in daily activities. The provider information return (PIR) explained how the provider had introduced a range of exercise sessions to enhance people's health. Dedicated staff members were trained and registered with National Activities Providers Association where they would obtain ideas to support people with 'meaningful activities'. On the day of our visit, we saw some people taking part in exercise classes, the activities coordinator was engaged with some people in different table top hobbies, for example drawing pictures or playing cards. One person told us, "One of my hobbies is knitting which I enjoy." Another person explained, "I don't have any hobbies anymore, I sit and watch television which is

what I prefer to do." A relative said, "People are not forced into activities, there is lots going on, they go on daytrips and entertainers come in." We saw one person had become distressed. The staff member encouraged the person to participate in the table top activities. Although the person was visually impaired, the staff member gave clear instructions to the person about their surroundings, what was on the table in front of them and how reassured them about well they were doing. This reassured the person and we saw they had become less distressed and more at ease with their environment during the activity.

Complaints information was displayed at the home. People and relatives we spoke with told us they knew how and who to complain to. One person told us, "I have no concerns or complaints." Another person said, "This is a lovely home and I'm happy but if I wasn't I would tell them [staff]." We reviewed the complaints file which contained an up to date policy and we found complaints were acknowledged, investigated and resolved to the satisfaction of the complainant. The registered manager told us the previous process had not always addressed complaints and concerns effectively. In response to this, the registered manager had introduced an effective way to monitor and record what actions had been taken. We saw any complaints raised were taken seriously and used as an opportunity to learn and improve the service. Staff told us if a person or relative wanted to complain they would support them if they needed to.

Good

Is the service well-led?

Our findings

At the last inspection in June 2016, we found effective systems were not in place to assess, monitor and improve quality and manage risks to people's health and well-being. We also found the provider had not always kept us informed of allegations of abuse of people using the services. This was a breach of Regulations 17 and 18(1)(2)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had been made and the provider was now meeting the requirements of these regulations.

At the last inspection there was no registered manager in post and we had not been informed of notifiable events that the provider was required to do so by law. At this inspection, there was a registered manager in place, therefore the conditions of registration were met. There was also an improvement with the notifying of reportable incidents. It is a legal requirement that organisations registered with the Care Quality Commission (CQC) notify us about certain events. We had been notified about significant events by the provider and we saw where accidents and injuries had occurred appropriate treatment and observations had been put in place to ensure the person's safety and no long term injuries had been sustained.

People and relatives were complimentary about the quality of the service. One person said, "I like living here, it's my home." A relative told us, "There is a community feel to the place." We saw that people approached the registered manager and other staff freely. We saw the registered manager had a presence around the home, supporting people and speaking with people and visitors. One person explained, when he saw the registered manager approach him, "That's the boss (laughing), he's very good, always pops in to say hello." Another person told us, "I've seen him [registered manager] come in at night to check everything is ok which is very reassuring." Staff we spoke with all told us how much the overall atmosphere in the home had improved with the arrival of the new registered manager. Comments included, "[registered manager's name] is a really nice gentleman." "We have been without a consistent manager for a while but with the arrival of [registered manager's name] this has changed, he's very nice, always has a smile on his face, a good manager." "There has been a difference since the new registered manager arrived." Staff we spoke with all confirmed they worked well as a team, one staff member said "Like everywhere we have our moments but generally we do all get on and I think we work well as a team." Another staff member told us, "I love working here and I love my job, I was made to feel very welcome and everyone has been so helpful."

People told us they attended meetings at the home and records we looked at confirmed this. One person said, "I have attended resident's meetings." Relatives said they attended events that took place at the home and they were encouraged to participate through emails and face to face discussions. The provider encouraged visitors to use the public review website www.healthwatchbirmingham.co.uk. Comments included, 'I have nothing but praise for Meadow Rose Nursing home, it is reassuring to know that my husband is being well cared for.' 'Mum's room is bright and airy, we can visit at any time and always made to feel welcome even at busy times.' 'On the whole, basic needs are adequate.' My mother has been a resident for a while now and has become part of a friendly, caring community with a family feel'.

At the last inspection, we identified the provider's internal quality assurance processes to monitor the safe delivery of the service to people were not always effective. The provider information return (PIR) stated there had been a number of changes implemented around the audits that included infection control, monitoring sore skin, accidents, incidents, medicine errors and the monitoring of complaints. On speaking with people, relatives, healthcare professionals and staff and reviewing the provider's processes, we found significant improvements had been made. We looked at medication audits and found the daily count down nurses conducted for medicines had reduced medicine errors, because any errors had been identified quickly. There was an improved, easy to follow, process introduced that monitored accidents and incidents which had led to a reduction in the number of incidents being recorded. Complaints raised with the provider were now more accurately recorded with a clear action plan together with any learning. A new process had recently been introduced to monitor the provider's DoL applications. We found there were a small number of applications that had not been followed up by the provider. For example, three applications submitted over 12 months ago, had only recently been followed up. At the time of our visit, the registered manager contacted the Supervisory Body to progress the applications. We discussed with the registered manager the importance of regularly checking the progress of applications. They agreed processes would be reviewed immediately to ensure all applications were regularly checked and reviewed. Although the new registered manager had not identified these three, we found that overall this system had worked effectively with keeping a clear audit trail of the majority of applications. This demonstrated the provider had overall, effective procedures in place to monitor the service to check the safety and wellbeing of people living at the home.

Staff members we spoke with told us the management team were approachable and if they had concerns regarding the service, they could speak with them. The provider had a whistleblowing policy that provided the contact details for the relevant external organisations for example, CQC. Staff told us they were aware of the provider's policy and would have no concerns about raising issues with the provider or registered and care home managers and if it became necessary, external agencies. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about malpractice, risk (for example, to a person's safety), wrong-doing or some form of illegality.

It is a legal requirement that the overall rating from out last inspection is displayed within the home. We found the provider had displayed their rating as required. Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. We found that the provider was working in accordance with this regulation within their practice. We also found the provider had been open in their approach to the inspection and co-operated throughout. At the end of our site visit we provided feedback on what we had found and where improvements could be made. The feedback we gave was received positively with clarification sought where necessary.