Anchor Trust

Meadowside

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

Meadowside is a purpose built care home providing care and accommodation for up to 51 people who may be living with a dementia type of illness or elderly and frail. The home is divided into seven small units, each with their own lounge and dining area. On the day of our inspection there were 51 people living at the home.

This was an unannounced inspection that took place on 24 May 2016.

The home did not have a registered manager. 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. We were told a new registered manager had been recruited and was due to commence in post in July 2016. The deputy manager's helped us during our inspection.

Although there were a sufficient number of staff on duty staff were not deployed appropriately to ensure people always received care in line with their care plan. Staff told us the increase in staffing levels had a positive impact on people and people said they did not have to wait for support.

Risks to people had been identified, however, some guidance for staff was missing. Although falls were monitored routinely by staff the same was not done for accidents and incidents. This meant action may not always be taken as promptly as it could be.

Although quality assurance processes were in place staff did not always follow up on actions identified. The provider had failed to ensure robust processes were in place for ensuring that all staff worked to a certain standard.

Medicines records were not always well maintained, however, staff held medicines securely and information in relation to other medicines, such as 'as required' and topical creams was in place.

Staff did not always comply with the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards requirements. People's care records were not always complete or contained sufficient information for staff which meant people might not always receive responsive care.

Staff helped to protect people because they were aware of their responsibilities in relation to safeguarding. Staff had received fire training which meant they would know what to do in the event of having to evacuate the building.

The provider had recruitment processes in place to help ensure they only employed staff suitable to work in the home. Staff felt supported by management and enjoyed working at Meadowside.

People were provided with a range of foods and enabled to make decisions about what they ate. People who had specific dietary needs were given food appropriate to these needs. People told us they enjoyed the food and could always ask for an alternative.

Staff enabled people to access health care services should they need it. Such as the GP, district nurse or optician. People were encouraged to make their own decisions and remain independent.

People were cared for by staff who treated them with kindness, respect and attention. Both people and relatives had only positive comments about the staff who worked at Meadowside. Relatives told us they were always made to feel welcome.

People had access to a range of activities and people with specific hobbies and interests were supported to maintain these. Should people feel the need to make a complaint there was information available to them in order to do this.

Everyone felt involved in the running of the home. They were encouraged to attend meetings as well as leave feedback and suggestions.

During the inspection we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also made a recommendation to the provider. You can see what action we told the provider to take at the back of the full version of the 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?

Requires Improvement

The service was not consistently safe.

The provider had not ensured that deployment of staff was done in such a way that people received the care they required in line with their care plan.

People's risks were assessed and recorded but guidance for staff was not always available.

Records in relation to people's medicines were not always complete; however medicines were stored safely and securely.

The provider carried out appropriate checks when employing new staff.

Staff were trained in safeguarding adults and knew how to report any concerns. There was a contingency plan in place in case of an emergency.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always follow the legal requirements in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were provided with a sufficient amount of food and drink and people's dietary requirements were recognised by staff.

Staff were trained to ensure they could deliver care based on best practices.

People had access to healthcare services when they needed it.

Is the service caring?

Good

The service was caring

People were treated with kindness and care, respect and dignity.

Staff encouraged people to make their own decisions about their care. People were supported to be independent.

People were supported to maintain relationships that were important to them as visitors were welcomed into the home.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were not always complete which meant people may not receive the person-centred care they should expect to.

People were supported to take part in a range of activities that meant something to them.

People were given information how to raise their concerns or make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Care records relating to people were not always consistent or contemporaneous.

The provider had failed to ensure the monitoring of staff performance was followed up and notifications to the CQC were not always submitted when they should be.

Quality assurance audits were carried out to ensure the quality and safe running of the home. However, actions identified were not always followed up.

Staff enjoyed working at the home and feedback from people and relatives was good. Everyone was given the opportunity to feel involved in the running of the home

Meadowside

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider 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 24 May 2016. The inspection team consisted of three inspectors.

Before the inspection we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

The provider had previously completed and submitted to us 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. We referred to the PIR during our inspection

As part of our inspection we spoke with eight people, the two deputy managers, six staff and six relatives. We observed staff carrying out their duties, such as assisting people to move around the home and helping people with food and drink. We sought feedback from two social care professionals following the inspection.

We reviewed a variety of documents which included seven people's care plans, five staff files, training information, medicines records and some policies and procedures in relation to the running of the home.

We last inspected Meadowside on 20 January 2015 where we made a recommendation to the provider in relation to cleaning of the sluice rooms.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe living at Meadowside. One person told us, "Of course I'm safe here." Another said, "I feel safe as there are enough staff around. They are always popping in and out." People told us if they had any concerns at all they felt they could speak to staff who would listen to them. A relative told us, "I feel she is safe and that is important to me."

There were sufficient staff on duty which meant people received the support they required when they needed it. However better deployment of staff would have ensured people received the support they needed in line with their care plan. For example, one person's care plan stated they should not be left alone with another person due to three recent incidents. However between 11:00 and 13:00 this person was left in the company of the other person unsupervised three times. One of these for 15 minutes. This was because care staff were on their own in the unit whilst their colleague was on their break. Staff are told to use the alarm if they need additional staff support. One staff member said, "When you're on your own what do you do if someone needs help?" We were told that staff could call on the team leaders for additional support; however we saw team leaders spending most of the day updating care plans, rather than contributing to hands-on support. A member of staff told us, "I don't feel supported by all of the staff, some team leaders are good, but they could do more to help."

Risks to people had been identified by staff and information was available in care plans, however further guidance for staff was needed to help ensure the risks to people was reduced. For example, one person was sitting in a recliner chair but staff did not know how to operate the controls to move the foot rest down. This meant the person was attempting to stand up from their chair without being able to put their feet on the floor. However, another person was at risk of falls and it was noted, 'wear slippers which have a grip sole'. We saw staff had ensured they were wearing suitable footwear.

The provider had told us in their PIR that they would increase the use of the electronic accident and incident monitoring system to ensure that trends and patterns were detected. However we did not find this was the case as accident and incidents were not routinely monitored which meant themes may not be quickly identified .For example, one person displayed behaviours which meant they may be at risk to themselves or other people. Although staff had taken action in relation to one particular situation if the monitoring of incidents was done routinely there may have been fewer incidents before the action was needed.

Medicines records were not robustly maintained meaning staff may not know if people had received their medicines or not. There were gaps in people's Medicines Administration Records (MARs). These were in relation to tablets and creams. We noted from the last internal and external medicines audits it was identified there were, 'gaps in MARs'. This showed that although this had been highlighted before, staff continued not to maintain accurate records. The provider's PIR informed us that, 'the service was working towards achieving 100% compliance in the signing of MARs by increasing audits carried out by team leaders'. Although we did not find team leaders auditing the MAR charts on the day, we did see the deputy manager's carry out spot checks.

The lack of staff doing all that is reasonably practical to mitigate risks to people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels were monitored and adjusted in order to meet people's needs. The deputy manager's told us that staffing levels had increased and there were now two care staff on each unit. One person told us they did not have to wait for staff if they needed support and staff told us they had noticed the difference with having additional staff on duty. One member of staff said, "I never thought I would see two staff per unit in my time here. It is much better and means we have time to interact with people now." Two other staff told us, "It's much less stressful now with extra staff. It means people don't have to wait."

Risk assessments were completed in relation to a person's mobility and where the risk of falls was high a mobility plan was included detailing how staff should support the person. Where a person may require a hoist and sling for moving, the sling type and size was recorded. Some people had specific risk assessments individualised for them. For example, in relation to one person who was partially sighted.

People were protected from continued risk of falls because staff monitored and reviewed information on a monthly basis to look for trends. Action plans were completed and action taken to prevent the risk of reoccurrence. Mats were used to alert staff if people tried to stand up unsupported or referrals to the falls team were made in the event that a person had continual falls.

People's medicines were stored appropriately and securely. Each unit had their own medicines trolley which was secured to the wall when not in use. Medicines stored in these were done so in an orderly fashion. Staff recorded the temperature of the medicines trolley on a daily basis to ensure the medicines remained fit for their prescribed use.

Each person's MAR contained the person's picture for identification and details of any allergies they may have. We noted this information linked with what was in a person's care plan. For example, one person was allergic to strawberries and this was recorded in both their care plan and on their MAR. This protects people because staff have the information they need to correctly identify them prior to giving medicine and also from being given a substance they may react to.

Where people had, 'as required (PRN) medicines protocols were in place which contained information on the PRN medicines they required, what may trigger the need for it and the maximum dosage they could take. Where people had topical creams information was available to staff to show them where this needed to be applied.

People were kept safe because staff recognised the signs of potential abuse. Staff were able to give us examples of what might constitute abuse and said they knew where to find information relating to what action they should take. One staff member said, "I would go to my line manager. The policy and numbers are in the staff office." Staff also had access to a whistleblowing policy which enabled them to report any general concerns they had about the home anonymously.

People's care would continue with the least disruption possible in the event of an emergency. This was because the home had a contingency plan which guided staff in the action to take should they need to evacuate the home. Each person had a personal evacuation plan which gave information to staff on the support a person would need should they need to leave the home during a crisis.

The provider had arrangements in place to help ensure they only recruited staff who were suitable to work at Meadowside. Staff files contained relevant checks on potential staff. For example, formal identification

information, past employment history and references from previous employers. Each staff member had undergone a Disclosure and Barring Check (DBS) so the provider could identify whether or not a member of staff had a criminal record.

Following our last inspection where we made a recommendation to the provider in relation to the cleaning of the sluice rooms we were told responsibility for this was now down to the housekeepers as it was part of their cleaning routine. We looked in the sluice rooms and had no concerns in relation to infection control.

Requires Improvement

Is the service effective?

Our findings

People told us staff asked them before they carried out care and we routinely heard staff offering people choices and telling people what was going to happen next or gaining consent before supporting with care. For example, a member of staff warned one person before they moved them in their wheelchair. They said, "I am going to move you. It's alright, you don't need to do anything."

Staff did not always follow the legal requirements in relation to the Mental Capacity Act 2005 (MCA). The 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. Care plans held mental capacity assessments for people, but these were not always completed for specific decisions. For example, one person had a mental capacity assessment for the key coded doors, their falls sensor mat and for living at Meadowside, but these were not separate specific decisions and there was no record of best interest meetings to discuss these aspects of this person's care.

Decisions for people had been made but records did not always demonstrate the reason for the particular decision. For example, one person had best interest meeting minutes in their care plan which recorded an urgent DoLS application had been made, however it was not clear what the best interest meeting and DoLS application related to. A staff member told us it was for staff to hold the door handle to detain a person in their room if they became upsetting to other people. However, when we spoke to another member of staff they said, "We would never do that." This staff member was not aware of the decision that had been made. If staff were preventing a person leaving their room without a best interest decision and a DoLS authorisation their right to liberty could have been restricted unlawfully.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The failure to comply with the 2005 Act was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People thought staff were well-trained. One person told us, "Yes, the girls are very good." Another relative said, "Oh yes, they know what they're doing."

Staff told us they had access to a wide range of training and records evidenced staff training was generally up to date. Training included medicines, dementia awareness, fire, health and safety and moving and handling. One member of staff told us, "I am up to date on my training." The provider told us in their PIR that, 'new staff are required to go through a 12-week induction period when starting in the home'. Staff confirmed that when they started work they completed this induction and shadowed a more experienced member of staff before working on their own.

People received care from staff who were checked to ensure they transferred their training into practice. A staff member told us they had supervision regularly and senior staff would point out if they were, "Not doing something quite right." Two other staff members told us they had regular supervisions and an annual appraisal. An appraisal is important as it gives staff the opportunity to discuss all aspects of their job with their line manager.

People were generally happy with the food and they always got a choice. One person told us, "The food is very good here." Another said, "The food is pretty good. I can have something slightly different if I want." A third person told us, "The food is lovely. What I don't like I leave and if I don't like anything at all I can change it." We heard one person say, "I like the mash" and another comment, "Oh, this is nice" as they ate their lunch.

People were involved in the decisions about what they ate and were provided with enough to eat and drink. Staff showed people the choice of meals already prepared on plates which helped people to make their decision as they could see what the food looked like. One person told staff, "I'll choose when you show me." People were offered fruit and biscuits during the morning and fruit and milkshakes mid-afternoon.

Staff were knowledgeable in people's preferences. For example, we heard a member of staff say, "The other option is beef and I know you don't eat that, but I can get you something else if you don't want this (fishcake)." Another person liked to have a beer at 11:00 and 16:00 and we saw this was provided to them.

People were supported by staff when they needed help to eat. Staff helped people to eat at a pace that suited the person and asked them if they were ready for their next mouthful. One person had been out for a hospital appointment during the morning and staff ensured their meal had been put aside so they could eat this upon their return.

The lunchtime experience for people was good. There was a calm atmosphere in the dining areas during lunch and staff chatted with people whilst they ate. People told us they had enjoyed their meal and we saw portion sizes were appropriate and the food looked and smelt appetising. When one person commented to staff that their food was a bit dry, staff provided them with some gravy.

Staff were aware of specific dietary requirements in relation to people. For example, if a person required food prepared in a specific way. Where people required fork mashable food they were also offered the same two choices as everyone else. People's weights were monitored monthly and action taken if it was noted people had lost weight. For example, in relation to one person who had lost weight and their food and fluid intake required monitoring.

People were supported to access health services should they need it. For example, the GP, district nurse, chiropodist or optician. One person told us, "I've never felt unwell, but I'm sure if I did they (staff) would get someone to look at me." Relatives confirmed that staff referred their family member to healthcare services when needed.

Good

Is the service caring?

Our findings

We asked people about their opinion of the staff that cared for them. One person said, "I'm happy here, staff are lovely, always on my side." Another person told us, "They're very good. Only have to ask and they're here to help." A third person said, "The staff are lovely. They are very kind." We were told by one relative, "A1, couldn't ask for nicer people." Another relative said, "Absolutely lovely here. Staff go out of their way to do things for people."

People were cared for by staff who knew them well. Staff chatted with people easily and they talked to people about their relatives and what they (the relatives) had been up to. Staff were aware of people likes and dislikes as well as individual characteristics people had. For example, when it came to the food they liked or which television programmes they preferred.

People received care from staff who demonstrated a positive approach. Staff always knelt down when talking to people and we did not hear anyone being talked down to. People responded positively to staff and there was an upbeat atmosphere in the units. Staff chatted, laughed and sang to people. Staff were very interactive with people. When one staff member was doing someone's nails they said, "Do you want pink to make the boys wink?" A person asked if staff could cut up their lunch and the staff member responded, "Of course I can darling."

People received attentive care because of the way staff acted. For example, one person had asked for a cup of tea and the staff member moved the furniture around so this person could have the table where they wanted it. Another person asked if they could talk to a staff member in private. The staff member said, "Of course" and went with the person to their room. Another person looked anxious and a staff member stooped down and gently rubbed the person's face whilst asking them if they wished to sit with them at the table. Staff fetched cardigans and blankets for people when they felt cold and an extra cushion for one person to make them more comfortable in their chair.

People were offered and supported with personal care discreetly. Doors were closed to people's rooms when they were having personal care. Staff asked people tactfully if they wished to use the toilet before lunch. People could have their privacy if they wished it. A relative said, "She's a private person, she prefers to sit in her room rather than here in the lounge."

Staff recognised things that were important to people. For example, a relative told us that it had always been important for their family member to look nice and they said staff maintained this. They said, "She has her hair done every couple of weeks and they (staff) always make sure she looks nice." Another person continually asked staff if they were, "Okay (sitting) here." We heard staff respond each time with patience and reassurance as staff recognised the need for this person to know they were okay where they were sitting. A further person had started to ask staff questions about their family and as a result staff were putting together a photo album of people close to them which they could use as an aide-memoir/prompt when this person was became muddled.

People were involved in making decisions. Staff gave people choices in the music that was playing. A staff member told us, "I go to an old-fashioned shop and buy CDs I know they will all like." One person liked to have a lie-in in the morning and staff knew they liked a cooked breakfast when they got up. We saw staff provide this when this person came into the dining area. People told us they could choose when they went to bed and what time they got up in the morning. One person was asked if they would like to eat their lunch in their room or in the dining area with others. When they chose to have it in their room we saw staff respected this and took them their meal.

People were supported and encouraged by staff. One person was sitting at the table and wished to move to an armchair. Staff were patiently trying to get them to stand up so they could help them. They said, "Let's stand up. We are going to stand up now." When the person was unable to do this, the staff member prompted and encouraged them again, eventually seeking the support of a second member of staff to encourage this person to stand.

People were encouraged to be independent. For example, one person had their own mobile phone and we heard them taking calls. Another person was asked if they wished to help lay the tables for lunch which they did. Some people were prompted by a member of staff to fold the napkins for their table. The member of staff demonstrated how to fold the napkin and prompted, assisted and encouraged people to do the same; congratulating them when they had done so.

People's dignity was respected. One staff member straightened out a person's skirt to protect their dignity and another staff member said to a gentleman, "Your trousers are inside out, let me come and help you with them" which they did.

Visitors were welcomed into the home and we heard staff offer them refreshments. Relatives said they could visit at any time. It was clear staff knew relatives well.

Requires Improvement

Is the service responsive?

Our findings

People may not always receive responsive care because their care records did not always contain the most recent information. The provider told us in their PIR that, 'personal planning is conducted in partnership with service users and their families to ensure that the care provided matches their individual needs and preferences'. Although care plans were in place and they contained guidance for staff in relation to people's care needs this guidance was not always followed. For example, one person's care records stated, 'she is deaf in her left ear, staff to talk in her right ear'. However, we saw staff speaking into this person's left ear several times and as a consequence they were unable to understand what staff were saying. A member of staff told us the district nurse had recommended this same person's legs were elevated, however, this was not written in their care plan. Other information in this person's care plan had not been included or was inaccurate. For example, they did not eat their lunch but staff had not made a note of this in the daily records. There was also an entry that staff had found this person with scratches on their body but no body chart had been completed.

Another person displayed certain behaviours which meant they were at risk to themselves and others. However, this was not recorded in much detail within their care plan. This meant staff who did not know this person well would not have access to sufficient information in relation to this or, guidance on how to respond if an incident did occur. This person's care plan stated, 'offer activities and communicate using communication cards,' however when we asked staff about the communication cards they were unable to locate them immediately which told us they were not routinely being used.

A third person had a record in March 2016 of suffering from a skin sore but there was no further reference to this. We spoke with staff about this who confirmed this had now healed, but the care plan had not been updated. A further person required a food and fluid chart to be kept for three days each week following a loss in weight; however the last recorded entry in the chart was 17 April 2016. A relative told us that their family member had an alarm mat put in place following a fall, however they found staff had turned the mat off as it was constantly ringing.

Where people were staying at Meadowside for respite care their care records were very limited, did not contain sufficient detail for staff or were contradictory. This meant staff may not always be aware of specific aspects of care a person required. For example, one person was diabetic and although the catering staff were aware of this there was no separate diabetic care plan containing information and guidance for staff. In one part of their care plan it stated they had no dietary requirements. This same person was recently widowed but this had not been mentioned in their care plan. If it had been it would have primed staff if this person had showed any signs of distress. Another person had guidance for staff in their care plan in relation to their behaviours, but this did not include possible triggers or what action staff should take if the de-escalation techniques did not work.

The lack of person-centred care planning was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the examples above show that care planning was not always robust and up to date other care plans were created as people moved into the home. These did contain information about people's likes and dislikes, their past history, mobility, nutrition and personal care needs and specific individualised detail relevant to people. For example, one person was noted as, 'loves milk' and we saw staff offer them glasses of milk during the day.

Some care plans were reviewed as people's needs changed. For example, one person had recently returned from a spell in hospital following a fall and their care plan had been reviewed and updated to reflect the change in their care and support needs. One staff member said, "If something changes for example, a person's mobility gets worse, we would notify the team leader and the care plan would be updated."

There was evidence in people's care records that they had signed to consent to care and family members had been involved in care plan reviews. A relative told us they had worked with staff to put together their family members care plan.

We asked people if they felt there was enough for them to do whilst living at Meadowside. One person told us, "There is enough going on. I go down (to the main lounge) and watch. There's plenty to see." Another person said, "Staff are always asking me to join in things." A third person said, "They give you things to make. I'm doing things I haven't done before." A relative told us, "She could join in things if she wanted to, but she can't concentrate for long." Another relative said, "There are always things going on."

Activities were available for people. We saw people sitting at tables doing arts and crafts, people reading the paper or staff playing games with people. Although there were planned activities we saw staff were flexible in their approach. For example, one person asked staff to read them their newspaper which they did. People were encouraged by staff to sit in the garden during the morning. One member of staff said, "What's missing is people being able to go out, they used to go out all the time." Staff told us this would start to happen again more as the weather got better.

The activities co-ordinator told us they tried to offer a range of activities. They said they always started the day by going around saying hello to everyone (which we saw them do) and letting them know about the activities on offer for that day. Organised activities included arts and crafts, bingo, music, dance and films. They told us activities changed with the seasons and individualised activities were arranged for people to enable them to follow their interests. For example, one person liked to crochet and resources had been provided to allow them to do this. Another person liked gardening and pots and a greenhouse had been organised for their use. A third person loved fish and they had a fish tank in their room which a member of staff helped them to maintain.

Staff were proactive in the activities they arranged which meant people benefited from involvement from the local community. For example, a local hotel hosted a cream tea twice a month in the home and with the involvement of some local charities the sensory pond in the garden of the home had been refurbished. A professional told us, "They have a brilliant activities coordinator who does her best to motivate the residents."

Complaint information was available which meant people had access on how to make a complaint should they wish to. One person told us if they were concerned about anything they would find someone to talk to. Another person told us, "I had a problem and staff talked to me. I was able to tell them everything I felt and as a result the issue was sorted immediately." A relative told us they had made a complaint in relation to a recent incident. They told us, "I always voice my concerns if I think someone's wrong. I tell whoever's here." Another relative said, "I've never had to complain, they're very good here but I'd say if something was

wrong." We noted five complaints in the complaints log. We spoke with the deputy managers about this who told us three had been resolved and meetings had been arranged with the families of the other two to discuss their concerns.

Requires Improvement

Is the service well-led?

Our findings

People were happy with the way the home was managed. A professional said, "I am happy to say that I have found things to be generally good. I have also had the chance to experience Meadowside from a relatives point of view and my opinion of the home is that it is clean, staff and residents are happy."

The provider was not aware of their statutory requirements to notify us of particular incidents. For example, serious injury or safeguarding events as notifications were not always submitted to the Care Quality Commission (CQC). For example, we noted at least nine incidents recorded which had been raised with the local authority as safeguarding alerts. However, notifications in relation to these had not been submitted to CQC.

The failure to submit notifications was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Care records were not always complete as although records evidenced that people had access to healthcare services, records were not always clear in relation to the outcome of any appointments. One person's care plan showed they had been admitted to hospital. It was noted the hospital were carrying out further tests, but the records had not been updated. Another person's speech was slurred, but they refused to go to hospital and staff were advised to check for an infection. There was no follow-up information in this person's care plan to evidence whether or not this had happened and what the outcome was. A relative told us they were not always informed of the outcome of any healthcare professional involvement. They said, "I can mention that she seems sleepy and am told she has been on antibiotics for three days."

Daily notes were written in a task orientated way which meant what people did, whether they had visitors or not and how their mood was on an individual day was not reflected in their care plan. For example, daily notes recorded, 'okay, ate well at breakfast, no concerns'. The staff and others would be better able to monitor changes in people's helath or wellbeing over time if the daily notes were more detailed. Because the staff were having many positive interactions with people, detailed notes would reflect the good care they were offering and the effect this had on people and their mood.

There was a quality audit programme for the home which covered all aspects of the service; however actions arising from these were not always completed. For example, a recent medicines audit by an external provider as well as an in-house medicines audit had identified, 'missing signatures in MAR's' which we had also found . Other audits carried out were helping to improve the service. For example, a care plan audit was underway. This had started in February 2016 and we noted there was an improving picture in the completeness of the care plans. Other audits included weekly fire alarm checks, monthly equipment checks and an environment check list.

The provider carried out regular audits to monitor the quality of the service being provided to people. Actions arising from the last audit included introducing a complaint log, repairs to the floor area by reception and installing a lock on the clinical bin. We found all three actions had been completed. However,

there was also an action to re-introduce relatives meetings but this had not happened.

The provider did not monitor progress of staff and take action without delay where progress is not achieved. The provider told us in their PIR that new staff are not signed off as completing an induction until they have been able to fully demonstrate that they are competent in delivering care to a high standard. During the day we observed one member of staff not acting in a way that demonstrated the values and behaviours we had witnessed from all other members of staff. We noted in this staff member's personnel file they had received supervision from their line manager and they were under performance review following their initial induction period. However, we noted that nothing further had been done to support this member of staff to improve their practice since March 2016. This meant they had been able to continue acting in way that was not consistent with what was expected in the home.

We recommend the provider ensures they have robust quality assurance systems in place which result in action to improve the service; particularly in relation to accurate record keeping.

Meadowside was currently without a registered manager, although a new manager had been appointed and was to commence in July 2016. This provider planned that this person would subsequently apply to become registered manager. During the absence of a registered manager the deputy manager's had been overseeing the home with the support from Anchor's area manager. Staff we spoke with told us the deputy manager's were very good and they had noticed little change or impact during the period without a registered manager. Staff told us that the deputy managers were very good and supportive and they could, "Go to them with anything."

Staff were happy working at Meadowside. One member of staff told us, "I love working here. It's my life." Another staff member said, "It is better managed now." A third member of staff said, "Definitely, definitely better. The care managers are very nice."

Staff were involved in the running of the home as meetings were held at all levels. For example, management, team leaders and care staff meetings. Staff told us they found meetings very useful and felt confident to speak out. We noted staff discussed recruitment, training, activities and general issues in relation to the home as well as sharing information from the provider's staff newsletter.

People were encouraged to give their feedback and suggestions and ideas were listened to by staff at Meadowside. For example, Wi-Fi had been installed, a Facebook page set up, comments cards had been introduced and new staff working patterns and rotas introduced to help increase the number of permanent staff working in the home. Feedback was sought from people regularly. We noted from 13 surveys which had been completed in May 2016 that people were happy with the activities, food, access to health services and management. People told us nothing would make it better for them living at Meadowside. One person said, "Nothing could make it better here for me."

People were involved in the running of the home because residents meetings were held. We noted meetings were well attended and from the notes we read people had discussed the food, laundry and activities. A professional told us, "I attend relative and resident meetings and the overall feedback is good."

Relatives' feedback was sought. The results of the 2015 survey which 13 relatives had completed showed that they strongly agreed that their family member was safe at Meadowside. Relatives also fed back that they felt staff were capable, the quality of the food was good, their family member was treated with respect and kindness and encouraged to participate in hobbies and activities and staff acted in a professional manner.

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 18 Registration Regulations 2009 Notifications of other incidents The registered provider had failed to submit statutory notifications.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to carry out person-centred care planning for people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had not followed the requirements of the Mental Capacity Act (2005).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure they were doing all that was reasonably practical to mitigate risks to people.