Meadowside Residential Care Home Limited

Meadowside Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on the 12 May 2016 and was unannounced.

At our most recent inspection on 4 June 2014 we found the service was meeting the requirements of the regulations in place at the time.

Meadowside is registered to provide care for up to twelve older people. Eleven people were being cared for at the time of our visit.

The service had 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 2008 and associated regulations about how the service is run.

We received consistently positive feedback on the quality of the service from people who lived in Meadowside and their relatives. "Everything is fine" and "The care is wonderful" were two typical comments made to us.

There were safeguarding procedures in place and staff received training on safeguarding vulnerable people. This meant staff had the skills and knowledge to recognise and respond to safeguarding concerns.

Risks to people were identified and managed well at the service so that people could be as independent as possible. A range of detailed risk assessments were in place to reduce the likelihood of injury or harm to people during the provision of their care.

We found set staffing levels were adequate to meet people's needs effectively. The staff team worked well together and were committed to ensure people were kept safe and their needs were met appropriately. The senior management team gave additional support when required.

Staff had been subject to a robust recruitment process. This made sure people were supported by staff that were suitable to work with them.

Staff received appropriate support through induction and supervision. All the staff we spoke with said they felt able to speak with the senior management team or senior staff at any time they needed to. There were also team meetings held to discuss issues and to support staff.

We looked at summary records of training for all staff. We found there was an on-going training programme to ensure staff gained and maintained the skills they required to ensure safe ways of working.

Care plans were in place to document people's needs and their preferences for how they wished to be

supported. These were subject to review to take account of changes in people's needs over time. We found the new format for care plans which had been introduced was very concise, clear and sufficiently comprehensive to ensure people were protected by accurate and up to date records of their care.

Medicines were administered in line with safe practice. Staff who assisted people with their medicines received appropriate training to enable them to do so safely. Where the storage temperature of medicines was measured and found to be higher than recommended, appropriate action was taken to address this.

The service was managed effectively. The registered manager and provider, together with the service's management team regularly checked quality of care at the service through audits and by giving people the opportunity to comment on the service they received and observed.

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.

There were sufficient staff available to meet people's assessed care needs.

Risks to people had been appropriately assessed as part of the care planning process and staff had been provided with clear guidance on the management of identified risk.

People were supported with their medicines in a safe way by staff who had been appropriately trained.

Is the service effective?

Good

The service was effective.

People received safe and effective care. Staff were supported to achieve this through structured induction, regular supervision and training.

People were encouraged to make decisions about their care and how it was provided. Decisions made on behalf of people who lacked capacity were made in their best interests.

People received the healthcare support they needed to maintain their health and well-being.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect and staff protected their privacy.

People were supported by staff who engaged positively with them whilst they provided care and support.

Staff knew people well and understood people's different needs and the
ways they liked their support provided.

Is the service responsive?

Good

The service was responsive.

There was a detailed care planning process which helped staff provide people's care in the way they wanted them to.

The service responded appropriately when people's needs changed. This ensured their needs continued to be met and that they could remain as independent as possible.

People were supported, when they wanted to take part in activities and social events in order to provide stimulation and entertainment.

Is the service well-led?

Good

The service was well-led

The registered manager and staff worked well together as a team.

People who lived in Meadowside, staff and relatives were able to talk with the manager and senior staff when they needed information, advice or support.

There were effective quality assurance systems in place to both monitor the quality of care provided and drive improvements within the service.

Meadowside Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12 May 2016 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we reviewed the Provider Information Record (PIR) for the service and previous inspection reports. The PIR is a form that asks the provider to give some key information about a service, what the service does well and improvements they plan to make. We also reviewed notifications and other information about the service we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

Prior to our visit we contacted four health and social care professionals to seek their views about people's care.

During our visit we spoke with seven people who lived in Meadowside and also to two relatives of people who lived in Meadowside who were visiting the service. We spoke with the registered manager, deputy manager and with five staff members including catering, domestic and activity staff.

We checked records about how people's care was provided. These included four people's care plans, five medicines records, three staff files containing recruitment checks and details of induction for two new staff and supervision and training monitoring records for all staff.

Good

Is the service safe?

Our findings

People were supported by sufficient staff with the skills required for them to be able to do so safely. On the day of our inspection we found there were enough staff to provide people with the support they needed. Staffing levels were assessed taking into account the number and dependency level of people. In their PIR the provider informed us staffing levels were reviewed weekly to ensure that each shift was covered by staff with suitable knowledge, skills and competencies to do so safely and effectively.

People we spoke with told us staff were available when they needed assistance and we found any calls for assistance were answered promptly. "You never have to wait very long, even at night" one person told us. We saw staff managed busy times of the day well to ensure people's needs were met appropriately. We observed staff interaction with people throughout the inspection. We found staff had the time for extended, non-task related conversations with the people they supported, which promoted a relaxed and calm atmosphere.

People were protected by the service's recruitment practice. There were appropriate recruitment processes in place. This meant people were supported by staff who were suitable to do so. The three recruitment files we looked at contained the required documents; for example, a check for criminal convictions, written references and confirmation of their physical fitness to undertake care work. In their PIR, the provider told us the interview and selection process included two members of staff and observed interaction of the applicant with people who lived in the home.

People were protected when they needed support with their medicines. We looked at the service's medicines records and spoke with staff responsible for the administration of medicines. We found people's medicines were managed safely and in line with the provider's medicines policy. There were robust processes in place to ensure people received their medicines as prescribed. We saw medicines were given at the correct time and those medicine administration records we saw were completed accurately to show the medicines people had received.

The temperature of medicines storage were recorded. We found there had been occasions when the recommended storage temperatures had been exceeded. This had also been identified in the medicines audit carried out by the service's medicines supplier. Overall, however, they had found the standard of medicines practice good. In those instances where the temperature exceeded recommended levels we were told the medicines trolley had been moved to a cooler part of the building. We discussed this with the senior management team who informed us of active plans to improve medicines storage to address this.

Staff who undertook medicines administration were provided with appropriate initial and refresher training. We saw staff had undertaken a competency assessment before they administered medicines on their own. In their PIR the provider indicated there had been four medicines errors in the previous 12 months. We were told competency assessment were re-done if any concerns were identified about the ability of staff to administer medicines safely. In February 2016 a new medication audit process had been implemented. This included improvements to the recording of non-blister-packed medicines. All staff had to read and sign to

indicate they were aware of and understood the service's medicines policy and procedures.

There were currently no medicines in use which required additional controls because of their potential for abuse (controlled drugs). The staff we spoke with about medicines administration were aware of the additional security procedures required to be used if this changed.

People were protected because the service had policies and procedures, in place and being followed, in respect of safeguarding people from abuse. These provided guidance for staff on the procedure to follow if they saw or suspected abuse. Staff had received training to help them to recognise and respond to signs of abuse. Staff were confident about the actions they would take if they felt someone was subject to abuse. Staff confirmed they had regular updates on safeguarding training.

Staff were advised of how to raise whistle-blowing concerns during their training on safeguarding people from abuse. This showed the home had created an atmosphere where staff could report issues they were concerned about and protect people from harm.

People were protected from avoidable risks. Risk assessments were in place to identify risks to people's health, safety and welfare. These set out how identified risks could be eliminated or reduced, to avoid the likelihood of injury or harm to people. These included, for example, the risks of falls and developing pressure damage. Risk assessments had also been written to assist in moving and handling people safely.

There were systems in place to protect people from the risk of infection. For example, staff completed training to increase their awareness about good infection control practices. We saw staff had access to disposable gloves and aprons, which they used appropriately when they assisted people with personal care. There were arrangements for the safe disposable of clinical waste to ensure this was managed in accordance with environmental regulations. The home had achieved a hygiene rating of "Very Good" for safe food preparation and storage practice when last inspected by the relevant independent inspection body.

People were cared for in a safe and appropriate environment. The building was well maintained. There were certificates in place which confirmed it complied with gas and electrical safety standards. Equipment to assist people with moving had been serviced and was safe to use. There was a Legionella risk assessment in place and regular fire alarm tests were carried out and recorded.

The building was secure. There was a signing in and out book for visitors and staff. This meant people were protected from the risks associated with unrestricted access to the home.

Appropriate measures were in place to safeguard people from the risk of fire. Staff had been trained in fire safety awareness and first aid. There were records in place which showed fire drills had been carried out and there were fire extinguishers and fire alarm test records in place. It was also confirmed that testing of portable electrical appliances had been undertaken.

Accidents and incidents were recorded appropriately at the home and appropriate action taken to prevent further injury to people.

The provider had a business continuity plan in place in the event of a major incident affecting the safe operation of the service. Personal evacuation plans were also in place.

Good

Is the service effective?

Our findings

People's needs were met appropriately. "The care is wonderful" and "Can't be better" were two assessments made by people who received care and support.

People's specific needs were very well understood by care staff. Staff had built up a good understanding of the individuals' needs over time and this was reflected in care planning and delivery. People told us staff were approachable if they had a problem.

People received care and support from staff who were appropriately trained. We spoke with five members of staff and with members of the management team. They were all positive about the training they received. The deputy manager showed us the systems which helped them ensure staff were up to date with the appropriate training for their role and provided us with details of all the training provided and planned for staff. These records showed they were up to date with the training determined to be essential by the provider; for example moving and handling, safeguarding and infection control.

Staff confirmed they had received a full induction when they started working. An induction checklist was completed for each new staff member. Health and social care professionals we received feedback from said they felt the staff were competent to carry out their roles.

Staff received appropriate support to help them effectively fulfil their specific roles within the service. We saw records were kept of when staff had met with their line manager for supervision. Additional assessments and annual appraisals were carried out to assess and monitor staff performance and development needs throughout the year.

Staff told us communication was good within the service. We saw a range of communication systems were used. For example, staff maintained daily records of people's health and welfare. Staff meetings took place to discuss and improve practice. Both the registered manager and provider had a very high profile within the service and were available to support and advise staff. Staff appeared very much at ease and told us they had no hesitation in discussing any issues or concerns with them.

People's healthcare needs were monitored effectively. Any changes in their health or well-being prompted a referral to their GP or other healthcare professionals. For example, people could be referred to the dietician and speech and language therapists if staff had concerns about their well-being. Care plans identified any support people needed to keep them healthy and well. Staff maintained records of when they had supported people to attend healthcare appointments and the outcome of these. The records showed people routinely attended appointments with healthcare professionals, for example, dentists, opticians and hospital specialists. GPs visited the home regularly from the local surgery. This provided consistency for the people concerned and enabled the home to plan when people could have a routine consultation. Additional visits by the GP or access to other health services were arranged on an 'as required' basis.

People also benefitted because the service were active participants in and had been accredited with the

"Smile for Life" programme, which promotes good oral health practice.

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 in order 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). When we talked with staff about this, we found they had a good knowledge and understanding of the MCA and had received relevant training.

People were given choices in the way they wanted to be cared for. People's capacity was considered in care assessments in line with legal requirements, so staff knew the level of support they required while making decisions for themselves. If people did not have the capacity to make specific decisions around their care, staff involved their family or other healthcare professionals as appropriate to make a decision in their 'best interest' as required by the MCA.

People were assisted and encouraged to have the opportunity to consent to the details of their care and how it was provided. When we spoke with staff we found they understood the importance of gaining consent from people before they provided any care. Throughout the inspection, we observed staff spoke clearly and gently and waited for responses.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there were any restrictions to their freedom and liberty these had been authorised by the local authority as being required to protect the person from harm. We found that the registered manager understood when an application should be made to the relevant authority and how to submit one. In their PIR the provider informed us that one person was subject to Deprivation of Liberty restrictions and their care records included appropriate records to support this.

People were given plenty to drink. Where necessary people's food and fluid intakes were monitored and recorded to ensure they were appropriate for the maintenance of their health and well-being. People's care records also included details of any allergies or food intolerances, for example to gluten or personal lifestyle choices such as vegetarians.

People told us the food provided was good and had improved since the appointment of a new cook. This was reflected in the minutes of a service users' meeting held on the 26 April 2016.
We observed part of the lunch period and saw people had choice of where they ate. This could be the dining room, other communal areas of the home or in their own rooms if they preferred. The people we spoke with about food said any staff assistance required was provided appropriately. We observed drinks being offered throughout the inspection. When we spoke with the cook, they confirmed they had access to people's care plans which set out any specific dietary requirement and details of food and drinks preferences. The cook was an integral part of the staff team and supported people appropriately within their role. For example, where people liked to help with laying the table this was encouraged and facilitated.

One of the key features of the service, which a number of people and their relatives mentioned was the scale

and 'homely' feel to the premises. "We looked at some much larger homes, but they were far too impersonal, Meadowside felt like a real home" was how one relative put it. We saw any necessary adaptation of the premises to provide a safe and effective environment had been undertaken, for example appropriate bathing and lift facilities were in place.

Good

Is the service caring?

Our findings

People told us they felt the staff were caring. "I am very well looked after" and "Staff are very kind and helpful".
Relatives had very positive views of the service and staff; "Wonderful, she has never been happier" and "They are all very caring" were two comments made to us.

People received care from staff who understood them and knew their personal tastes and preferences. We observed people appeared very relaxed in the company of staff. Interactions between people were relaxed and demonstrated a sociable atmosphere in the communal areas of the home, especially at mealtimes.

Staff confirmed they had received training in equality and diversity and how this should be reflected in appropriate and sensitive care provision. The staff team was representative of people who lived in Meadowside.

When people asked for assistance, for example with going from a communal area to their rooms or to the toilet facilities staff responded very quickly and with patience. Personal records were stored and kept securely to prevent inappropriate access to them. Staff had received training during their induction and afterwards in the need to promote people's dignity and maintain their privacy. If people needed to be supported to move, this was done in a way which promoted people's dignity, staff spoke with people throughout the whole process. Throughout our inspection we saw staff consistently treated people with dignity, respect and compassion. Those relatives we spoke with did not raise any concerns about the preservation of people's privacy and dignity during their frequent visits.

People were able to express their views and were involved in making decisions about their care and support. They were able to say how they wanted to spend their day and what care and support they needed. People were able to make choices about their day to day lives for example if they wanted to spend time with others in one of the lounges, or if they preferred to spend time
alone in their rooms.

People were also involved in the running of the home. Resident and relatives' meetings were held on a regular basis. These provided people with the forum to discuss any concerns, queries or make any suggestions. Minutes showed people spoke about, for example, activities, food options and staffing. Where people made suggestions, the provider and registered manager acted upon these wherever possible to do so. For example, at the meeting on the 26 April 2016, suggestions were asked for and given about activities; 'more gardening, more chairs and more music ' were some suggestions made. We were told these were all being or had been actively considered.

Staff training included the implications for their care practice of providing care to people at the end of their lives. In their PIR the provider informed us there were at that time eight people with 'Do not attempt resuscitation (DNAR) forms in place, nine people had information in their care plans which set out their advanced care preferences and four people had a valid advanced decision to refuse treatment in specified

circumstances. We were told by senior staff that they would always try and meet people's wishes to remain in what was their home, rather than be transferred to hospital. This was unless their medical needs could not be appropriately met within the home, even with external specialist input.

People had access to advocacy services when they needed them. Advocates are people independent of the service who help people make decisions about their care and promote their rights. We were told that where advocacy was required, most people had members of the family who did this on their behalf. There were however details of independent advocacy services available on the main notice board.

Good

Is the service responsive?

Our findings

People had their needs assessed before they moved to the home. Information had been sought from the person, their relatives and other professionals involved in their care. Information gained through the assessment was then used to draw up an individual care plan.

People's care plans reflected their individual circumstances. They were personalised for each individual. They detailed daily routines and preferences specific to each person. There were sections in care plans about supporting people with different areas of daily living, for example, their health, dressing, washing, continence and mobility.

People continued to receive appropriate support when their needs changed. Care plans showed evidence of regular reviews taking place, involving the person concerned, their family where appropriate as well as key staff with knowledge of the person. This meant any changes to people's circumstances, for example, to their mobility or weight could be identified.

The care plan format had recently been revised. The format being introduced was very clear, easy to read and understand and helped staff to have ready access to key information about people's care needs and how they were to be met.

People received care and support from staff who knew them well. We spoke with housekeeping staff about how care was taken of people's laundry. Staff showed concern for people's well-being in a caring and meaningful way, and they responded to their needs quickly. People told us they were happy with the care they received. "Top notch" was one assessment.

Staff knew about people's individual communication needs. People could move freely around the home and choose where to spend their time. Staff respected people's choices to be in their rooms if they wished. There were areas in the building where people could sit and talk with visitors and family.

From what people told us and from what we observed during the inspection, including at lunchtime, people were offered choice. They could, within reason, determine how their care and support was provided. Staff were able to tell us in detail about people's needs and how they were met.

People's cultural and religious needs were taken into consideration. Activities were arranged to reflect different cultural celebrations, important national events and other special occasions, for example Christmas and New Year. In the PIR the provider provided details of contacts with the local community including church, schools and brownie pack.

We observed activities being undertaken, all staff actively involved people in decision making about what was happening, and offered choice. We observed people were able to spend time in their own rooms or to sit quietly without being pressured to 'join in' when they showed no signs of wanting to do so. We were aware of the activity organiser taking one person for what was said to be a four mile round trip in their

wheelchair to look at the river in Marlow. Another person came back from a walk and told us; "I have been looking at the lovely flowers in people's gardens."

Individual service users had the opportunity, for example to help with routine tasks within the home. This helped them retain skills and feel they were actively continuing with activities which had been and still were important to them.

People who lived in Meadowside had worked with the activities staff to create a particular type of flower bed in the service's garden. The activity co-ordinator was very positive about the support they received from the registered manager and provider, for example through provision of materials for craft activities and outside 'entertainment".

There were procedures for making compliments and complaints about the service. Information about this was displayed prominently in the home. In the PIR, the provider recorded that in the last 12 months there had been one complaint managed under their formal complaints procedure, which had been resolved within 28 days of being made.

Good

Is the service well-led?

Our findings

When we spoke with people who used the service, relatives and staff they were very supportive of the registered manager and providers. Staff gave positive comments when asked if they felt supported. One staff member told us they were able to speak up and voice their views and raise any concerns. Another told us "We have regular staff meetings and daily handovers of care." Staff commented on how well they worked together as a team. We found staff interacted with the registered manager and each other to provide people with support with everyday tasks to ensure people were cared for in a timely manner.

Throughout our visit we observed that staff, visitors and people who used the service were comfortable talking to the providers. As a family run service the 'hands on' management style was both effective and appreciated by people who lived in Meadowside and staff who worked there.

People benefitted from the ethos and values of the provider. There was a relaxed and informal 'feel' to the home. Relatives we spoke with and three of the people we spoke with about Meadowside, specifically compared it very favourably to some of the larger and as they saw it 'impersonal' care services they had experience of. "It is like a real home not a care home" was one person's assessment. This judgement was in keeping with one of the explicit values of the service, which were described in a statement on the main notice board; 'Our residents do not live in our workplace, we work in their home'. Another example of how the senior management team sought to improve standards was in their acceptance of the principles of 'Compassion in Practice' and the six 'C's; Care, Compassion, Competence, Communication, Courage and Commitment'.

The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). They had submitted any notifications to us, in a timely manner, about any events or incidents they were required by law to tell us about. We used this information to monitor the service and ensure they responded appropriately to keep people safe. The provider was aware of the new requirements following the implementation of the Care Act 2014, including the duty of candour. This is where a registered person must act in an open and transparent way in relation to the care and treatment provided.

The home worked in partnership with health and social care professionals to promote people's well-being. We received positive feedback about the liaison and co-operation between the service and health community services, for example 'Smile for Life' and 'My Home Life' programme. The service also maintained links with the local community, for example schools and churches.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. There were regular quality assurance audits undertaken which looked at how the service performed as a whole. There were a number of regular internal and external audits carried out, for example medicines management, care plans, health and safety and employment. In their PIR the provider indicated external consultants were used to inform forward plans for the service as appropriate. This helped ensure people benefitted from a service which kept abreast of and sought to follow current best practice within the

care sector.

Records were well maintained at the service. Records or information we asked to see were provided promptly. Staff had access to general operating policies and procedures on areas of practice such as safeguarding, restraint, whistle blowing and safe handling of medication. This meant staff had ready access to the detailed guidance they required.

We found there were good communication systems at the service. Residents' meetings were held regularly. These provided an opportunity for communication between people who use the service and staff about concerns or improvements that were being made.

Staff and the registered manager shared information in a variety of ways, for example face to face, during handovers between shifts and in team meetings. There was a clear management structure and staff knew who to contact in the event of any emergency or concerns. Staff told us they were able to raise concerns and they were confident concerns would be acted on.