Minster Haverhill Limited

The meadows care home

Inspection report

Brybank Road
Hanchett Village
Haverhill
Suffolk
CB9 7YL
Tel:
Website: www.example.com

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

The inspection was carried out on the 24 November 2014.

We previously inspected this service on the 27 January 2014 and the service was meeting the requirements of the essential standards.

The service is required by the Care Quality Commission (CQC) to have a registered manager. At the time of this inspection there was no registered manager in post. The current manager had had applied to be registered. 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.

The Meadows provides accommodation for up to 55 people who require nursing or personal care. The home also accommodated people living with dementia. On the day of our inspection there were 47 people at the home.

Summary of findings

We identified concerns about staffing levels based on what people told us and through our observations. This meant we could not be sure care was always delivered effectively.

There were systems in place to ensure people received their medicines safety by staff who were adequately trained to do so.

CQC is required by law to monitor the operation of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions for themselves and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others.

We found staff were providing care and treatment after they sought people's consent but could not always see how they assessed people's capacity to make decisions and not all staff had been trained in understanding the legal requirements in relation to MCA.

Staff were able to recognise when a person was at risk of abuse or harm and knew what actions to take to protect people and uphold their rights. Risks to people were recorded and steps were taken to reduce the risk and ensure people received safe care.

People living on the dementia unit received constant supervision to ensure they were safe and as far as possible protected from falls. Staff intervened to diffuse situations before they arose and to minimise people's distress.

The accommodation was appropriate to people's needs and there were various activities taking place on each of the units, which people were observed to be participating in and enjoying.

People were encouraged to eat and drink sufficient quantities for their needs.

Records told us about people's needs and how they should be cared for. Staff spoken with demonstrated a good knowledge about how to care and support people.

The manager was proactive in managing complaints and reporting and investigating any concerns.

Audits helped the manager to identify what was working well and where improvements were needed. The manager had only been in post a short while and was already introducing things which would improve the service such as increased vigilance and monitoring of the service as a whole. However we found staff shortages which had the potential to affect levels of care being provided. Staff required more consistent support from the manager to fulfil their roles.

Summary of findings

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 safe.

Staffing levels fluctuated which meant we could not be assured that people's needs were always met safely.

Risk assessments were completed and identified steps to be taken to reduce risks. These were kept under review to ensure the steps taken remained appropriate to the level of risk.

Medicines were given according to the prescriber's instruction and were signed for. Medicines were stored safety and locked away to ensure people were unable to take medicines not administered to them.

Staff knew what actions to take if they suspected a person was at risk of abuse.

Is the service effective?

Good

The service was effective.

People were supported to eat and drink in sufficient quantities for their needs and staff provided appropriate support.

People's consent was sought before care was provided and saw that staff tried hard to promote people's independence and wishes All staff required up to date training in MCA 2005.

Staff were supported in their role but we identified some gaps in training and the level of support each member of staff received.

Is the service caring?

Good

The service was caring.

Staff were familiar with people's needs and provided people with meaningful stimulation and positive encouragement.

Staff were equally skilled at recognising and helping people to reduce their distress and anxiety.

Staff were inclusive and respected people's dignity and privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were documented and we saw that staff knew how to meet people's needs. However we saw some people did not get their needs met adequately.

People were engaged throughout the day in different activities provided around their individual needs.

Summary of findings

People's complaints and concerns were listened to and acted upon

Is the service well-led?

Requires Improvement

The service was not always well led.

Staff were not always well supported.

There were systems in place to assess the effectiveness of the service delivery to drive improvement although these were not always effective.

The acting manager was being well supported into their job role and had made some progress in addressing concerns.

The meadows care home

Detailed findings

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Requires Improvement

Is the service safe?

Our findings

There were not always sufficient numbers of suitable staff to keep people safe and meet their needs. The home had assessed people's needs and organised their rotas to meet this assessment, however we found that some people did not get their needs met. For example one person told us they wished to join in the morning's activity. They told us, "I would like to go but need help from the care staff." Staff had not provided the help this person needed to attend the activity. We observed another person waiting for staff to take them to get a newspaper. They waited for over an hour.

Staff told us that during busy times, when people needed to bathe or at tea time, there were not enough staff available to meet people's needs. Staff said this was particularly a problem at weekends. A relative told us, "In my opinion, the home is understaffed. I visit the home regularly in the week as does, another relative and we regularly have to sort out problems, such as finding [My relative] in soiled bed clothes, and their pad unchanged from the night."

One person told us that due to mobility issues they were not always able to reach the call bell and said when they used the call bell the response time could be slow. This could be indicative of not enough staff. We asked the manager how they monitored call bell response times and they said they checked daily that people had access to the call bells and staff responded quickly to these. We observed people's call bells were responded to in a timely way.

The manager told us that they reviewed staffing levels when people's needs changed based on their audits of care. The manager had not completed audits at the weekends and had not identified any concerns about staffing levels. Staff told us that they redeployed staff to cover any absences but this often left unit's short. The rota's we viewed did not always account for these changes.

Risks to individuals were well managed so that people were protected. We carried out observations on the ground and first floor. On the first floor the majority of people went into the main lounge. One member of staff was permanently in the lounge which meant people were supervised for their own safety. We saw staff were quick to diffuse any situations which arouse. For example one person became upset and began shouting and waving their arms around. Staff quickly intervened and reassured them and distracted them which reduced their distress. We checked their care plan and saw that staff were using strategies described in their care-plan. Staff were able to monitor people and support them with their mobility when they were standing or attempting to walk without using walking aids where these were required which promoted their safety.

People had care plans in place for all areas of daily living and these were clearly linked to any identified areas of risk. For example we saw that staff monitored people's risk in relation to falls, nutrition, hydration and skin integrity. When there was a change in need or risk we saw what actions the staff had taken to manage the risk. People at risk of pressure ulcers had appropriate equipment and were turned regularly to protect their skin. However we noted that skin charts did not always tell us what position people were placed in which meant we could not see if people were sufficiently rotated to relieve pressure on their skin and prevent it breaking down.

The manager showed us how they recorded the numbers of accidents, incidents, falls and any other events affecting the well-being and, or safety of people using the service. The manager used this information to assess the level of risk to people and whether steps taken to reduce risk were appropriate. Where necessary the manager referred people to other agencies to ensure risk was managed as comprehensively as possible. We saw an example of a recent safeguarding that had been raised where the persons care fell below an expected level. This was being currently investigated to establish the facts and determine what actions they provider had taken and if they were appropriate.

People were protected from bullying, harassment, avoidable harm and abuse. One relative told us, "I feel my family member is safe and this is a pleasant home. " People we spoke with told us they felt safe at the home and were treated kindly by staff. We observed staff supporting people appropriately and regularly checking that people were alright.

Staff spoken with had a good knowledge of types of abuse and how they should protect people. They were aware of who they should report to if they suspected a person to be at risk of abuse. They knew which external agencies they could report to if they had any concerns. One staff member

Requires Improvement

Is the service safe?

said, “I have not had any concerns about safeguarding.” Another said “I have not had concerns about abuse. I would escalate concerns to a senior or the manager. There is a safeguarding pack in the office if I needed to find out more.” The staff noticeboard downstairs displayed useful information such as safeguarding contact numbers, arrangements of whistleblowing, the on-call protocol and information about health and safety. This meant staff had the information they needed should they need to escalate a concern. However we found that one third of staff had not had safeguarding training within the last year which meant we could not be assured staffs knowledge was up to date. The manager told us training was scheduled.

Medicines were managed safely**.** One person told us “Staff support me with my medicines. They remind me and check that I take it.” We observed the lunchtime administration of people’s medicines and the staff member administered medicines according to the prescriber’s instructions and at the correct time. They observed people taking their medicines before signing for it to ensure the person had safely taken it. The medication round was completed in a competent, unhurried way, and staff gave people information about their medicines and asked for peoples’ consent before administrating it. Medicines were secure when not in use.

Staff received training to help then administer medicines safely and the manager told us following the training they carried out three direct observations of staff practice to assess staff’s level of competency.

Some people received their medication disguised in food. The reasons for covert administration were clearly recorded and the Mental Capacity Act 2005 complied with. The general practitioner and pharmacist had also been consulted to ensure this was a safe method to administer the particular medication.

Good

Is the service effective?

Our findings

We spoke with staff on duty; all were permanent staff with varying degrees of experience and knowledge. Newer staff told us about the recruitment procedures, their induction and probationary period. They said they were well supported by more experienced staff and were working through a recognised common induction and had received other training to help them with their role. The manager told us about staff recruitment and had a good knowledge so we did not need to look at recruitment files

On the day of our inspection the staff on duty were all regular members of staff and were familiar with the needs of people they were caring for. They told us about staff handover and their involvement in the care plans which helped them understand people's needs.

Staff annual appraisals were underway which gave the manager the opportunity to appraise staff's performance and identify any training and, or development needs. Staff told us about recent training they had received and how it informed their practice. Some training was not up to date but we were provided with evidence that training had been rescheduled in the very near future and it had only recently lapsed.

People were asked for their consent to care and treatment in line with legislation and guidance People were supported to make choices about how they lived their daily life and were involved in making decisions about their care. Consent was sought before care or treatment was provided. For example we observed staff explaining to people and asking for consent when giving people medicines. We noted that where people had their medicines administered covertly this decision had been taken with the appropriate consultation. The decision was recorded and regularly reviewed.

People's care was given according to their wishes and where staff were acting in their best interest the least restrictive option was used. For example where people were at risk of falls, a risk assessment was in place clearly describing the rational for options considered. Where people had bed rails consent had been sought for these and this was reviewed monthly.

However we found that in some instances it has been recorded that people were not able to consent to their care or treatment. There was no evidence that a mental capacity assessment had been completed to support this recorded decision. Some staff had not received training in either the Mental Capacity Act, (2005) or the Deprivation of Liberty Safeguards (DoLS) which meant they might not be familiar with how to support people within the requirements of the law. The manager told us training for all staff had been booked.

People were supported to eat and drink enough and maintain a balanced diet. Everyone we spoke with about the food told us it was nice or okay. We observed lunch on both floors. People on the first floor were encouraged to sit at the table whilst a lot of people on the ground floor ate in their room. This meant that they did not have as much opportunity to socialise with others; however we were told that this was their choice. People had a choice from the menu which was available in both written and picture format and helped people to select what they wanted. We observed staff offering people alternatives if they did not want something from the main menu and people's individual dietary needs were known by staff. We saw throughout the day that staff encouraged people to drink in sufficient quantities for their needs and both hot and cold drinks were offered through lunch.

We saw that where people were not eating or drinking enough for their needs, staff monitored this through recorded food and fluid charts and regular weight checks to monitor the person's weight loss. We saw that referrals were made to other health care professionals where there were concerns about people's hydration or nutrition and supplements were prescribed when needed. Senior staff had received training on meeting nutritional needs and using universal screening tools which were designed to assess the risk of malnutrition. This helped staff monitor people's weight and take the correct actions to prevent further weight loss.

People were supported to maintain good health and had access to health care services. We saw from people's care plans that their health needs were recorded. For example one person had diabetes. Their care plan included information on their condition and a management plan. This would help staff monitor the person's condition and take corrective actions when required. Health care needs were kept under review and we saw that staff contacted other health care professionals when there had been a change in the persons needs or a change in their health

Good

Is the service effective?

status. This was recorded and showed what actions or recommendations had been made. The manager told us that they had good working relationships with other health care and social care agencies.

Good

Is the service caring?

Our findings

Positive caring relationships were developed with people using the service. One person said, "The carers are all good, lovely ladies, I won't hear a word said against them." A relative told us," The home is always clean and friendly, whatever time I come in, and the carers are nice." They told us they came to the home a lot and always found the same standard regardless of what time they came.

Most people in the service were unable to tell us about their experiences of the care provided because they were living with advanced dementia or were poorly. We used observation as the main source of evidence. We observed staff responding to people gently and spending time chatting with them. Staff picked up on how people were feeling and responded appropriately. During the morning we observed staff skilfully intervening in situations where people had become upset and staff provided people with reassurance. For example one person's care plan stated they did not like noisy environments. Staff were aware of this and supported the person to have some quiet time and to access different activities all be it for a short period of time. Another person's care plan stated they needed encouragement to join in activities to avoid social isolation. We observed staff gently encouraging them and giving them support to participate. Another person had recently moved to the service and was unclear of the reason for this and was quite distressed. We saw throughout the morning staff spent time with them, reassuring them and making frequent conversation which we saw helped them feel more established in the home as all staff were familiar to them and their needs.

Throughout the morning different social activities were provided on both the units and people were given one to one support by staff. Staff encouraged people to participate. We found the activities enhanced people's well-being. On the first floor we saw people spontaneously singing, dancing and cuddling staff. Other people were present and tapped away to the music and singing. On the ground floor people were being encouraged to enter the lounge for a group discussion facilitated by the Activities Co-ordinator. Music that may appeal to people was played and helped promote people's memories. We saw people reliving and sharing experiences with each other which helped people feel reconnected with the past

We saw many people had their bedroom doors open. We were told that that this was their choice and we could see that this was documented in their care plans. Staff frequently popped their heads in to make sure people were alright and have a chat with them so they were not socially excluded.

The service supported people to express their views and be actively involved in making decisions about their care, treatment and support. People were involved in their care as we saw staff offering people choices about their meals, activities they would like to do and asking people about their personal care needs. People's needs were recorded in their care plans and there was some evidence that people or their families had been involved in the planning and reviewing of people's needs. We considered more evidence was required as to how the home engaged with people about the service they received. Resident/relative meetings had taken place and another was scheduled but these were poorly advertised and poorly attended. The manager told us a notice was put up in the home about three weeks beforehand. However this might not be appropriate for relatives who do not visit often or not at all but still have a contribution to make.

People's privacy and dignity was respected and promoted. People were free to move around and sit where they liked. Staff gave people choices about their care in a way they could understand and gave people time to answer. They gave people chance to respond and listened to people. Staff provided support sensitively when assisting people to the toilet or assisting with meals and drinks. Relatives told us they were free to visit whenever they chose according to their family member's wishes and were always made welcome and kept informed about their family members care.

Staff were very obliging and met people's requests in a timely way. They saw that people ate and drank in sufficient quantities and where people were asleep staff gently woke them up to offer them fluids. This was done sensitively. Staff worked well as a team and communicated with each other what they were doing so the care provided to people was consistent. We observed manual handling practices and staff worked together communicating effectively with each other and the resident to ensure their comfort, safety and dignity.

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Requires Improvement

Is the service responsive?

Our findings

People usually received personalised care that was responsive to their needs. One person told us, "Its fine here, there are things going on here and the staff keep me informed."

Before a person arrived at the home, senior staff completed an assessment of need which they used to draw up a plan of the person's care. The manager told us this was in place before the person moved in to the home and then adapted as they got to know the person better. We saw evidence that people's needs were reviewed at least monthly, more often where necessary. However we found the initial assessment did not provide much background information of the person's previous history or family background or who was consulted about the person's needs at the point of the assessment. More detailed information would help staff respond people's individual needs and help them settle down more readily. For example we saw a person who was experiencing distress. There was very little analysis of their behaviour or understanding as to why the behaviour occurred. The staff had made referrals for the appropriate support, however needed more information to be able to support the person appropriately. We saw that the activities coordinators recently recruited, were working hard to get to know people and develop their trust. They were tasked with finding out more about each person's background to assist care staff.

We saw staff promoting people's well- being and helping people stay in contact with their friends, family and the local community. The environment gave people the space to socialise with others or to have quiet time with family members when they wanted to. A room which was underutilised had been turned into a pub and a number of people told us they used this room to socialise, have a beer and watch the sports channel together. A television had recently been donated to the home and staff told us their fundraising efforts were enabling them to purchase items to help support people follow their own interests and hobbies, and to support different social events.

Some people told us they were supported by staff to go out into the community and there were plans to increase people's participation in these outings. The garden was accessible and there was seating outside. We saw people from each unit were encouraged to socialise with people from other units and staff assisted them to do so. A person told us that they were supported to continue with their specific religion and that this had been very important to them. We observed that some people chose to join in the activities provided whilst others sat quietly and staff offered them things to do. Staff helped people maintain their appearance and their care plans told us what people liked and how they liked to be dressed. We saw staff adhered to this. We saw people sitting quietly by themselves or with others. Some people had newspapers and others had objects of interest they could engage with, such as soft toys and scrap books.

Two of the staff providing activities had only been in their role a short period of time and were still developing their role. They said they were getting to know people and finding out what they liked. They told us they regularly evaluated the activities they provided to assess if they benefited people and if they enjoyed it or would rather do something else. This meant they were meeting people's individual needs and adapting activities accordingly. They told us their hours were flexible according to people's needs. For example they recently worked at the weekend to help a person and their family celebrate the person's birthday. We clearly observed them enhancing people's well-being.

The staff told us that they listened and learnt from people's concerns and complaints. Everyone we spoke with said they did not have any current concerns about the service. We saw the complaints procedure was available and a number of complaints about the standards of care had been made. We saw what actions were taken as a result of concerns identified which showed that the staff had responded and tried hard to improve the service provided to people. Complaints were recorded and people were asked for their views. Daily service audits included observations of care and records of what people had told staff. Where concerns were identified through these audits the staff had responded quickly to make the required changes. There was a formal complaints procedure but the manager said in reality most concerns were identified early and addressed before a formal complaint was made.

The manager asked people and their relatives for feedback by sending out surveys. However so far that had received very few back so it was difficult for them to draw on too

Requires Improvement

Is the service responsive?

many conclusions. Previous surveys had been completed, analysed and the outcome published to let people know where the service was doing well and where they needed to improve.

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Requires Improvement

Is the service well-led?

Our findings

The home had a new manager who had recently been recruited into the role, the manager had recently applied to CQC to register as the manager and this application was being processed. The manager was experienced and knowledgeable regarding their role. One person living at the home told us, “Management is as good as it’s been. There have been so many managers coming and going.” On the day of inspection the quality compliance manager was at the home and said they were there at least twice a week to support the manager. They had previously managed the home so were aware of the needs of the people using the service. They showed us what systems they had put in place to support the manager.

People using the service and staff felt that the home would benefit from a stable management team. We found that the deputy manager had left recently and some senior staff were new to their role which meant they were still developing their role and familiarising themselves with the needs of people.

Staff spoken with reported differential experiences about how they were supported. Staff who had recently joined the service told us they were well supported and had received the training they needed for their job role. Some staff said the manager was approachable and led by example. However other staff said they received poor support and limited opportunity to discuss care practices. Staff told us care was fragmented as not all staff pulled their weight and when staff were really busy this was not always acknowledged. We found that the new manager was trying to address some of these issues. Staff appraisals had been introduced and these were underway but not all staff had received one. The manager told us not all senior staff had received training in supporting staff which meant that they not able to support the manager in undertaking supervision. Some staff had not received recent supervision and did not feel fully supported. We saw that staff meetings had been planned in advance but had been poorly attended in the past by staff.

As a result of our feedback the manager decided to circulate staff questionnaires to get feedback from staff about how they were feeling and what improvements they could suggest to create a more harmonious atmosphere and to identify ways in which they could be better supported.

The manager completed regular audits to measure the effectiveness of the service they provided and where possible eliminate risks to people’s health and safety. We saw examples of audits monitoring areas such as health and safety, infection control and medication. The manager also conducted daily service audits where they monitored staff practice, observed care being provided and spoke with people using the service. We saw they were quick to step in, help staff and model the behaviour they wanted to see in practice.

From an audit we saw that a medication error had been identified and this was clearly recorded and actions taken to ensure the person did not suffer any adverse reaction and the staff were given additional support and training. However this was not always the case and whilst the audits identified issues there was not always action plans in place to ensure future improvement.

The manager reported issues of concern to the appropriate authorities and worked in cooperation with other agencies to put things right. Where incidents had taken place affecting the well- being or safety of people using the service these had been recorded, investigated and conclusions reached so staff could learn from these. The manager recorded concerns about the service and we could see from their response that they took concerns seriously and responded in appropriate timescales.

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 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There were not always enough staff to meet people's individual needs thus putting people at risk of receiving unsafe or inappropriate care. Regulation 13