Care Quality Commission

Mr Farhad Pardhan

Meadowview Nursing Home

Inspection report

48 Rack End
Standlake
Oxford OX29 7SB
Tel: 01865 300205
Website: www.example.com

Date of inspection visit: 10 March 2015
Date of publication: 24/04/2015

Ratings

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

Overall summary

We carried out our inspection on 10 March 2015. This was an unannounced inspection.

The service had a registered manager who was responsible for overall management of the home. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Meadowview Nursing Home is a care home providing nursing care for up to 42 people. The home supports people living with dementia. At the time of our visit there were 35 people living at the home.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager had made appropriate referrals to the supervisory body. However, where people lacked capacity to make decisions the registered manager was not acting within the principles of the Mental Capacity Act (2005).

Summary of findings

We found some areas of concern. People were not always protected from risk in relation to the management of medicines. Equipment was not always used and monitored safely.

Some people's care needs were not met in line with their care plans. Care plans did not always contain accurate up to date information.

The service had some systems in place to monitor the quality of the service but these were not always effective.

There was a calm and relaxed atmosphere during our visit. Staff were kind and caring. We saw people being encouraged to interact with each other and staff. People were laughing and enjoying time spent in the communal areas of the home. Relatives described how people's lives had improved as a result of living at Meadowview.

Relatives told us the registered manager was open and approachable. We saw the registered manager interacting with people, relatives and staff in a friendly manner. The registered manager was knowledgeable about the needs of people living in the home.

Staff were well supported by the registered manager and were happy working in the home. Staff had access to development opportunities and felt able to ask the registered manager for any support they needed.

We found several breaches of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 always safe.

People's equipment was not always used and monitored safely.

Medicines were not always managed safely. There was no guidance relating to the administration of 'as required' medicines.

Staff had a clear understanding of safeguarding adults and their responsibilities to report safeguarding concerns.

Is the service effective?

Inadequate

The service was not always effective.

Where people lacked capacity to make decisions the provider was not working to the principles of the Mental Capacity Act (2005). People's rights were not always upheld.

People did not always receive support that followed healthcare professionals recommendations. This put people at risk of inappropriate care.

Staff received support and had access to development opportunities.

Is the service caring?

Good

The service was caring.

People were supported by staff who knew them well.

People were treated with dignity and respect by staff who were caring and kind.

People were supported to make choices about their care and these were respected.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's care plans did not always contain accurate and up to date information

People enjoyed the activities available.

People and their relatives were able to comment on the quality of the service

Is the service well-led?

Requires improvement

The service was not always well led.

There was no system to monitor trends and patterns in relation to accidents and incidents. Quality assurance systems were not always effective.

Summary of findings

People, relatives and staff were complimentary about the open, approachable nature of the registered manager.

The management promoted a caring culture in the home.

Meadowview Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 inspection took place on 10 March 2015 and was unannounced. At the time of our visit there were 35 people living at Meadowview Nursing Home. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

Prior to the inspection we looked at notifications received from the provider. A notification is information about important events which the provider is required to tell us about by law. We contacted social and healthcare professionals and received feedback from two social and health care professionals.

During our inspection we carried out a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed care practices throughout the day.

We spoke to eight people who used the service, six visitors and three visiting health professionals. We looked at ten people's care records, five staff files and other records showing how the home was managed. We spoke to the registered provider, the registered manager, two nurses, two senior carers, four care assistants, the chef and the maintenance person.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe. One person said "I have no worries about safety". Relatives felt people were safe. One relative told us "I feel she is very safe here". However people's positive comments did not always reflect what we found during the inspection.

People were at risk of pressure damage as equipment was not being used safely. Several people had risk assessments relating to pressure care, these identified the need for pressure relieving equipment, including pressure relieving mattresses. Some pressure relieving mattresses had automatic pressure settings and some required setting according to people's weight. There was no system in place to monitor the equipment was being used to protect people from pressure damage. We spoke with staff who were not aware of the different types of settings and controls. We discussed this with the registered manager who took immediate action to check the manufacturers instructions to ensure all pressure relieving mattress settings were correct.

Some people had bedrails fitted to their beds. We spoke with the member of staff responsible for fitting the bed rails. They understood there was a risk related to the space at the top and bottom of the rails, however the member of staff was not aware of the Health and Safety Executive guidance relating to the fitting of bed rails. We could not be assured bed rails were fitted safely.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not always managed safely. Most medicines were administered from a monitored dosage system. We checked the balances for five people's medicines administered outside of the monitored dosage system. We found three people's medicine balances were incorrect. Some medicines did not have balances recorded on the medicines administration record. We spoke to a nurse who told us they were aware some balances were incorrect. This was due to a change of pharmacy and the introduction of a new system the day prior to our visit. The nurse advised all balances would be checked. Records were kept for homely remedy medicines. Homely remedy medicines are non-prescription medicines. We checked the balances and found the balance for one homely remedy was incorrect. We could not be sure that people were receiving their medicines safely.

Where people were receiving medicines prescribed 'as required' (PRN) there were no protocols in place. PRN protocols provide information as to why the medicine has been prescribed and how and when it should be given. This meant people may not receive PRN medicines when required.

One person's medicines care plan stated 'refuses sometimes'. Nurses told us the GP had agreed the persons medicines could be administered covertly when required and was normally written on the medicines record by the GP, however the person had not required covert medicines recently. There was no record of this in the person's care plan. The medication policy did not provide guidance about covert medicine administration.

These issues were breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessments were undertaken to identify risks to people. Where risks were identified risk assessments were completed and management plans put into place. However, risk assessments did not always contain up to date information on how the risk would be managed. For example one person was assessed at risk of falls, the risk assessment stated the person walked short distances with a frame and supervision. The registered manager and nursing staff told us the person no longer walked.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored safely. Medicines were stored in locked trolleys. The trolleys were stored in locked treatment rooms when not in use. Room and refrigeration temperatures were monitored and recorded daily.

Qualified nurses administered medicines. Medicine administration records were checked prior to administering medicines and were signed after people had taken their medicines. The new medicines administration records did

Requires improvement

Is the service safe?

not contain photographs or detail of people's allergies. Nurses told us this was due to the new system introduced the day before our visit. New photographs had been taken and records were being updated.

Relatives told us they felt there were enough staff to meet people's needs. One relative told us, "Staff are relaxed and have time to look after the residents and have a chat. I see them do regular checks".

Staff spent time talking with people and call bells were answered promptly. The registered manager used a dependency assessment tool to ensure there were sufficient staff to meet people's needs. We looked at the rotas for a four week period and saw that the required number of staff were on duty.

The registered manager operated safe recruitment practices. Recruitment records showed that all relevant checks were carried out before staff began work at the home. Checks included a disclosure and barring certificate and references. Staff received induction training and shadowed experienced members of staff before working alone.

Staff had received safeguarding training. They understood the different types of abuse and the signs and symptoms that might indicate abuse. Staff said they would raise any concerns with a senior member of staff. Nurses explained their responsibility to escalate and report any allegations of abuse within the management structure of the home and to the local authority social services department. The registered manager was aware of their responsibility to report all allegations of abuse to CQC.

Inadequate

Is the service effective?

Our findings

Some staff told us they had received training in the Mental Capacity Act 2005 (MCA). The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack capacity to make decisions are protected. Some staff were able to describe how they supported people to make decisions in relation to their daily lives. One care worker told us, “We always ask, everyone has a right to make choices if they can”.

However, care plans did not contain clear information relating to people's capacity. For example one person's care plan stated 'I have capacity to make decisions for myself. I can make minor or major decisions'. The care plan also stated 'Sometimes the staff have to make decisions on behalf of my best interest'. There were no mental capacity assessments in the care records and no evidence of the decisions that may need to be made in the person's best interest. This meant people's rights may not have been upheld. .

One person was no longer being given a walking frame to mobilise as they were considered at high risk of falls. The person's relative and nurses told us the person no longer walked. The registered manager told us this decision had been taken in the person's best interest. The care plan contained no mental capacity assessment relating to the decision to remove the person's walking frame. There was no record of a best interest decision making process being followed.

Some care records contained bed rail consent forms signed by family members. There was no record of family members having lasting power of attorney giving authority to make this decision on the persons behalf. There was no record of a best interest process being followed. We could not be sure that people's rights were being upheld.

The registered manager was aware of their responsibilities under the Deprivation of Liberty Safeguards (DoLS) and had made some applications to the supervisory body. However, we could not find applications for the person who no longer had access to their walking frame.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Healthcare professionals told us people were referred to healthcare services appropriately. Health professionals were complimentary about communication with staff in the home. One health professional told us the management team would call for advice if they were unsure about any recommendations made. However, professionals positive comments did not always reflect what we found on the day.

Although care plans showed people had been referred to specialist services when their needs had changed. Recommendations had not always been followed or a further referral made when people's needs changed further. For example, one person's care records contained a recommendation from the physiotherapist to use a piece of equipment. This recommendation was not included in the care plan. The person was not using the piece of equipment on the day of our visit. Nurses told us the person did not like it and had removed it. The person had not been referred back to the physiotherapist for further guidance.

Another person's care plan contained recommendations from the speech and language therapist. The care plan stated the person should not be left alone with food or drink due to high risk of choking. We saw the person was left alone with a drink. We immediately alerted the manager who arranged for a care worker to sit with the person and support them. One staff member we spoke to was not aware the person should be supervised at all times when eating and drinking. This person's care plan also contained recommendations from the speech and language therapist (SALT) relating to thickened fluids. The fluids given to the person were not of the recommended consistency. The nurse told us the person did not drink as quickly if the drink was thicker. This had not been discussed with the SALT and we could not be assured the person was protected from the risk of choking.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were complimentary about the food. One person told us, "It was a very tasty dinner and just the right amount. I don't like too much". One relative told us, "My relative had lost a lot of weight but since coming here they are eating really well".

Inadequate

Is the service effective?

In one area of the home two staff were supporting 11 people. Four plates of food were left on an unheated trolley while staff were supporting people in the dining area. Staff told us the plates of food on the trolley were for people 'who need to be fed'. We were not assured that people were always served food at the correct temperature. We spoke with the registered manager who advised extra staff could have been available had staff on the unit made a request for support.

People were able to chose between two meal options. We saw a member of staff write down the menu choices for a person who was hearing impaired. Another person was shown the two meal options on plates.

The atmosphere at lunchtime was calm and people were able to eat at their own pace. Where people were supported to eat and drink this was done in a kind and encouraging way.

Food looked appetising. Where people required pureed food, this was presented in an attractive way, with food items served separately on people's plates. People's dietary requirements were met in line with their care plan.

Staff told us they felt well supported by the registered manager and nursing staff. Staff we spoke with had received supervision. Although staff were not always clear how often supervisions took place or who was responsible for completing them. Some staff records contained notes of supervisions. Supervision records included where skills could be improved and how this had been achieved. We spoke with the registered manager about staff files where there was no record of supervision. The registered manager showed us additional records that were not filed in staff files. The registered manager did not have an effective system to monitor whether all staff had received supervisions.

Staff who had recently started work at Meadowview told us they had received an induction and completed training. Training included moving and handling, food safety, infection control and safeguarding. One member of staff told us they were still shadowing more experienced staff as they were still in their induction period. Staff felt well supported and were able to access development opportunities. One senior care worker had completed their National Vocational Qualifications in health and social care at level two and three.

Nursing staff kept their skills and knowledge up to date. One nurse told us they had just completed additional training in diabetes care. Records of qualified nurse's supervision with the registered manager showed nurses had updated skills in PEG (Percutaneous Endoscopic Gastroscopy) feed regimes and the use of syringe drivers.

Good

Is the service caring?

Our findings

People told us they felt well cared for. One person said, “They are all kind and caring”. Relatives were complimentary about the care people received. Comments included: “They are lovely and caring here”, “There is such warmth and a lot of laughter” and “The home has a big heart”. Health professionals we spoke with were complementary about the care staff and felt they provided a good standard of care.

We saw many kind and caring interactions throughout the day. People were addressed by their preferred name and preferences were documented in people’s care records. Staff supported people in a dignified way. We saw one care worker sitting with a person who needed support with personal care. The care worker asked the person discreetly if they would like some help and then provided the support whilst maintaining the person’s dignity.

One person was supported to transfer from a wheelchair to a chair using a hoist. Staff explained to the person what they were going to do and made sure they were comfortable. Staff made sure the person's dignity was maintained throughout the procedure.

People's privacy was respected. Staff knocked on people's doors before entering. People were supported with personal care in their rooms and doors were closed.

Staff knew people well. Staff talked to people about things that interested them and encouraged them to interact with others. One person was being supported into the lounge, the care worker pointed out another person who was a friend. The care worker supported the person to stop and chat with their friend and asked if they would like to sit together. The care worker then arranged the seating to enable this to happen.

People had positive relationships with staff supporting them. One care worker had supported a person to attend a family occasion. There were pictures in the person's room of the event. During our visit we heard the care worker sharing some of the memories of the day with the person.

People were supported to make choices. Staff were patient when explaining the choices available to people. One person was being asked what they would like to drink. The care worker used their knowledge of the person to offer drinks they knew the person liked. The person smiled and nodded in response.

People were involved in their care. Care staff spoke to people in a calm manner when supporting people. Care staff explained what they were going to do and respected people's choices. One person had not wanted to get up for breakfast and was offered breakfast in their room.

Requires improvement

Is the service responsive?

Our findings

People and their relatives were positive about the care provided. However, their views were not always supported by what we found during our inspection.

One person had been identified by staff as exhibiting behaviours which challenged. We looked at this person's care plan which provided no guidance to care and nursing staff on how to support this person's behaviour. We discussed this with the registered manager who told us the learning disability team had provided support, however this was also not documented. We observed that staff checked on this person regularly when the person shouted, however care staff were unaware of how to support this person. One care worker told us they had been told to 'keep calm' when supporting the person. We could not be assured the person received support that met their needs.

Some people's care plans contained assessments relating to the risk of pressure damage. One person's care plan stated a pressure relieving mattress should be in place. The person did have a pressure mattress, however the mattress was not set at the correct pressure for the person's weight. The person was not receiving care that minimised the risk of pressure damage.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were assessed before they moved into the home. The information was used to complete the person's care plan. However, information was not always accurate which put people at risk of inconsistent care or not receiving the care and support they needed. For example one person's care plan stated, 'Likes to sit in their room'. This person was sitting in the lounge and appeared calm and happy. The registered manager told us the person now enjoyed being out of her room. The care plan did not accurately reflect the person's needs.

Staff were knowledgeable about people's needs, however assessment records were not always completed. One person's care plan contained incomplete assessments relating to oral health, foot care, mobility, personal safety, medication, skin integrity, mental health and communication.

Some care records contained incomplete care plans. One person's care plan did not contain any information relating to their communication needs. Staff communicated effectively with this person, however this method of communication was not contained in the person's care plan.

These issues were a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives were positive about the social interactions people experienced. One relative told us they were 'delighted' with how their relative had improved since moving to the home. The relative said, "They have coaxed her into the lounge and she is very relaxed. It gives me great peace of mind now she is here".

People had access to activities that interested them. People told us they liked to go out in the garden when the weather was good. Two people told us they liked to have a daily paper. They received their papers on the day of our visit.

The activity coordinator was not present during our visit, however people and their relatives were complimentary about the activities organised. People who preferred to remain in their rooms had visits from the activity coordinator.

People told us they would go to the manager if they had any concerns and were confident to do so. One person told us, "I have no complaints at all". Relatives were confident to raise issues with the management team and felt they would be addressed promptly. One person said, "I have raised issues and they have always been dealt with".

There was a record of complaints received by the provider. Records showed complaints were responded to in line with the complaints policy.

An annual survey was carried out to gather people's views of the service. An action plan was then developed as a result of the survey to improve the quality of the service. The 2014 survey results showed that people and their relatives were unsure of the staff structure within the home. The action plan stated information would be displayed in the home. There was a board in the entrance showing photographs of staff and their roles.

Requires improvement

Is the service well-led?

Our findings

Accidents and incidents were recorded by staff, however there was not always a record of outcomes. Where recommendations had been made as a result of an accident it was not always clear whether these had been followed. For example, one person had a fall that resulted in a referral to the falls service. Recommendations were made, however there was no system in place to ensure the recommendations were followed. There was no system in place to enable the registered manager to look for patterns and trends in relation to accidents and incidents.

There were audits in place to monitor the quality of the service. These included audits of care plans, infection control and medicines. However, these audits were not always effective. For example, care plan audits had not identified the issues found during the inspection. An infection control audit identified a suction machine was dirty and stored on the floor in a sluice room. The action plan identified the machine should be cleaned and stored correctly. We saw the suction machine was on the floor in a bathroom. We spoke to the registered manager who arranged for the machine to be moved.

These issues were breaches of Regulation 10 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were complimentary about the home. One person told us, "I like it very much. The people are very nice, both the staff and other residents". Relatives were positive about the care provided and the atmosphere in the home. Comments included "There is a family 'feel' about the home", "The welcome here is amazing, they are all so friendly".

Relatives were complimentary about the registered manager. Comments included, "We very much like the managers' approach. They are very reassuring", "The manager always keeps us informed".

Staff felt well supported by the management team. They were complimentary about the registered manager. One member of staff told us, "I have daily support from the manager. I have been allowed to grow" and "The manager's very approachable; an excellent manager who is good with people". Staff felt confident to raise any concerns with the manager. Staff understood the whistleblowing procedures and felt they would be listened to.

The style of leadership in the home encouraged staff to understand the caring culture of the home. On the day of our visit the registered manager was actively involved in day to day activities and spent time talking to people, relatives and staff.

Staff told us communication in the home was good. There was a handover at the beginning and end of each shift. Information was recorded on a handover sheet and included information regarding people's changing needs. Staff viewed the handover as a daily supervision as it was an opportunity to discuss any issues.

Staff meetings enabled staff to identify and discuss issues. For example staff meeting records identified staff had discussed safeguarding adults procedures and additional training had been agreed. This training had taken place.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The registered person did not have an effective system to regularly assess and monitor the quality of service in relation to assessing and monitoring risk in relation to the health safety and welfare of service users. Ensuring accurate and complete records in respect of each service user. Regulation 17(1) (2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The registered person did not have appropriate arrangements in place to ensure service users were protected from the risks associated with management of medicines. The registered provider did not ensure equipment used was safe and used in a safe way.Regulation 12 (2) (e) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to care and treatment provided for them. Regulation11 (1) (2) (3)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met. The registered person did not ensure service users were protected from care or treatment that is unsafe by carrying out an assessment of service users needs and planning and delivering care to meet service users individual needs and ensure their welfare and safety.

The enforcement action we took:
A warning notice was issued. To comply with Regulation 9 by 30 April 2015