Meadows Edge Care Home Limited

Meadows Edge Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Meadows Edge Care home is a residential care home providing personal and nursing care to up to 45 people in one adapted building. The service provides support to both older and younger adults. At the time of our inspection there were 30 people using the service.

People's experience of using this service and what we found
People were not always supported in line with their personal preferences. People were often recorded as being distressed when receiving personal care against their wishes.

Care plans did not always contain information that was important and relevant. This meant staff did not have the appropriate information and guidance to ensure they were supporting people in line with their needs and preferences.

The provider continued to not identify and assess risks through quality assurance processes to keep people and staff safe.

People were given as required (PRN) medicines routinely and not in line with protocols. People were at risk of being over medicated when staff found their needs difficult to manage.

The environment continued to not always promote safety and good infection prevention and control practices. We identified areas in the environment that required repair and renovation to ensure they were safe and could be effectively cleaned.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The provider had not identified or reviewed the day-to-day culture in the home to ensure people were treated with dignity and respect and given maximum control over how they wanted to be supported.

There were some management systems in place to assess, monitor and improve the quality-of-service people received. However, these were not always effective and did not identify the shortfalls we found during inspection.

Staff had not always completed training specific to people's needs to ensure they had the competency and skills to support people safely.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for

granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 18 November 2022). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations. This service has been rated requires improvement for the last 3 consecutive inspections.

Why we inspected
We undertook this focused inspection to follow up on breaches identified at the last inspection. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.
The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.
You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to dignity and respect, safe care and treatment, safeguarding people from abuse and improper treatment, good governance and staffing at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe.	**Inadequate**
Is the service well-led? The service was not well-led.	**Inadequate**

Meadows Edge Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by 2 inspectors and an Expert by Experience made phone calls to relatives to request feedback about the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Meadows Edge Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Meadows Edge Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager, however there was a manager in post who had completed their application to be registered with the Care Quality Commission.

Notice of inspection
This inspection was unannounced on the 28 February 2023 and we gave a short period of notice on the 2 March 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We requested feedback from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used all this information to plan our inspection.

During the inspection
We spoke with 11 family members about their experience of the care provided. We spoke with 4 members of staff including the manager.

We reviewed a range of records. This included 6 people's care records and 15 medicine records. We looked at 3 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At our last inspection the provider had failed to ensure medicines were managed safely and risks relating to the health, safety and welfare of people and the service environment were robustly managed, monitored and assessed. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● Information contained in protocols for PRN medicines was not always correct. We saw in a medicine protocol used only for the treatment of sleeping disorders, instructions for it to be administered for the management of pain. This put people at risk of medicine not being given in line with its intended use or the prescriber's instructions.
● Peoples medicines were not always managed safely. For example, an error was made when counting the amount of medicine in stock, however it had not been identified or corrected so the balance continued to be wrong throughout the month. This meant people's medicines could not be safely accounted for.
● Prescribed medicines were not always in stock. This meant medicine was not always available when people might have needed them.

Preventing and controlling infection
● We identified areas in the environment that required repair and renovation to ensure they were safe and could be effectively cleaned. The environment continued to not always promote safety and good infection prevention and control practices. Areas for improvement that had been identified in the previous inspection, remained unchanged and still required repair.
● Pressure relieving cushions were put on chairs in the lounge for any people to use. Staff were not given appropriate guidance or procedures to ensure people were protected from the risk of cross infections when sharing pressure relieving equipment.

Assessing risk, safety monitoring and management
● Systems in place to identify, assess and monitor risk were not effective. When people's needs had changed or they were a known risk to others, risks had not been assessed to keep people and staff safe. Risk assessments which were in place lacked guidance for staff on how to support people safely.
● Care plans did not always contain information that was important and relevant. In 1 person's care plan we saw actions to keep them safe was a continued list starting when the person's needs were different which

meant they were at risk of staff not supporting them in line with their current assessed needs.
● People were at risk of injury from equipment. We observed 2 people sat on slings in the lounge. There were no risk assessments in place to assess the safety of people sat on slings for long periods of time and the care plans did not contain any guidance for staff.
● The provider had not implemented any precautions to reduce risk before allowing staff to live in the care home in bedrooms next to rooms occupied by people using the service. This situation was not effectively managed and could have resulted in harm to people and staff.
● The fire risk assessment was not suitable or sufficient and required reviewing. Lincolnshire Fire and Rescue had fed this back to the provider during an audit in October 2022. Lincolnshire Fire and Rescue visited the location again on Monday 6 March 2023 and noted the provider had not reviewed the risk assessment and it was still not suitable or sufficient. This put people at continued risk of harm.

Learning lessons when things go wrong
● Systems for learning lessons were not reliable or robust.
● Incident forms showed that appropriate actions had not always been put in place following incidents. We saw in 1 person's care records how they had experienced regular falls. However there were no reported actions other than to monitor which did not sufficiently mitigate the risks and they continued to experience regular falls.
● Care plans and risk assessments were not always updated following incidents. We saw in 2 people's care plans that updated information had not been incorporated following significant incidents that had caused injury.
● When incidents had occurred reviews had not been carried out to reduce risk and improve safety which meant people were at continued risk.

The provider had failed to ensure PRN medicines were managed safely and that risks relating to the health, safety and welfare of people and the environment were robustly managed, monitored and assessed. This placed people at risk of harm. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● The provider had not assessed the risks or put any control measures in place when people displayed distressed reactions to other people and staff. This meant there was an ongoing risk of people and staff being hurt or emotionally abused.
● People were not supported in the least restrictive way. We saw in records a person was supported by 3 staff for all personal care with evidence this had caused significant distress. Staff used restrictive practice such as holding the person's hands down when they displayed distressed reactions which was not an agreed technique and put the person at risk of unjustified control and restraint. Records showed this person had bruises which were indicative of restraint that had not been appropriately reviewed or referred to the local adults safeguarding team.
● PRN medicines used to affect behaviour and mood were used routinely instead of when required. We saw in 3 people's medicine administration records (MAR), medicines given daily at regular times which was not in line with the agreed protocols. This meant people were at risk of unlawful and unjustified chemical restraint.
● We observed people using bucket chairs which were laid back chairs with a foot stool that a person would not be able to get out of without full assistance. Care plans did not give appropriate guidance for staff to know when these chairs should be used in people's best interests. There was evidence these chairs had been used to restrain a person for monitoring purposes.

The provider did not ensure appropriate systems and processes were in place to prevent the risk of abuse.

This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had not ensured staff had received appropriate training to meet people's needs. This was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18

● At the previous inspection staff said they would benefit from additional training in specific health needs. Specific and specialised training was still not available to staff even though they continued to support complex people which put people and staff at risk.
● Staff had completed training in the Mental Capacity Act (MCA) however training was not effective as staff could not demonstrate a sufficient level of understanding. We spoke with 2 members of staff who could not outline the main principals of the MCA and how they would put it into everyday practice.
● Staff had not always completed specific training to give them the knowledge and skills to effectively meet the needs of people to keep them safe. For example, only a small number of staff had completed training in diabetes and dementia. This meant there was an increased risk of people's needs not being met.
● There were insufficient arrangements in place to support staff. Staff did not receive regular supervisions to ensure they were able to safely meet people's needs.

The provider had not ensured staff had received appropriate training to meet people's needs. This was a continued breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were sufficient staff to support people in a timely way. However, we were not assured staff were utilised appropriately as we saw in records people were often supported by up to 3 members of staff which was restrictive and undignified.
● We found staff had been safely recruited with appropriate references and Disclosure and Barring Service (DBS) checks in place prior to their appointment. DBS checks provide information, including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

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 MCA 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 to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● Mental capacity assessments had not been reviewed regularly when people's circumstances had changed. Regular assessments of people who had been using the service long term, had not been carried out to

ensure the provider continued to work in line with the MCA.

- We found the service was requesting appropriate legal authorisations to deprive people of their liberty.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider failed to ensure that effective governance systems were in place. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

- The systems and processes to assess, monitor and improve the quality and safety of the service were not effective. This meant people were at risk of unsafe care and support.
- The provider did not carry out reviews of behaviour charts and incident forms to ensure staff were supporting people in the least restrictive way and in their best interests. Lessons were not learnt after incidents. There was no effective system to analyse how incidents could have been managed better to ensure the safety of people and staff.
- Reviews of care plans and risk assessments was not sufficient. Staff did not always have access to up-to-date information reflective of people's current needs or risks.
- The provider had not ensured staff understood how to protect people from the risk of harm. Risk assessments had not been completed when there was a clear identified risk to people and staff.
- Audits were not always effective in identifying concerns that put people and staff at risk. We identified several environmental concerns that did not always promote safety and good infection prevention and control practices. This put people and staff at increased risk of infections and outbreaks of infectious diseases.
- Medicine audits were not effective and had failed to identify mistakes in PRN protocols meaning people were at risk of medicines not being administered when required for the right reasons.

Managerial oversite and the providers systems and processes that monitored quality and safety were not robust. This was a continued breach of Regulation 17 (Good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering

their equality characteristics
● The provider had not reviewed the day-to-day culture in the home to ensure people were treated with dignity and respect and given maximum control over how they wanted to be supported. For example, people were woken up so staff could support them with personal care which regularly caused distress.
● Terminology and language used in care records showed a closed culture. We saw examples in records of language being disrespectful and offensive.
● People were not always included in decisions about their care and treatment. For example, a person's cigarettes were rationed and kept in a locked safe. There was no evidence the person had been involved in this decision with the care plan stating that asking the person to wait for the next cigarette could cause distressed reactions.
● People were not protected from the risk of isolation. For example, in an incident record it stated a person was isolated from others following an incident. This was unjustified and put the person's health and well-being at risk.
● Care plans did not give staff guidance or information when people expressed their sexuality. For example, we saw a care plan with this section blank and behaviour charts in place for when they did express their sexuality. This meant people were at risk of not being appropriately supported with their basic needs without it being seen as a behaviour.

The provider had failed to ensure people were receiving care and support that met their individual needs and reflected their preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility
● The duty of candour is a regulation which all providers must adhere to. Under the duty of candour, providers must be open and transparent, and it sets out specific guidelines' providers must follow if things go wrong with care and treatment.
● The provider had not identified incidents which required investigation to identify what had gone wrong and could have been done differently. As a result, they had not fed back to people, relatives or other concerned persons.
● Relatives told us they were not kept informed or updated about their family members. One relative told us, "They [staff] do not communicate with me unless they are taken to hospital. If I phone up to ask, they just say [relative] is fine."

Working in partnership with others
● Medicines were not reviewed with the GP in a timely way to ensure safe and appropriate use. We identified 3 PRN medicines that were given daily at the same times. 1 of these medicines had been flagged by 2 other visiting professionals as requiring a review, however at the time of inspection this had not been reviewed and was still being administered daily.
● Referrals were made to health professionals when health needs changed. For example, a person on a soft food diet had requested chips so a referral was made to the speech and language therapy (SALT) team to request appropriate advice on how they could support the person safely.