Mr Farhad Pardhan

Meadowview Nursing Home

Inspection report

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Ratings

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

Overall summary

We inspected this service on 1 July 2015. This was an unannounced inspection.

Meadowview provides accommodation for up to 42 people who require personal or nursing care. At the time of our inspection there were 24 people living at the service.

At a comprehensive inspection on 10 March 2015 we identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued the provider with one warning notice and three requirements. The warning notice required the provider to meet the legal requirements of the regulation by 30 April 2015. After the comprehensive inspection the provider sent us details of how they would meet the legal requirements relating to the three remaining regulations.

We undertook this focused inspection to check that the provider had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Meadowview Nursing Home on our website at www.cqc.org.uk.

People's care plans contained up to date information and were regularly reviewed, this included risk assessments and risk management plans. However, there were still

Summary of findings

improvements needed to one persons care plan. People's medicines were being managed safely. The provider had taken action to ensure staff had the knowledge and skills to delivery care and support safely.

The registered manager had introduced effective systems to monitor the service and had an overview of all accidents and incidents.

People's best interest was considered where they were assessed as lacking capacity to make a decision. Some people's records were not clear about the decisions they were unable to make. We have made a recommendation about the Mental Capacity Act 2005.

Although we found most of the required improvements had been made we have not changed the overall rating for this service because we want to be sure that the improvements will be sustained and embedded in practice. We will check this during our next planned comprehensive inspection.

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

We found that action had been taken to ensure the service was safe.

People's medicines were managed safely.

People's care plans contained up to date risk assessments and risk management plans.

We could not improve the rating for this key question from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service effective?

Requires improvement

We found some improvements had been made to ensure the service was effective.

Care plans contained recommendations from health professionals and recommendations were being followed.

Care plans did not always contain clear information relating to people's mental capacity.

We have improved the rating for this key question from inadequate to requires improvement. We will check for further improvement at our next planned comprehensive inspection.

Is the service responsive?

Requires improvement

We found some action had been taken to ensure the service was responsive.

Records relating to people's care were completed consistently.

People's care plans did not always contain guidance that enabled staff to meet people's needs.

Is the service well-led?

Requires improvement

We found action had been taken to ensure the service was well led.

Accidents and incidents were monitored for trends and patterns.

Effective audits were in place.

We could not improve the rating for this key question from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook an unannounced focused inspection on 1 July 2015. This inspection was carried out to check improvements had been made by the provider after our comprehensive inspection on 10 March 2015. The inspection looked at four of the key questions we ask about services: is the service safe, effective, responsive and well led. This was because the service was not meeting all of its legal requirements.

This inspection was undertaken by one inspector. We spoke with two people who used the service, We also spoke with the registered manager, the provider, a nurse and two care staff. We looked at four people's records, medicines records and records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

At our inspection in March 2015 we identified that people were not always protected from the risk of unsafe care. 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. We asked the provider to send us an action plan to tell us how they would meet their legal requirements.

In March 2015 people were at risk of pressure damage as there was no system to check that pressure mattresses were set at the correct pressure for people. At our inspection on 1 July 2015 we found the provider had introduced a system to monitor pressure mattresses. Records included people's weights and the correct setting of the pressure mattress for the person. Settings were checked daily by staff and recorded. We checked the pressure mattresses for three people and found they were correct.

In March people were at risk of harm as bedrails were not correctly fitted. The registered manager told us staff had completed the Health and Safety Executive on line training on the correct fitting of bed rails. In July we saw that bed rails were fitted correctly and a safety check was completed monthly. Staff were aware of the guidance around the correct fitting of bed rails.

At the March inspection we found people's medicines were not always managed safely. Balances of people's medicines were not always recorded and where they were recorded balances were not always correct. Where people were prescribed medicines 'as required' there were no protocols in place to determine when people may require their medicines. People who were receiving their medicines covertly did not have a record of how this decision had been made and who had been consulted.

At our inspection on 1 July 2015 we found the registered manager had taken action to meet the legal requirements. We checked the balances of three people's medicines and found they were correct. Where people were prescribed medicines 'as required' there were clear protocols in place to identify when people may require medicines, the indicators that the medicine was required and the dose and frequency prescribed. Care records for people who required medicines to be administered covertly detailed who had been consulted and the covert medicines care plan was signed by the person's GP. Records included detail of how the medicines would be administered.

At our inspection in March 2015 we found people's care records did not always contain up to date information relating to risks and how risks would be managed. 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.

At this inspection (July), we found risk assessments were up to date and contained information relating to how risks were managed. For example, one person's care record included a risk assessment and risk management plan related to the risk of falling. The care plan stated the person should be supported to spend time in the communal area of the home. When the person wished to remain in their room the care plan stated their call bell must be to hand. The person had also been referred to the falls service.

Requires improvement

Is the service effective?

Our findings

At the March inspection we found the provider was not working to the principles of the Mental Capacity Act 2005. 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. We asked the provider to send us an action plan telling us how they would meet the legal requirements.

In March care plans did not contain clear information relating to people's capacity. At this inspection in July we found some improvements had been made. Where people had been assessed as lacking capacity there was a record of the best interest process. For example, one person did not have the capacity to consent to bed rails. There was a record of discussions with the person's relative, GP and the registered manager and a best interest decision had been made. However, one person's care plan contained conflicting information. The person had been assessed as lacking capacity to make decisions relating to personal care, however the person's care plan also stated, "I have capacity to make decisions for myself". It was not clear what decisions the person had capacity to make. We spoke with the registered manager who told us they would review the person's care plan. We have made a recommendation relating to this issue.

In March we found people's care and welfare was not protected because care was not provided in line with care plans. We took enforcement action to ensure the provider took appropriate action in a timely manner. 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. At this inspection (July) we found the provider had made improvements to meet legal requirements.

At the inspection carried out in March people had been referred to health professionals, however people were not always receiving care that followed recommendations made by professionals. At this inspection (July), people who had been referred to health professionals were receiving care as recommended. For example, one person had been referred to speech and language therapy (SALT). The person's care plan contained the SALT assessment. The recommendations required the person to have drinks thickened to 'double cream consistency'. We spoke with staff who told us the person needed their drinks thickened and were aware of the correct consistency. Staff told us they had recently received training from the manufacturers of the thickening agent. They told us, "The training was really useful".

We recommend the service refers to the Mental Capacity Act 2005 codes of practice for guidance relating to mental capacity assessments.

Requires improvement

Is the service responsive?

Our findings

At the inspection in March 2014 we found care plans did not always contain accurate and up to date information. 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.

This put people at risk of not receiving care to meet their needs. We asked the provider to send us a plan outlining what action they would take to bring the service up to the required standard. At this inspection (July) we found improvements had been made.

Most people's care records contained information about their health and social care needs. Care plans detailed how people's needs should be met and guidance for staff about how people wanted to be supported. Care plans were reviewed and changes made when people's needs had changed. For example one person's care plan contained a risk assessment relating to falls. The risk assessment had been reviewed showing the risk of falls had increased. The care plan had been reviewed and updated to include closer monitoring. Health professionals had been consulted as a result of the person's changing needs.

One person's care record still required improvement. The person had been assessed as having behaviour that may be described as challenging. Although the care plan contained details of the behaviour the person may present, there was no guidance for staff on how to respond and support the person during this behaviour.

Staff were aware of people's changing needs and monitoring records were complete, for example when people were at risk of weight loss food and fluid charts were completed.

Requires improvement

Is the service well-led?

Our findings

At the inspection in March 2014, there was no effective system in place to enable the registered manager to monitor or identify trends and patterns relating to accidents and incidents. Recommendations following incidents and accidents were not monitored. Audit systems in place were not always effective. 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.

Accidents and incidents were monitored monthly and where issues were identified actions were taken to reduce the risk of further events. For example, one person had experienced several falls. The person had been referred to the falls service and recommendations followed. These included protective equipment for the person and a review of their medicines with the GP.

The registered manager had implemented effective audit systems, included auditing of infection control, medicines and care plans. The care plan audit had identified the issues we found during this inspection and had been allocated to a member of staff to address.