Ultima Care Centres (No 1) Limited

The Meadows Care Home

Inspection report

New Road
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Date of inspection visit:
19 September 2017

Date of publication:
01 December 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The Meadows Care Home is a residential service situated in Boldon Colliery. The home has two floors and all rooms have en-suite facilities. It provides accommodation, personal and nursing care for up to 69 older people with physical and mental health related conditions. At the time of our inspection 43 people used the service.

This is the first inspection of this service under the management of Ultima Care Centres (No 1) Limited. This service had been taken over by a new provider since our last inspection in August 2016.

In September 2016, the new provider Ultima Care Centres (No 1) Limited took over the running of this home and implemented a comprehensive action plan to support the registered manager to improve the service. However, due to the history of non-compliance at the service, a multi-agency decision was made to place the service under South Tyneside Council's 'Provider Concerns' process. This meant that this provider had to produce an action plan which would be closely monitored by the local authority contracts monitoring and safeguarding teams. This provider also agreed not to admit any new residents for a period of time.

In August 2017, following several unannounced visits by the local authority contracts team, a multi-disciplinary meeting was held and a decision was made to remove the service from the 'Provider Concerns' process due to the considerable improvements made and the positive feedback received from all external agencies involved. It was agreed by the multi-disciplinary team that the home's on-going improvements should be closely monitored in line with the local authority's quality assurance programme.

This unannounced comprehensive inspection took place on 19 September 2017.

There was a registered manager in post who has been employed to manage the service since April 2015. They re-registered with the Care Quality Commission (CQC) to carry on regulated activities in September 2016 when the new provider took over. A registered manager is a person who has registered with the 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 2008 and associated Regulations about how the service is run.

The action plan drafted to address the areas which previously required improvement had worked well and positive outcomes had been achieved. Audits and checks were carried out to monitor aspects of the service. The registered manager and provider had oversight of the service but not all aspects of the service had been comprehensively audited or analysed which meant the issues we highlighted had not been identified through their quality assurance systems. Throughout the service record keeping was not always accurate, complete and contemporaneous which showed that the governance systems in place were not operated effectively.

We found that the registered manager and provider were not meeting all of the conditions of their

registration. They had failed to submit a large amount of notifications. Notifications are changes, events or incidents that they are legally obliged to tell us about. We have dealt with this breach of the registration regulations outside of the inspection process and will report on the outcome in the near future.

People told us they felt safe. There were safeguarding procedures in place and staff were knowledgeable about what action they should take if they suspected people were at risk of harm or abuse. Risk assessments were in place to minimise the risks people faced in their daily lives.

Accidents and incidents were managed well by staff and they were recorded and reviewed. The registered manager reported them onto external professionals if necessary. However we found that some accidents had not been included in the registered manager's analysis and subsequently four serious injuries had not been reported to the CQC as legally required.

The premises were clean and tidy. Checks and tests of the premises had been carried out to ensure they were safe and well maintained.

Robust recruitment procedures were conducted to ensure that staff were suitable to work with vulnerable people. There were sufficient numbers of staff deployed to meet people's current needs.

Medicines were managed safely and consistently throughout the home. People's nutritional needs were met and they were supported by staff to access external health and social care services.

Records confirmed that training courses were delivered to ensure existing care staff were refreshed with key topics, however other topics which staff may find beneficial had not been completed by all staff. There had been a delay in implementing a robust induction process which meant a small number of staff had not completed one as we would have expected. We have made a recommendation about this.

All staff were supported though a supervision and appraisal system. Staff told us they enjoyed working at the home and that they felt valued by the registered manager. They told us morale had notably improved.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The registered manager told us they had made applications on behalf of most people to restrict their freedom in line with the MCA. However the CQC had not been notified of these as legally required. All staff demonstrated an understanding of the MCA and worked within its principals.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

We observed staff interacted positively with people. Staff promoted and protected people's privacy and dignity. There was a system in place to ensure people and/or their supporters were involved in the development of their care plans.

Care plans were person-centred and contained the specific health and social care needs of each person. The arrangements in place for social activities and community engagement met people's social, emotional, cultural and religious needs.

Complaints received by the service were managed in line with company policy and resolved in a timely manner. The complaints procedure was on display and had been shared with people and their families.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff understood their role in safeguarding people from harm. Medicines were well managed.

Risks which people faced in their daily lives were addressed and mitigated against.

The building was safe and well maintained.

There was a sufficient amount of staff on duty who had been recruited appropriately.

Is the service effective?

Requires Improvement

The service was not always effective.

A robust induction programme had not yet been implemented. There were gaps in staff training which meant some staff had not received training in courses that would be beneficial to them in their role.

Staff applied the principles of the Mental Capacity Act 2005 in their role.

People were supported well with their nutrition and hydration needs.

The premises were purpose built and took into consideration best practice guidance.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff who respected their wishes and protected their dignity and privacy.

People and relatives were involved in the care planning process.

Staff knew people well and had established positive friendships.

Is the service responsive?

Good

The service was responsive.

Person-centred care plans were in place which described people's individual needs and preferences.

We were given examples of the positive outcomes people had achieved through the supportive staff.

A range of meaningful activities had taken place.

Complaints were recorded and well managed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager and provider did not have a thorough oversight of the service.

Record keeping required improvements.

Regular checks on the quality and safety of the service took place.

Staff were confident in the management of the service and had witnessed big improvements recently.

The Meadows Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 19 September 2017 and was unannounced. The team consisted of two adult social care inspectors, a specialist advisor and an expert by experience. A specialist advisor is a person employed by the Care Quality Commission to support inspectors during an inspection; they have specialist knowledge in a certain area. The specialist advisor on this team was a qualified nurse. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed all of the information we held about The Meadows Care Home, including any statutory notifications that the provider had sent us and any safeguarding information we had received. Notifications are made to us by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. These are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

In August 2017 we asked for a Provider Information Return (PIR) which was completed and returned to us in a timely manner. The PIR 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.

Additionally, we consulted staff from South Tyneside Council's contracts monitoring team and safeguarding team and staff from South Tyneside Clinical Commissioning Group (CCG). We used their information to help with the planning of our inspection.

During the inspection we spoke with two people who used the service and five relatives. We spoke with 11 members of staff: the registered manager, the deputy manager, a nurse, two senior care workers, two care workers, a domestic, the cook, one activities coordinator and the administrator. A representative from the provider's organisation visited the home during the inspection and we were able to talk to them about their

involvement and the governance of the service. An external healthcare professional also visited the home that day and we were able to gather their feedback.

We reviewed a range of care records and the manager's records kept regarding the quality and safety of the home. This included looking at nine people's care records in depth and reviewing others. We also looked at seven staff recruitment files, training records and audits.

Good

Is the service safe?

Our findings

People told us they felt the home was a safe place to live. Comments included, "The girls are lovely, and they look after me." Relatives told us, "I would recommend the home, it's good" and, "I've no concerns at all with her being here." A visiting healthcare professional told us, "People are safe here and well cared for, I'd be quite comfortable for my own relatives to live here."

Safeguarding policies and procedures were in place to assist staff protect people from abuse or improper treatment. Care staff were trained and knowledgeable about safeguarding the people they cared for. They displayed a good understanding when we asked them about their responsibilities. This demonstrated that the service protected people from improper treatment that may breach their human rights.

People's care needs had been assessed on admission and they had a corresponding risk assessment around aspects of daily living such as mobility, medicines, choking and nutrition. We saw individual risks people faced and environmental risks were regularly reviewed. Records of accidents and incidents which had occurred were kept, as was a log of any falls people had. This enabled staff to monitor people's well-being and refer them onto other healthcare services, such as the falls clinic if necessary. Risks were well managed and reviewed in order to protect people from harm and reduce the likelihood of an incident.

The property was safe and well maintained. Checks which are required by law, including servicing of equipment and the utilities had been carried out. We found no issues with infection control. The home was clean, tidy and comfortable. Designated domestic staff had responsibility for cleaning bedrooms and communal areas. The catering staff ensured the kitchen area met expectations. They had achieved a 5* hygiene rating from the local authority, which is the highest rating that can be awarded. We observed staff following best practice guidelines in relation to infection control and food hygiene which reduced the chances of cross contamination.

Personal Emergency Evacuation Plans (PEEP's) were available in the main office. These are plans which staff devised after assessing a person's ability to escape from the building in the event of an emergency, such as a fire. People had corresponding stickers on their bedroom doors so staff knew at a glance what level of support each person required. Firefighting equipment was in situ and we saw practice evacuation drills had taken place. All the staff we spoke with told us they were confident about the emergency plans. The provider had a business continuity plan in place which would be implemented in the event of an incident which may stop or disrupt the service. The plan included local contact information and information for staff on how to deal with emergencies such as a loss of power or a flood. This meant the provider had considered the needs and safety of people in an emergency situation.

Staff carried out their duties in a relaxed and unhurried manner. We saw that they had time to chat with people in between their tasks. We reviewed recent staff rotas and the service dependency tool. A dependency tool measures the complexity of people's needs and calculates the amount of staffing hours required. The tool indicated that there were enough staff deployed to meet people's needs in a safe and timely manner and this was reflective of what we observed. One person told us, "They [staff] come quickly

when I call them" and another person said, "I don't call them often, but when I do they come quickly." Most relatives we spoke with perceived staffing levels to be low. One relative told us they had noted there was less staff on a weekend. Other comments included, "It just needs more staff to keep it safe" and, "There needs to be more carers upstairs. New people are coming in but staffing levels are not increasing and I now feel like I have to be here 24/7. I have to feed (relation) as the staff have others to help and (relation) wouldn't get any food until much later if I didn't." We shared this feedback with the registered manager and they told us they would speak to relatives about their concerns.

We saw there was a robust recruitment procedure in place to ensure staff were suitable to work with vulnerable people. Staff completed an application process which included an interview and identity and reference checks. The service undertook an enhanced check with the Disclosure and Barring Service (DBS). These checks help employers make safer recruitment decisions as the DBS check a register to ensure candidates are not barred from working with vulnerable people. The staff we spoke with confirmed pre-employment checks were carried out prior to them starting work. The registered manager monitored sickness absences and had taken disciplinary action where appropriate to deal with any staff conduct or performance issues. This showed that the registered manager ensured staff continued to be suitable for their role and their performance was monitored.

Medicines were managed safely and consistently throughout the home. We spent time with a nurse who was responsible for administering medicines to people. We observed they dispensed people's individual medicines carefully and hygienically. They approached people with care and spoke gently. People were not rushed and they were encouraged to take their medicines one at a time. Medicine administration records (MAR's) were completed after each administration task was completed. This meant accurate records were made if people accepted or refused their medicines. A relative told us, "When they give (relation) their medication, staff always stay with her and make sure she has it."

We inspected the treatment room. We found medicines were stored safely and securely in line with nationally recognised best practice guidance. A locked trolley contained each person's individually labelled medicines. There was a separate locked cabinet fixed to a wall which contained controlled drugs. Controlled drugs are those medicines which require tighter legal control measures under the Misuse of Drugs Act (1971) because they are liable to misuse. We conducted a random check of the medicines and the controlled drugs. We found they were accurately recorded and properly monitored.

Medicines which are only taken when required, such as paracetamol for pain relief, were correctly managed and individually labelled. Topical medicines were handled in line with best practice and a separate MAR was in place for these. These MAR's contained instructions about where to apply the topical medicines and how much should be used. Topical medicines are those which are applied to the skin, such as creams and ointments.

A refrigerator was in place for those medicines which required refrigeration. Staff completed daily checks on the temperature of the refrigerator and the treatment room. Nursing and senior staff conducted daily, weekly and monthly audits. These were to ensure medicines were administered as directed and that staff accurately maintained records with regards to the ordering, receipt and disposal of medicines.

Requires Improvement

Is the service effective?

Our findings

All Staff had undergone a basic induction into the company which covered policies, procedures and the operational activity conducted within the service. It also included shadowing of experienced staff. One member of staff told us their induction included a tour of the building, review of the fire policy, how to complete paperwork and time to get to know people.

As of 1st April 2015, the Care Quality Commission (CQC) expects registered providers to have introduced the 'Care Certificate' for care workers. While it is not mandatory, providers should be able to demonstrate that staff are competent in 15 core standards within their first 12 weeks of employment. The Care Certificate is a benchmark for the induction of staff. It assesses the fundamental skills, knowledge and behaviours that are required by people to provide safe, effective, compassionate care. We found five staff who should have been enrolled on, and completed a common induction package such as the 'Care Certificate'. Instead, they had been signed up to undertake a qualification in Health and Social care which can take up to one year to complete. This meant that these five staff had not had their competencies assessed in line with nationally recognised best practice guidance.

Approximately half of the care staff had been given the opportunity to enrol in qualifications in Health and Social care at level two, three, four and five depending on their role, in order to enhance their personal development. Although all members of the management team were working towards or had achieved nationally recognised qualifications at a higher level, only nine care staff had gained a qualification. This meant that there may not always be a sufficient amount of suitably qualified, competent and skilled members of staff on duty.

The training information we reviewed showed that there were gaps in the systems set up to ensure staff had the knowledge, skills and competence to carry out their role before they were allowed to work unsupervised. The registered manager told us they had sourced online training to deliver the core induction standards and they had intended for all staff to complete them. However the staff had only very recently gained access to their online accounts. Staff told us their training was not up to date, but that the new providers were sourcing training and expected training dates to be implemented soon.

The registered manager used a training matrix to record the dates of when staff training was completed so they could monitor when refresher training was appropriate, however the system was not accessible that day. We asked the registered manager to supply this information to us after the inspection. We received a spreadsheet containing the staff data but it did not specify when staff had been employed so it was difficult to ascertain if training had been delivered in a timely manner.

The provider expected care staff to complete regular training in topics which they deemed mandatory such as moving and handling of people, food hygiene and medicine awareness during their employment. We saw this had been completed. However, we found there were gaps in the information where staff not had yet completed other key topics which would be beneficial to them such as nutrition and hydration, dignity and respect and end of life care.

Although training in safeguarding vulnerable adults and dementia awareness had been completed by care workers, we saw it had not been completed by staff in non-care related roles such as the activities coordinators and domestics. We considered that it would be appropriate for all staff to undertake these vital awareness courses.

Despite this service's history of serious choking incidents, a choking awareness course had not been made available to staff and we found only 14 members of staff had completed a dysphagia awareness course. Dysphagia is a condition where people have problems with swallowing. There was also no record of staff completing a challenging behaviour awareness course despite some care workers working with people whose behaviour may challenge staff on a daily basis.

We recommend that the provider undertakes a robust review of the training, learning and development needs of each individual staff member, taking into consideration nationally recognised best practice guidance in order to meet the current needs of the people who use the service.

Staff told us that they received regular supervision and that an annual appraisal took place. Records confirmed this. We reviewed a selection of the most recent supervision and appraisal records. We saw topics such as safeguarding people and whistle blowing were routinely discussed and staff had an opportunity to speak with their supervisors openly and confidentially. Staff development plans were implemented which included training and any performance related improvements.

Handover meetings took place twice per day. The senior staff held these meetings with the staff team at the start and end of each shift. They then passed any relevant information to the registered manager to deal with. A daily 'huddle' meeting took place with the heads of each department. The registered manager told us, "Myself or [deputy manager] attend the huddle every morning." We reviewed the minutes from staff meetings which showed that staff where communicating effectively to ensure people received necessary care and support.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when it is in their best interests to do so and when it is legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider worked within the principles of the MCA. Care records showed, and the registered manager confirmed that 31 people were subject to a DoLS. We reviewed the records regarding the applications to the local authority and outcomes of these decisions. The registered manager had omitted to inform the CQC of these applications and/or the outcomes. People who lack mental capacity may still have the ability to consent to some aspects of their care and support. Records showed that people had been included in any decision making processes along with their supporters as far as reasonably possible. Records also showed that people (and/or their supporters) had given their consent to receive the planned care and support and we heard care staff gain consent before assisting people with tasks.

The cook told us they had access to a wide variety of good quality produce and fresh ingredients which enabled them to meet people's nutrition and hydration needs. We saw they followed best practice guidance in relation to the storage of food, had separated areas for cooked and raw produce and monitored equipment and temperatures. Routine deep cleaning took place.

The kitchen staff received copies of nutritional care plans when new people moved in to the service or when people's needs changed. This informed them of people's differing dietary needs, such as diabetic, allergy and textured food requirements. Menus were produced which took into consideration people's preferences although people could choose something else if they wished. The cook displayed an excellent knowledge of individual people's needs and preferences.

We observed staff supporting people over 'lunchtime' and 'teatime'. People chose where they preferred to sit and eat their meals. We observed staff discreetly supported some people to eat their meal. Other people had equipment and adaptations such as plate guards to allow them to remain as independent as possible. We heard staff offered people choices, which included choices about food, drinks, portion sizes and additional servings. There were plenty of staff during mealtimes, nobody waited long for their meals and people were not rushed.

People's health and social care needs continued to be met with the involvement of external healthcare professionals as necessary. Routine appointments with a GP, dentist, optician and chiropodist had taken place. A visiting healthcare professional gave us several examples of positive outcomes for people being achieved. They said, "They are doing a brilliant job here. They are proactive and don't sit on problems. I've been really impressed with the joint working here." We examined the food and fluid charts that were in place for some people with complex nutritional and/or hydration needs and we saw their food and fluid intake and their weights were monitored.

The décor was homely and pleasant throughout the building. The reception area was welcoming with music playing and a seating area to encourage socialisation. All of the communal areas had ornaments and memorabilia on display to stimulate interest and conversation.

The premises were purpose built and met the needs of the people who lived there. People had personalised bedrooms and had brought soft furnishings, ornaments and pictures with them. There were handrails in place, shower rooms with walk-in facilities as well as bathroom's with bath lifts and seats. The service had considered best practice with regards to people living with a dementia related condition. Signage contained words and pictures to ensure people understood them and the walls, doors and handrails were painted with contrasting colours to help people orientate themselves. This meant people had access to appropriate space for privacy or they could socialise with other people and visitors in nice surroundings. The well maintained garden areas provided access to outdoor space.

Good

Is the service caring?

Our findings

The atmosphere around the home was welcoming and friendly. People described the staff who supported them as caring and kind. One person said, "I love the staff, they're all my children, they help me when I need it." Comments from relatives included, "It's like my home too, I spend most of my time here, I'm even offered meals" and, "[My relation] often stops breathing during the night, they are in a room opposite the office, so during the night the door is left open, but the staff often just sit on the chair in the room with [my relation] while they are sleeping, that gives me comfort knowing they are being cared for as well during the night."

Staff carried out their roles with affection and compassion. A relative told us, "They are a bunch of good kids (staff). They really do care." We spoke with staff in a variety of roles and they were all able to tell us about the people they cared for, their life histories, needs and preferences. It was apparent that staff knew people and understood their needs. People looked well cared for with their hair and nails groomed. People were dressed appropriately and they engaged fully with the staff. A visiting healthcare professional told us, "Staff seem to know a lot about people, they have good relationships – they see the person!"

We observed positive interactions throughout the day between people, staff, relatives and visitors. Staff displayed a warm and friendly manner. People and relatives described having established friendships with the staff and others within the community of the home. Staff demonstrated that they were thoughtful and considerate and that they respected people's wishes. Staff promoted people's independence by assisting them only when necessary and allowing people time to complete some tasks themselves. The provider also encouraged independence by promoting positive risk taking. This meant that staff respected people's choices and gave them the freedom they needed to make their own decisions (within safe limitations).

People were supported to attend church and local church leaders visited the home in order to provide religious services. Records showed positive plans were in place to ensure people's needs were met in a way which reflected their individuality and identity. This showed that the provider took people's diverse needs into consideration in order to fulfil their wishes.

We asked the registered manager whether any person currently used advocacy services. An advocate is a person who represents and works with people who need support and encouragement to exercise their rights, in order to ensure that their rights are upheld. The registered manager told us that they were aware of how to access an advocate if people needed this support. One person had an independent advocate but most people had family who acted on their behalf with legal arrangements' in place such as relatives acting as a Lasting Power of Attorney for finances and health related matters. The registered manager told us this information was recorded by the administrator and kept with the finance records. A staff member told us, "If there are decisions to be made, they (the advocates) are called first."

People and relatives told us they had been involved in devising care plans and we saw in care records that people and their relatives (where appropriate) had been involved in providing information to inform the staff of how care should be delivered. One relative told us, "I was a part of writing the care plan as they (their relation) can't anymore and if there's a change, I'm always informed." Another relative told us, "[My

relation's] care plan needed changed the other week, staff waited until I got here and we did it all together."

People's privacy was protected and they were treated with dignity and respect by all staff. We saw on a noticeboard that the provider encouraged staff to become 'dignity champions' and promoted dignity in care. The role of the designated lead dignity champion within the staff team was to ensure dignity was a staff priority. We saw staff knocked on people's doors before entering, spoke nicely to people and discreetly assisted people to eat in the dining area with dignity and consideration. We heard staff gently encouraged people to wear an apron at mealtimes so their clothing would be kept clean. However, only seven members of staff had been recently refreshed with a dignity and respect awareness course. The registered manager attended to address this with an online training course.

At the time of our inspection there was no-one receiving end of life care. We saw that care plans were in place for those who had shared their wishes with regards to end of life care for when that time arrived?. Preferences were documented with regards to resuscitation and medical assistance. In some care plans people had chosen not to share their end of life wishes and this was recorded and reviewed on a regular basis. However, we found that staff had not been recently refreshed with an awareness course for end of life care which meant that they may not be up to date with current best practice guidance. This was also to be addressed through online training.

Good

Is the service responsive?

Our findings

We saw staff were thoughtful and responsive to people's needs throughout the inspection. A visiting healthcare professional gave us three examples of people who had achieved positive outcomes with support from staff. For example, they told us one person needed to have a role within the home and the staff organised for them to assist with the tea trolley or ice-cream cart. The healthcare professional said, "They [care staff] involve [person] in what's happening and it keeps them occupied and less agitated."

Staff told us they were monitoring 11 people on the ground floor who required support with nutrition and/or hydration. They showed us the food and fluid intake monitoring sheets for those people. The information was comprehensive and accurate. Staff had completed the forms in a timely manner to ensure they were reflective of what people had consumed. We saw the forms had a target marked on them and their daily totals had been calculated to ensure those targets were met. Where targets had not been met, actions were recorded in care notes, such as, "Encourage more fluids" and "Referred to dietician." The historical forms were signed and dated as checked by a senior care worker or a nurse.

The service ensured there was a rounded approach to caring for people and that all needs were met such as physical, social, emotional and religious. Information was made available to staff to ensure they provided care and support to people in the way that they preferred. Person-centred care plans were drafted which detailed people's individual needs and preferences. Each person had an individual care record with care plans in place for the aspects of their daily lives in which they required support, such as personal care, medicines, mobility and nutrition. We saw records contained entries and updates from staff where needs had changed following falls, pressure damage or weight loss. This included actions taken by staff and guidance from external health professionals.

The senior staff carried out a number of reviews to ensure the service continued to meet people's needs appropriately. However we found these had sometimes not highlighted the issues we identified with record keeping. For example, out of the nine care records we reviewed in depth, we found all of them contained some blank documentation. Through discussions, we found this had not impacted on people's care because staff knew people well and were meeting their needs in a safe manner but their most current records did not reflect this. Senior staff told us this was an oversight and they would have these documents completed immediately.

Throughout the day, we saw most people engaged with staff and each other. The home was busy with people and visitors coming and going. People could choose which area of the home they preferred to sit in and we saw people talking to each other, staff and visitors in the communal lounges, the dining rooms and the reception area, which had been furnished with large comfortable chairs. This demonstrated that the provider actively promoted socialisation and inclusion for the people who lived there.

Two part-time activities coordinators were employed at the service. We saw the activities coordinator on duty interacted with people throughout the day, playing the guitar, holding sing-a-longs and serving ice-creams from an ice-cream cart. There was no set activities schedule in place but the activities coordinator

told us this was something they were planning to devise. There was evidence that lots of activities had taken place which included one to one sessions, group activities such as bingo, quizzes and trips out into the community. There was a large designated activities room, which had photos on display of people enjoying a variety of activities and also large posters and paintings which people had crafted during art sessions. A visiting healthcare professional told us, "People are never just sitting about, staff are very engaging. There seems to be a lot of one-to-one time. The activities coordinators are excellent."

Most of the relatives we spoke with were complimentary about the service and they could not provide any examples of when they had needed to make a complaint. However there were two relatives who shared some concerns with us which they had already discussed with the manager.

There was a complaints policy and procedure in place which we saw was displayed around the home and it had been shared with people on admission in their 'Service User Guide'. There had been 20 complaints (or minor concerns) recorded in 2017. We saw these were recorded on a complaints form which included information about how the issues had been addressed.

All of the complaints had been made verbally to the registered manager. The registered manager told us their 'open door' culture had encouraged people, staff and relatives to speak with them immediately if they were dissatisfied with anything. The registered manager also told us about the action they had taken to manage some of these issues effectively and how they had strived to reach a satisfactory outcome for the complainants. There was one formal complaint in progress; this was being dealt with by the regional manager and required a written response. This complaint had already been formally acknowledged in writing. This demonstrated that there was an established and effective complaints process in place which included thorough investigations and aimed to achieve satisfactory outcomes for people who used the service.

We found that the registered manager has not implemented the provider's 'Complaints Register' to record an overview of each complaint which would enable them to track trends and look for any patterns that may emerge. They told us they would implement this without delay in accordance with company policy.

The service had received 13 compliments from relatives and external healthcare professionals, which praised the staff and the provider for their efforts in supporting people to live well at The Meadows. This positive feedback had been shared with the staff team.

Requires Improvement

Is the service well-led?

Our findings

The registered manager and the provider have a legal responsibility to notify us of certain incidents as specified in Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Our records showed that we had not received any notifications related to the outcome for people whose freedom was restricted through the Deprivation of Liberty Safeguards (DoLS) process. During our inspection, the registered manager confirmed that they had omitted to send us this information. Furthermore, we found four serious injuries and one safeguarding matter where notifications had not been made. We are dealing with this matter outside of the inspection process.

The established registered manager was on duty on the day of this inspection. They had managed the service for over two years but had transferred to work for the new provider organisation in September 2016. This had ensured the staff team remained stable and provided consistency for the people who used the service and their relatives.

The registered manager had played an integral role in the service improvement plans and had worked with the local authority, the clinical commissioning group and the new provider to develop and implement an action plan following the last inspection of the service. We found the service had achieved most of the objectives set out in their action plan, however careful auditing of the service and meticulous provider oversight had not been conducted thoroughly enough which meant most of the issues we highlighted during our inspection had not been identified by the registered manager or the provider prior to our visit.

The records we reviewed were not always contemporaneous, accurate and up to date. We found several blank care plans inside people's records. Despite people's needs being reviewed on a regular basis, action had not been taken in a timely manner to address the missing documentation.

Audits and formal checks on the safety and quality of the service were carried out on a daily, weekly, monthly, quarterly and annual basis, such as tests of equipment, examination of window and door locks and servicing of machinery. Most of these checks has been documented within the maintenance records, but we found a small amount of hoists used to lift and move people who cannot weight bear were overdue a service. We also observed one emergency pull cord in a bathroom which has been cut off at the ceiling was not identified or addressed in the maintenance records. The registered manager's daily walk-arounds and their checks of management records had not highlighted these issues. Furthermore, neither had the provider's monthly service audit.

We noted that following an external fire risk assessment completed in November 2016, no action plan was in place to address the multiple actions highlighted by the assessor. Despite an action plan template provided at the back of the documentation, the registered manager has not used it to record what action was taken to address the immediate issues and what issues would be addressed with a programme of works. When we asked the registered manager about this they could not recall a programme of works being drafted nor were they familiar with what action had been taken. The registered manager told us they would contact the provider's estates manager immediately to check if there were any outstanding issues. We are awaiting

follow up information on this matter.

Although accidents, incidents, complaints and safeguarding matters were recorded appropriately they had not being duly analysed for oversight of the service. Trackers or contents lists were not included at the front of records to help the registered manager identify patterns or trends. The registered manager told us they would address this immediately. The implementation of these trackers will also act as a prompt to notify the CQC of these matters if applicable in the future.

Training and induction not had been robustly monitored; this had allowed five new members of staff to continue working without completing a formally assessed common induction package, such as the Care Certificate. There were non-care staff who had not been trained in topics such as safeguarding vulnerable adults and dementia awareness and training in topics such as dysphagia, diabetes and challenging behaviour had not been routinely sought for existing care workers who were supporting people with these needs. This meant the registered manager had not assured themselves that all new care workers were competent to carry out their role prior to being allowed to work unsupervised or that established care workers were kept up to date with current best practice or provided with training to meet individual's needs.

We considered that the governance of the service and record keeping required improvement. Although the management and staff were able to explain most things we enquired about, there was a lack of robust documentation to demonstrate their compliance with the regulations.

These issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a clear staffing structure in place, which included the registered manager, a deputy manager, (both of whom had current registrations to work as a qualified nurse) nursing staff, care staff and ancillary staff. The whole team were aware of their responsibilities and what they were accountable for. The staff worked regular shifts which were consistent for both them and the people who used the service. There was very little use of agency staff. The staff we spoke with told us they had no issues at all with the management of the service. Policies and procedures were available and a periodic reviewing process was in place.

The culture of the service was open and transparent. During the inspection and afterwards during feedback, the management team displayed openness and transparency towards the evidence we presented to them and were proactive in their response to our findings.

The registered manager or deputy manager attended a daily 'handover' meeting to ensure important information was passed between staff on differing shifts and that information was signed for when actioned to confirm who had taken responsibility for addressing the issues raised. They also held a 'huddle' meeting with the heads of departments with the same practice in place. This meant staff were held accountable for their actions and responsibilities.

Monthly management meetings had taken place to discuss the safety of the service and regular staff team meetings were also routinely conducted. This meant that staff had had a regular opportunity to meet formally with their managers and discuss aspects of the service, share best practice or be involved in the development of the service.

Overall the opinions from people and relatives about the management of the service were positive. Relatives told us and records confirmed that 'Resident and Relatives' meetings were held monthly. One relative told us their feedback was always acted upon and one person told us they found all staff including management

extremely approachable, saying, "I can speak to [registered manager] like my brother, he always listens." Another relative told us, "I have noticed improvements since the new provider took over." However, one relative said, "I don't feel like complaints are acted upon, I attend the residents meetings but don't hear anything more."

We asked staff if they enjoyed their job and they all told us that they did. One said, "Morale is so much better." The deputy manager told us that the registered manager was very supportive. A visiting professional told us, "They (registered manager) work hard to provide the best care – they take on board what you say." And, "There has been a big improvement in the last 12 months. It seems like the manager is getting supported now." The registered manager told us they felt well supported by the new provider, adding, "We get on well and have an open relationship. I can challenge things and have my say. Then we move on and sort it."

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Established systems and processes were not being effectively operated to ensure compliance with this regulation. Record keeping was not always accurate, complete and contemporaneous in respect of each service user. Audit and governance systems were not robust enough to identify the issues we have highlighted during this inspection. Regulation 17(1)(2)(c)(f)

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The registered manager and provider have failed to ensure the Care Quality Commission was informed of 'other incidents' without delay. The incidents referred to include requests made to a supervisory body in relation of the Deprivation of Liberty Safeguards, serious injuries and a safeguarding matter. (Registration) Regulation 18(1)(2)(a)(b)(e)(4)(a)(b)

The enforcement action we took:

We have issued the provider with a fixed penalty notice for failing to notify the Care Quality Commission of 'other incidents' which they are legally required to inform us of. The sum of £1250 has now been paid in full.