Age Concern Wirral

Meadowcroft

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

Overall summary

We undertook this comprehensive inspection on the 11 and 13 May 2015. Meadowcroft provides a range of services for older people and people living with dementia. In December 2013, a respite care unit accommodating up to eight people was registered and in April 2015 the number of places provided was increased to 13. The manager told us that they intended to use four of these places to accommodate people on a long-term basis. The service is also registered to provide personal care for people in their own homes.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

The service encouraged people who used the service, their relatives and carers to complete a questionnaire at the end of their stay to gain people's feedback on the quality of the service. These showed that people were very happy with the service they had received.

Age UK Wirral had produced a leaflet which gave clear details about recognising and reporting abuse. Most staff had received training about safeguarding.

There were enough qualified and experienced staff to meet people's needs and checks were carried out to ensure that new staff were recruited safely.

We found that the premises were clean and bedrooms were appropriately decorated and furnished. Health and safety checks had not identified deficits in staff training, in particular with regard to fire safety, or that regular fire alarm tests had not been carried out. There were no personal emergency evacuation plans to provide information about people's evacuation needs in case of an emergency.

Medication was appropriately stored. A number of medication errors had been reported by staff working in the service during April 2015 and no action plan was recorded to address this .

There were significant shortfalls in staff training and staff working on the residential unit had not been appropriately supported in their job role. We saw that regular meetings took place for senior staff and management but there were no meetings for care staff.

People who used the residential service had a diagnosis of dementia which had an impact on their ability to consent to decisions about their care. Their capacity had not been assessed in accordance with the Mental Capacity Act 2005.

People had a choice at mealtimes and were given a suitable range of nutritious food and drink. People identified at risk of malnutrition had their dietary intake monitored, however nutritional risk assessments had not been completed in a satisfactory way.

We observed staff supporting people at the service and saw that they were warm, patient and caring in all interactions with people. People were seen to be relaxed and comfortable in the company of staff.

We looked at the care records for the three people who were receiving respite care. Each record held information regarding people's individual health and social care needs. People's care plans did not cover all of people's needs and risks. They lacked person centred information to enable staff to understand and relate to the people they were supporting and people's emotional needs.

A range of social activities was provided every day and people could choose which activities they participated in.

Complaints records were incomplete and did not show that the manager had responsibility for investigation and responding to complaints received.

There were some audits in place to check the quality of the service, however these required further development to ensure the risks to people's health, welfare and safety were identified and addressed.

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.

The service had a safeguarding policy and staff we spoke knew how to respond to suspected abuse, however records we looked at showed that not all staff had attended safeguarding training.

People's individual risk assessments did not provide sufficient information for staff to know how to support them safely.

Staff were recruited safely and there were enough staff on duty to meet people's needs.

Medication had not always been administered safely.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the Mental Capacity Act 2005 had not been followed to ensure people's capacity to make decisions was assessed.

Staff had not received regular supervision and appraisal. There were significant gaps in the staff training records.

People had enough to eat and drink and a choice of suitable nutritious foods to meet their dietary needs.

Is the service caring?

Good

The service was caring.

Staff were observed to be kind and respectful when people required support.

Interactions between people and staff were pleasant and people appeared relaxed and comfortable with staff.

Is the service responsive?

Requires Improvement

The service was not always responsive

People's needs were assessed but the quality of the information in people's care files was not adequate to provide guidance for staff about how to meet individual needs.

A range of social activities was provided every day.

There was a complaints procedure in place but complaints records held within the service did not show how complaints had been investigated and/or responded to.

Summary of findings

Is the service well-led?

People who used the service and their families had the opportunity to complete satisfaction questionnaires.

The service had a registered manager, however roles, responsibilities, and lines of accountability were not always clearly defined or appropriate to enable the registered manager to fulfil his role.

There were some quality assurance systems in place to monitor the quality of the service but they required further development to identify all of the risks to people's health, safety and welfare.

Requires Improvement

Meadowcroft

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.

The inspection took place on 11 and 13 May 2015 and was unannounced on the first date. The inspection was carried out by an Adult Social Care inspector. Before the inspection we looked at information CQC had received since our last visit and we contacted the quality monitoring officer at the local authority.

During our visit we spoke with three people who used the service, two relatives, and eight members of staff. We saw written comments that had been made by relatives of people who used the service. We looked at care plans for three people who received respite care and three people who had a home support service, medication records, staff records, health and safety records, and management records.

Requires Improvement

Is the service safe?

Our findings

We spoke with a family member who told us "He is very, very safe here." A letter from another family member said 'It was a comfort to know Mum was safe and in good hands while we were away.' The service had safeguarding policies and procedures and a recently produced leaflet gave clear details about recognising and reporting abuse. Two members of staff we spoke with were aware of their responsibilities in relation to safeguarding. We noticed that the 'No Secrets' guidance file was locked in the medicines room on the residential unit which meant that it was not readily available for staff.

The training matrix we were provided with showed 44 staff employed, however it was not clear which of these staff worked in the parts of the organisation that provided regulated activities. The records showed that 28 staff had done safeguarding training in 2015 and one in 2014. For two people there was no date, and 13 were identified as being out of date but there was no date of when they last had safeguarding training. We were informed that safeguarding training had been booked for senior managers and trustees.

We looked at care files for three people who used the residential service and three people who received home support. In one of the home support files, an environment risk assessment had not been recorded. We found that risk assessments for areas such as nutrition and hydration, mobility and falls, skin integrity, and challenging behaviour were either not completed or were completed in insufficient detail to provide clear instruction for staff about how to keep the person safe. There were no personal emergency evacuation plans to provide information about people's evacuation needs in case of an emergency.

Accidents and untoward incidents were reported to the manager, however we saw that three of the incident reporting forms all related to the same event. This was an accident that had resulted in a serious injury to a person who used the service and had not been reported to CQC as required by legislation. There were no records to show that the accidents and incidents reported had been investigated and followed up, however the manager was able to tell us about the action he had taken. A monthly risk management report from the manager to the Chief Executive lacked any detail.

These are breaches of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The service shared a maintenance person with another service provided by Age UK Wirral. Members of staff told us that routine maintenance issues they reported were responded to in a timely manner. We found that fire alarm checks had been carried out and recorded weekly until maintenance hours were reduced in March 2015 and had only been done once since then. The fire panel display was in the reception area of the building which meant that if the alarm sounded during the evening or night, a member of staff would have to leave the residential unit in order to find out where the problem was. Also, a fire door on the residential unit which opened out into the garden was linked to the alarm system but sounded in a different part of the building which was only occupied during office hours. This meant that staff may not be aware that someone had gone outside during the evening or night.

We saw that up to date service and maintenance certificates were in place for electrical installations, gas, Legionella, fire extinguishers, call bell system, and moving and handling equipment. Portable appliance testing had been carried out in November 2014 and a contract for waste disposal was in place. We found the premises to be clean and disposable gloves and aprons and antibacterial hand gels were available in the residential unit.

When we visited on 13 May 2015 there were three staff on duty on the residential unit, one of whom was a senior, and there were four people using the service. We were told that for up to eight people there was a senior and two care staff on duty over the 24 hour period. For more than eight people the staff number would be increased. Night staff completed some laundry and housekeeping duties. Staff told us that another care worker was available between 8am and 10am, after which they worked in the day centre. There was always a manager on-call.

Staff told us that shifts for care staff were 8am to 3pm, 3pm to 10pm, and 10pm to 8am. Senior staff worked from 9am to 4:30pm, 4pm to 10pm, and 9:30pm to 9:30am, with a half hour handover between each shift. It was not clear why senior staff shifts were different from care staff shifts or why the care staff were not included in the handovers to ensure they were aware of any changes. The staff we spoke with said that there were enough staff but a number were 'bank'

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Is the service safe?

staff who were available to work in various parts of the service and did not have regular hours. At the time of our visit the provider was addressing this by recruiting and appointing more permanent staff.

Most people who used the residential service spent their time in the day centre during the day and staff supported them there, however there was always a member of staff present in the unit. We were told that the senior carer on duty also provided an out of hours on-call service for the home support.

We looked at the recruitment procedure to be followed when employing new staff and noticed that it did not mention the role of the registered manager in the selection of staff. We looked at the staff files and recruitment records for five members of staff who had recently been employed to work in the service. Three files contained a job application, interview record, two references, a record of the Disclosure and Baring Service (DBS) disclosure number, and other relevant information. The other files did not contain two references and we were told that the people had not yet commenced employment.

The residential unit had a secure room for the storage of medicines. This was only accessed by the senior care staff who were responsible for administration of medicines. Room and fridge temperatures were recorded daily. Two people were living at the service when we visited. Staff ordered monthly repeat prescriptions for one person and these were checked in with two signatures. A family member took responsibility for ordering and collecting prescriptions for the other person. These were also recorded and checked in by staff. Two people who were having a respite stay had brought in blister packed medication which was checked in.

The training matrix showed dates when 25 staff had received medication training, some by e-learning, but the matrix did not identify which were senior staff, or staff working in home support who may support people with medication.

We saw that nine medication errors had been identified and reported by staff during April 2015. These related to five instances of missed medicines, one medicine given twice, one incorrect dose given, one medication found on the floor, and an incorrect balance of paracetamol left when a person was going home. We did not find any records of an investigation or what action had been taken. We found that, although there were only four people using the service, the folder which contained the medication administration record (MAR) sheets was full of various documents, for example information about medicines. We saw that MARs were written two weekly, with only three items on each page so that some people had a considerable number of sheets. This made it more likely that staff could make an error.

This is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

Two members of staff we spoke with said they had been doing a lot of training recently by e-learning. The topics they mentioned were moving and handling, first aid, medication, safeguarding, dignity, food hygiene and hand hygiene. They also had practical training about moving and handling. They said that all staff had to do this training but that some of the bank staffs' training may be out of date.

The training matrix showed 44 staff were employed but it was unclear which staff worked in the residential unit, the domiciliary care service, or in other parts of the organisation. The records showed that 33 had done dementia care training in 2015, one in 2014 and one in 2013. Nine had no date. Moving and handling training had been completed by 21 staff in 2015, some by e-learning, two in 2014, nine had no date and ten were recorded as overdue. 28 had a date recorded for health and safety training. Only one member of staff had fire training recorded in 2015, 17 in 2014, two in 2013, and 21 had no date. Fewer than half had a date recorded for food hygiene training.

New staff had a certificate to show that they had completed a programme of induction training before they started work. All of the staff files we looked at included a copy of the Skills for Care common induction standards, but none of them had been filled in. Nine staff had a national vocational qualification (NVQ) level 3 and 24 had NVQ level 2. The names on the NVQ list did not all match the names on the training matrix, and again it was not clear which part of the service these members of staff worked in.

We saw that staff files contained an 'Induction and Probation review record' but this had not been completed after the initial induction day for a member of staff who started in January 2015. A supervision planner showed the names of 27 staff who worked on the residential unit. Only 12 had a date when they had an individual supervision meeting. Two of these were in 2012, two in 2013 (which were before the unit opened), six in 2014, and two in 2015. It was unclear when or whether any of these staff had an appraisal. Five home support staff all had a supervision meeting in March 2015.

This is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The manager told us that he had attended training provided by the local authority about the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. The people who used the residential service were living with dementia, however mental capacity was not included in the Age UK Wirral training programme and people who were supported by the service did not have capacity assessments in their care plans. This meant there was no guidance for staff about people's ability to make their own decisions and how this affected the support they required. The manager told us that he had requested mental capacity assessments from the local authority for people who were placed at the service by them, however it is the responsibility of the service provider to assess the needs of the people they provide a service to.

This is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

A person who used the service told us "The food is very good and more than enough." and another person had told their family "The food was good and there was plenty of it." The residential unit did not have its own dining room and staff told us that people went to the main dining room for their meals and could choose what they wanted to have for breakfast including a full cooked breakfast. There was no facility on the unit for staff to prepare drinks or snacks but the main kitchen was within easy reach and a trolley was available to take food and drinks from the kitchen to the unit. A three course lunch was provided and people were asked in the morning whether they wished to have the main meal of the day or an alternative. The menu was displayed on a board in the day centre but not in the residential unit. A light meal was served in the evening and people had a choice of a hot or a cold meal. People also had supper which included sandwiches and cakes.

A member of staff told us "The kitchen are really accommodating." and gave us an example of how a person with an allergy was supported. A senior care worker told us that when people came for a respite stay, a 'dietary needs' form was filled in with their family and given to kitchen. Records showed that people were weighed, but their body mass index (BMI) score was arrived at by guessing the person's height. There was no detailed nutritional risk assessment in people's care files.

The residential/respite unit occupied part of the ground floor of a large two-storey building. It had 13 bedrooms and two bathrooms. Each bedroom had en-suite toilet and

Requires Improvement

Is the service effective?

wash basin. There was a lockable drawer in each room and a TV. There was a call point in each bedroom and in the en-suite. There was a sitting room on the unit that could accommodate ten people, but other communal space was in the part of the building that was used seven days a week for day care. Some bedrooms had glass panels at the top of one wall which let in light from the corridor. The manager told us that there were plans to block off the glass panels but he had no date yet for this to be done.

Bedroom doors were painted in different colours to help people find their room. Signage of bathrooms was in quite small writing with a picture. We considered that there was scope to further develop the environment to be more 'dementia-friendly' to help people find their way around. The gardens were in need of attention and we were told that this was being addressed. The residential unit did not have its own entrance and visitors to the service in an evening had to ring main door bell and wait for staff to go to the reception area to let them in and out.

Good

Is the service caring?

Our findings

People we spoke with were very happy with the service provided. The relatives of a person who was having a respite stay told us "I can't fault this place, the staff, the way he is treated." Another relative said "He looks forward to coming here." A person who used the service said "There are plenty of people to chat to."

We also saw many very positive comments that people had made in writing:

'The care and dedication of all the Age UK Wirral staff is exceptional.'

'Mum immediately settled in respite as she recognised many of the care staff.'

'It is such a pleasure to visit, always a warm welcome from all the staff.'

'He is so much better in so many ways – even his voice is different.'

'The respite and care my mother gets is excellent and all the staff are very caring. It is a great help for me.'

'[Name] loves coming to Meadowcroft and all the staff are so kind. The food is good and the daily activities are a bonus.'

'My mum has been very happy here and all the family have been really happy with all the love and attention my mum has had.'

'The staff were excellent and treated him with respect, dignity and understanding. His individual needs were understood. His room was comfortable and spotless and the meals of the highest quality.'

A number of the people who used the respite care service also attended the day centre regularly and/or received a home support service. This meant that they may already be familiar with the building and with some members of staff. Family members we spoke with found this reassuring. Interactions we observed between staff and people who used the service were positive and respectful. Staff did not wear uniforms which contributed to a friendly and informal atmosphere. The service's information leaflet gave details of how to contact the 'Advocacy in Wirral' organisation.

Requires Improvement

Is the service responsive?

Our findings

Relatives of a person having a respite stay told us they were aware of the care plan and they had been asked for a lot of information. A senior carer described how relatives were involved in compiling care plans and were asked to fill in a 'This is Me' form to provide personal information. We observed that the senior carer asked the family whether there had been any changes since the person's last visit. We found that the care files contained a large number of documents but these did not all provide useful information for staff, for example a 'summary of abilities' form was a yes/no checklist which did not reflect the person's individual support needs or how these might fluctuate; a daily 'care form' was more suited to the day care service and gave staff little space to write in; records of night-time checks appeared to be duplicated on two different forms; a 'fluid balance chart' was poorly presented and gave insufficient space for staff to write in.

We were told that approximately 26 people received a service from home support, but for most people this involved support with household tasks or social needs. Only three people received a daily personal care service, and another person had weekly support with a shower. The support was reviewed every six months.

The service provided an information leaflet which gave details of the services that could be provided, including the cost. One person we spoke with said "I was allowed to have a look before moving in." We saw evidence that the manager, or a senior member of staff, visited people before a respite stay was arranged, and information was also provided by social services although we were told that this was sometimes significantly out of date.

We saw that a wide range of social activities were provided in the day centre, which was open seven days a week, and people staying on the residential unit were able to join in activities of their choice. A weekly plan of activities was in place but staff told us that this was flexible according to what people chose to do.

We looked at the complaints procedure which was included in the information leaflet. It was easy to understand and gave people details about who they could contact if they wished to make a comment or a complaint. We looked at the complaints records and saw that the last complaint had been recorded in 2013. We also saw records of two issues that people had raised, but no evidence of how these issues had been investigated and/or responded to. We were told that the complaints had been addressed by the Chief Executive but no records of this were available within the service as they were kept at the organisation's head office in Birkenhead. There was also a response letter in the file, but no record of the complaint that it related to.

Requires Improvement

Is the service well-led?

Our findings

People were invited to complete a feedback form 'Are we getting it right?' and we found that people who used the service and their families had given very positive feedback. Unfortunately people were not asked to put a date on the form so we were not able to check how recent the feedback was. Also, the feedback form contained the names of five senior managers who could be contacted but this did not include the registered manager.

We found that the staff working on the residential unit had not had individual supervision meetings with their manager and had not had a performance review or appraisal. As this is a relatively new service which is continuing to develop, it is particularly important for staff to be supported and have an opportunity to share their views and discuss any problems. There was a two weekly meeting for senior care staff but no meetings for care staff. Staff we spoke with told us that they enjoyed working at the service but they only had their rota one week in advance, which was difficult.

At our previous inspection we had some concerns with the way that the service was assessing and monitoring the quality of service provision as the care plan and risk assessments reviews completed by the service did not identify the shortfalls regarding the information recorded about people's care needs to ensure staff supported people in accordance with individual need. We found that the service was in breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) 2010 which relates to Regulation 17 of the Health and Social Care Act (Regulated Activities) 2014.

During this inspection we saw that there were some quality audits in place, however they did not fully identify and address potential risks to people's health, safety and welfare. For example, the 'guest file audit' had such small boxes to be filled in that it was very difficult to read. It had not identified that an environment risk assessment had not been completed for a person who used the home support service. A health and safety audit dated April 2015 did not identify gaps in staff training or that fire tests had not been carried out since the maintenance person had left the service in March 2015. We were concerned that the registered manager was not involved in the health and safety audit because another manager was responsible for premises safety. The accident and incident audit did not identify what action had been taken to address issues reported.

We found that the overall standard of record keeping was unsatisfactory and information we requested was not always clear, for example we were told that 26 people received home support but the list we were given showed 24. Staff records we looked at didn't identify which part of the organisation they worked in or what their job role was. A serious injury sustained by a person who used the service had not been reported to CQC. Complaints records kept in the service were incomplete.

These are breaches of Regulation 17 of the Health and Social Care Act (Regulated Activities) 2014

At the end of the inspection we shared our concerns with the manager and the provider. We found that they were very responsive and expressed their intention to address the issues raised without delay.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risk assessments relating to the health, safety and welfare of people using the service were not completed to a satisfactory standard and plans for managing risks were inadequate. Regulation 12(2)(a) Assessments were not carried out in accordance with the Mental Capacity Act 2005. Regulation 12(2)(a) Medicines were not always managed safely. Regulation 12(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff employed by the provider did not receive appropriate support, training, supervision and appraisal. Regulation 18(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and improve the quality and safety of the services provided. Regulation 17(2)(a)