Meadows Edge Care Home Limited

Meadows Edge Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Meadow Edge Care home is registered to accommodate up to 45 people with residential, nursing needs, including people living with dementia. On the day of the inspection, 27 people living at the service had nursing needs, 14 people had residential care needs and three people were in hospital.

People's experience of using this service and what we found
People were at risk of harm. Risks associated with people's care and treatment needs, including how clinical needs were assessed, monitored and managed were of significant concern. Guidance for staff about how to meet people's individual care and treatment needs either lacked detail or was not available for staff.

There was no clinical leadership or oversight at the service, including clinical supervision of nursing staff. The lack of clinical training completed by nursing staff impacted on people receiving safe care and treatment.

The governance framework in place was not sufficiently robust to ensure risks were assessed, continually monitored and mitigated. This included how prescribed medicines were managed and monitored. How equipment such as mattresses were monitored to ensure they were effectively working. Care plans and risk assessments, including supplementary records were not sufficiently monitored and completed correctly. There was a lack of action and priority, when risks had been reported to the registered manager and provider.

Incident and accidents were recorded and analysed for lessons learnt, but needed to be more detailed and robust to ensure actions were taken to reduce further risks.

People, visitors and staff had access to safeguarding information. Staff had received training in safeguarding. There were sufficient staff available to meet people's needs and safe staff recruitment procedures had been followed. The service was found to be clean.

Rating at last inspection
Goods (published 1 December 2018)

Why we inspected
We received concerns in relation to how people's clinical needs and risks were assessed, monitored and managed. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only.
We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this

inspection.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified three breaches in regulation; how people had their care and treatment needs assessed, monitored and managed. How medicines were administered and managed, the training and support staff received and the systems and processes that monitored safety.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.
Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.
Details are in our safe findings below.

Meadows Edge Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
One inspector and a specialist advisor who was a registered nurse, completed this inspection.

Service and service type
Meadows Edge Care Home is a nursing home. People in nursing homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection in relation to safe and well led which we focussed on.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information received from the local authority and the local clinical commissioning group (CCG). We also reviewed information that we held about the service such as notifications. These are events that happen in the service that the provider is required to tell us about. We also reviewed other information we had received about the service since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During our inspection

We spoke with the registered manager, two nurses and one senior care worker. During the inspection, four external nurses from CCG were present, this included a specialist nurse who was a tissue viability nurse. CCG were undertaking reviews of people's care and treatment and shared information with us that we considered as part of our inspection.

We reviewed records related to the care and treatment of 12 people. We looked at records of accidents and incidents, audits, six nursing staff files, the staff training plan, the staff duty rota. We reviewed how medicines were managed, checked pressure relieving equipment and observed care provided and interactions between people and staff.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training and staff supervision data, staff meeting records and confirmation of registration of nurses with the Nursing and Midwifery Council.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● When risks to people's health and safety were identified, actions to mitigate the risks were not always taken. For example, steps to prevent pressure ulcers such as the provision of specialist equipment and the provision of care to re-position people regularly, were not always undertaken or documented to confirm care and treatment had been provided.

● Pressure relieving mattresses were found not to be working correctly and put people at risk of harm. For example, we found two pressure mattresses we checked were alarming as being at low pressure. A further two mattresses were not set at the correct weight for the person. This reduces their effectiveness and can contribute to the development of pressure ulcers if they are over inflated and therefore provide a hard surface.

● People were at greater risk of developing pressure ulcers, or their healing of pressure ulcers were compromised because they were not repositioned as required. For example, one person's skin care plan stated they required repositioning regularly throughout the day and four hourly turns during the night. There were no care records to confirm the person was being repositioned, despite them being treated for three pressure ulcers.

● Significant concerns were found in the care and treatment of wounds, which could have impacted on heeling and recovery. We found frequent gaps with dressing changes that exceeded the guidance in people's wound care plans. For example, two people's care records showed during June and July 2019, they should have had their dressings changed at three – five days. One person had their dressings changed up to seven days and another person up to eight days.

● When risks to people's food and fluid intake were identified, their intake was not always recorded. When people's fluid intake was recorded, the amount they drank daily was not totalled and therefore we were not assured that this was being monitored. Food and fluid intake monitoring is essential for people with pressure ulcers and wounds to aid healing.

● The monitoring of people's weight was inconsistent, and several monitoring records were used that gave conflicting information. Where people had decreased in weight, action was not always taken such as making a referral to the GP or dietician. For example, one person's recorded weight on 11 June 2019 was 36.6kg and 12 July 2019 35.3kg, this gave an overall score of two – high risk. The malnutrition universal screening tool used to assess weight advised a score of two, required action that included to weigh weekly, keep food charts for three days and offer three meals plus snacks per day. From viewing care records we were not assured these actions had been taken.

● One person had a diagnosis of diabetes and their care records stated 'at risk of hypos'. There was no further guidance provided for staff of how a 'hypo' would present and the action required if was to occur. The diabetic care plan was blank. This person was at risk of harm because staff did not have sufficient

guidance of how to manage and mitigate risks.

Using medicines safely

● Where people had been prescribed medicines to be taken as and when required for the management of anxiety and behaviour, staff were not correctly following the administration details. This put people at risk of being over sedated. The medicine administration records (MAR) for five people, who had medicines prescribed to be administered when required, showed two administration times (morning and evening) were circled to indicate times to be given. Two people's MARs showed they had received this medicine for the last 27 days and there was no rational recorded why the medicine was administered.

● There were protocols in place for medicines prescribed as and when required, but these were not personalised for the person and reasons for administering where usually "unsettled." This is not a sufficient description.

● Medicines stored in the refrigerator were found to exceed the acceptable temperature limits during July 2019. This may have impacted on the effectiveness of medicines. The refrigerator had been replaced during this time due to issues with the temperature control however, since the replacement the temperature continued to be higher than it should. A nurse was unable to tell us the acceptable range and the pharmacist had not been contacted for advice about the use of the medicines stored in the refrigerator. The temperature may have affected their effectiveness. We discussed this with the registered manager and they ordered a new refrigerator immediately.

Taken together, the provider's failure to ensure that risks were mitigated to ensure peoples safety and ensure that medicines were administered safely placed people at risk of avoidable harm. This was a breach of regulation 12 (1) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Serious concerns have been identified with the assessment, management and monitoring of wound care and how clinical risks were managed. Nursing staff have no clinical supervision or leadership and their clinical practice and competency was not assessed. This impacted on people's safety and receiving correct care and treatment.

● Nursing staff training records showed gaps in clinical training and this impacted on the quality of care and treatment people received and put them at greater risk of harm. For example, six nurses were employed at the service, two had received training in wound care including sepsis (a serious life threatening infection) in June 2019. One nurse training records showed they had received training in tissue viability and dressing procedure in 2011.

● Concerns were identified in the competency of nurse to; correctly stage or grade pressure ulcers. There was a lack of recognition that a long non-healing wound required a referral to a TVN. A person was described as being ischaemic (restriction in blood supply to tissue). However, the visiting TVN found there was an indication of a good blood supply to the foot.

● The wound care records of five people showed photos taken of wounds to monitor healing were of poor quality and did not have a measurement to scale the wound. Gaps were identified in wound dressing records, showing the recommendations of the frequency they should be changed were not being followed.

● Where people had wounds, care plans and risk assessments had not always been developed to ensure they received consistent care and treatment. This put people at greater risk of wounds not being managed effectively and delaying healing. For example, the TVN visiting on the day of the inspection, identified a person had a grade one This person's care records did not record this skin damage. Neither was there a care plan, wound care documents or risks assessment to provide staff with guidance of the care and treatment needs.

This was a breach of regulation 18(1)(Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● At the time of our inspection, there was an ongoing police investigation in relation to a serious safeguarding incident.

● Information about how to raise any safeguarding concerns was on display for people, visitors and staff. A staff member told us they had received training in safeguarding and had access to the provider's safeguarding policy and procedure.

Preventing and controlling infection

● There were no sterile packs for re-dressing wounds. Staff told us they used a clean technique. However, in the nursing home environment and with the range of wounds occurring, the use of an aseptic technique and sterile equipment would be needed.

● The service was found to be clean and free from malodour. Staff used personal protective equipment such as single use disposable gloves and aprons,

● The local CCG completed an infection control audit in February 2019 and recommendations had been made. The registered manager told us what action had been completed and details of ongoing improvements.

Learning lessons when things go wrong

● Incidents and accidents were recorded, this included falls and incidents of behaviour. However, the process in place to reflect, analysis and mitigate risks could have been more effective.

● The registered manager told us how they analysed falls to consider themes, patterns and lessons learnt. Whilst records confirmed what we were told, it was not clearly apparent what action was taken to reduce further risks. For example, a person had experienced two falls in June and one fall in July 2019. Care records did not confirm a referral had been made to the community falls team. We saw this person walking around with a bent over posture and that they used hand rails and furniture to support their walking. This information was not in their care records or risk assessment to inform staff. Neither did care records show a referral had been made for either a physiotherapy or occupational therapy assessment.

● Behavioural incidents were recorded, but the registered manager told us these were used by external professionals to review people's behaviour. This was a missed opportunity by staff to gain a greater understanding into people's anxiety, mood and behaviour.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The lack of clinical leadership, including oversight of clinical risks, supervision and management of nursing staff, put people at risk of not having their clinical needs met effectively or safely.
- Care plan audits were not comprehensive and effective. This failure to identify and address poor quality care plans, places people at risk of receiving inconsistent and unsafe support exposes them to risk of harm.
- A new care plan recording system had recently been introduced, but new care plans did not take account of information recorded in previous care plans. This meant there was a risk important information about people's care and treatment needs may not have been followed. Care plans also lacked specific details and guidance and we found examples, where care and treatment to meet health conditions were missing.
- The records used to show people had received care and treatment to meet their assessed needs, such as repositioning, food and fluid, wound care and weight monitoring was not monitored effectively.
- The procedure to monitor mattresses to ensure they were set correctly to meet people's individual needs was ineffective. This placed people at greater risk of their skin integratory being compromised. The monitoring of medicines had not safeguarded people from being at risk of over sedation. The monitoring of people's mobility needs was ineffective in managing and reducing risks.
- The leadership and approach to quality assurance was reactive rather than proactive and reliant on third parties identifying issues of concern. Whilst the registered manager told us of how they had made some improvements, this was limited. An action plan had been developed, but the timescale for improvements and the person responsible had not been completed.
- Issues raised by the local CCG and Local Authority had not always been responded to in a timely manner. For example, CCG visited on 15 July 2019 and requested a person's behavioural care plan to be updated. This had not been completed on 24 July 2019. Risks in relation to wound care and pressure ulcer care was also raised by CCG on a visit on 22 July 2019 following safeguarding concerns raised in relation to skin wounds. Whilst it was identified nursing staff lacked specific training in wound care and sepsis no urgent action had been taken to ensure this was completed as a matter of priority.

This was a breach of regulation 17 (1) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities)Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● At the time of the inspection, the provider was working with the police to investigate serious concerns into the care and treatment of wound care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People received opportunities to share their experience about the service in the form of meetings and quality assurance questionnaires.

● Meetings were arranged with staff to share information. This included daily hand over meetings, daily meetings with heads of department and staff meetings. Recently clinical team meetings had been introduced.

● A staff member spoke positively about their role and working at the service. They said, "The majority of staff here are brilliant , so is the manager, you can raise any issues and concerns, The manager is compassionate and supportive."

Working in partnership with others

● The registered manager had developed positive relationships with external professionals.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess risks to the health and safety of people and to mitigate risks. Nursing staff were not sufficiently competent or had the right skills.

The enforcement action we took:

Urgent NOD

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and mitigate risks relating to the health, safety and welfare of people. Accurate and complete records of people's needs were not consistently completed.

The enforcement action we took:

Urgent NOD

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to provide sufficient numbers of suitable qualified, competent, skilled and experienced staff. Staff did not receive appropriate training, professional development, supervision and appraisal.

The enforcement action we took:

Urgent NOD