Four Seasons (DFK) Limited

Meadowbrook Care Home

Inspection report

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Ratings

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

Overall summary

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, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection. This meant the home did not have advance notice that we were carrying out the inspection. Meadowbrook Care Home provides a service for up to 79 people who have care and nursing care needs including those living with a dementia type illness. There were 69 people living at the home when we visited. The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We found there were not sufficient staff on duty in the home. Staff were task focused and had no time to spend

Summary of findings

with people to socially stimulate them. Relatives told us the home was always short staffed and people had to wait for their call bells to be answered for long periods of time. We saw that people were left unsupervised in the main large lounge for long periods.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. Staff we spoke with were knowledgeable about who to, and how to, report any suspected or potential abuse. Some staff did not have knowledge about the Mental Capacity Act 2005 and its application. This meant that staff might not understand when a mental capacity and best interest assessment should be completed. This action would ensure decisions were being made within an agreed legal framework. The provider had a recruitment process in place that checked people's suitability to work with adults.

The provider did not have systems in place to minimise the risk of infection. This meant that the service did not protect people from the risk of infection because guidance had not been followed and people were not cared for in a clean, hygienic environment.

The registered manager told us staff had not have regular support meetings and annual reviews this meant that potentially people could be cared for or supported by staff that are not competent.

People told us they had access to community health and social care professionals who were involved with people's care. We spoke with a health professional who visited the home on a regular basis and told us the home always seemed to be a happy place.

People told us they could choose how to spend their days and choose what they wanted to do and where they wanted to be. We looked at a sample of care plans and saw people's preferences were recorded. This meant that people had choice and care was personal to the individual.

The registered manager had been covering at another home for seven months. CQC were not informed of this absence. They told us that improvements needed to be made in some areas at the home and spoke to us about where improvements were necessary. Morale was low at the home. Staff did not feel supported and this was apparent through discussions with them. The registered manager held regular staff meetings, resident and relative meetings. This meant that people were actively involved in developing the service. However some people told us they did not feel their concerns were listened to or acted on. This meant that potentially people did not receive care and support from staff that felt valued and listened to.

We found some breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and of the Care Quality Commission (Registration) Regulations 2009.

You can see what action we told the provider to take at the back of the full version of this report.

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 safe.

We identified shortfalls in staffing. This was a breach of regulation 22 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010. We have told the provider to take action about this.

We found systems were not in place to minimise the risk of infection. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We told the provider to take action about this.

People who used the service and relatives we spoke with told us they felt safe at Meadowbrook but there were not enough staff.

Staff were clear about the process to follow if they had any concerns in relation to people's safety and welfare. Staff we spoke with were knowledgeable about who to, and how to, report any suspected or potential abuse. Some staff did not have knowledge about the Mental Capacity Act 2005 and its application.

We found that recruitment practices ensured that staff were suitable to work with people.

Is the service effective?

Requires Improvement

The service was not effective.

Staff received essential training to do their job. However they did not always receives the opportunity to discuss their work through support meetings with the registered manager.

We saw that care plans contained information about people's preferences and interests. Nutritional assessments and dietary needs were recorded which meant people's nutritional needs were managed.

People told us they had access to community health and social care professionals who were involved with people's care which enabled people to remain healthy and well.

Is the service caring?

Requires Improvement

The service was not caring.

We saw staff were sensitive and caring and respected people's dignity.

People were supported at meal times. However, we saw that this was not always delivered in a consistent way. This meant that not everyone had a positive meal time experience.

Staff gathered information about people's life history's in a positive way and used this to understand more about the person before they moved into the home.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not responsive.

People received care and support that was tailored to their needs and wishes.

Some staff and people who lived at the home told us there were not enough social interests at the home so that people had stimulating and interesting things to do. People were not supported to pursue individual hobbies or interests. This meant the provider did not always maintain and promote people's wellbeing by providing social interests for people.

A complaints procedure was in place and was displayed in the reception area of the home. Some relatives told us that their concerns or comments were not always listened to. This meant that the provider did not always listen and act on people's concerns or ideas.

Is the service well-led?

Requires Improvement

The service was not well-led.

The registered manager had been absent from the service covering at another service in the group. This was for over a period of 28 days. The provider is required by law to inform CQC of any absences of this nature. They did not do this and therefore we found a breach of Regulation 14 of the Care Quality Commission (Registration) Regulations 2009.

Staff told us for a number of reasons they did not feel supported at the time of our inspection and this had led to low morale.

The provider carried out internal quality assurance audits. However these did not always identify issues, for examples shortfalls in infection control and insufficient staffing levels. There was a system to manage accidents and incidents. This meant that the registered manager monitored any trends or patterns and would take action to prevent similar occurrences in the future.

Residents, relatives and staff meetings took place. This meant that people were actively involved in developing the service.

Meadowbrook Care Home

Detailed findings

Background to this inspection

We carried an inspection at Meadowbrook Care Home on 30 July 2014. The inspection was unannounced, which meant the provider and staff did not know we were coming.

The inspection was carried out by two inspectors, a specialist advisor who had a dementia nursing background and an Expert by Experience who had personal experience of nursing and residential care for older people.

Before our inspection we reviewed the notifications the provider had sent us since our last inspection. These contained details of events and incidents the provider is required to notify us about. We also contacted Shropshire County Council Local Authority Quality Monitoring team. They told us they did not have any concerns about the service. The provider also completed a Provider Information Return. This is information we asked the provider to send us about how they are meeting the requirements of the five key questions. This helped us to decide what areas to focus on during our inspection.

We looked at records in relation to six people's care. We spoke with 18 people who used the service, two relatives, 14 staff and the registered manager. Not all the people we met were able to speak with us about the care they received and their experience of living in the home. Therefore we observed how staff interacted and supported people and looked at some records including staff training records and audits. We also looked at records relating to the management of the home. These included audits and minutes of meetings.

Requires Improvement

Is the service safe?

Our findings

All of the people we spoke with told us they felt safe at Meadowbrook. One person who used the service told us, "The staff are very good and do their best but they are very busy". Another told us, "The staff are always very busy" and another person told us, "The staff are lovely but they are always busy". During the time of our inspection we observed there were not always sufficient numbers of staff to meet people's needs. For example we saw that the main lounge did not have a member of staff to observe people's safety throughout the day. Some people were unable to summon assistance when they required it because of their limited mobility or mental health needs. We were told by a visitor and saw accident records that confirmed a person fell out of the wheelchair and sustained injuries from the fall the day before our inspection. There were no staff in the area at the time to oversee the safety of people.

Staff told us, "We are always short staffed it's ridiculous, it's not covered and all we get is 'it's the budget' and "It's the staff shortage that's getting everyone down, once it's down it's difficult to get back up". On Garrett Anderson and Mary Powell units we saw that staff were only able to complete care tasks for people and were unable to spend any meaningful time with people. There were no social interests or people encouraged to follow their own individual hobbies on either unit. We were told by staff that the staffing numbers were short for the day on both units. The registered manager had not been told the numbers on each unit were short by one member of staff and they had not checked the unit staffing levels during the inspection. We discussed this with the registered manager. This meant no attempt to cover the shortage had been made and people that used the service were put at risk because there were insufficient numbers of staff to meet their needs.

One visitor told us that they had visited the home and used the call bell to summon help to take their relative to the toilet. The call bell rang for ten minutes; they had to ask a nurse for assistance. The nurse told them the care staff would help. When this did not happen they returned to the nurse and told them their relative was trying to get up out of the chair themselves. The nurse replied, "You should have told me that before and I would have come and helped you".

Another person visiting the home told us that they had observed the call bell ringing and staff had turned the call bell off, told the person, "I can't do you on my own" and that they would return and this had not happened.

The shortfalls we found breached regulation 22 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010, and you can see what action we told the provider to take at the back of the full version of the report.

We looked at the way the provider dealt with managing infection control and found there was not a system in place to minimise the risk of infection.

Throughout the home and particularly on Mary Powell and Garrett Anderson units there was a strong offensive odour. We saw cleaning schedules were in place for carpet cleaning, but these were not effective. The registered manager told us the corridor carpet on Garrett Anderson unit was due to be replaced with carpet. We discussed the fact that replacing like for like will not address the problem of the strong smell experienced in the area. The laundry hand washing sink was cracked. Areas on the laundry walls around the hand washing sink had paint peeling from them. This meant areas such as these were not easy to clean and posed a risk of cross infection.

Staff confidently described procedures for handling soiled linen and the procedures followed at the home. We saw supplies of personal protective clothing around the home. However, we asked staff who were in the dining room to assist someone into a more comfortable position. The person was in their bedroom. Staff left the dining room, did not remover their protective aprons and attended to the person. They did not wash their hands after assisting the person, kept their protective aprons on and returned to the dining room. This was not good practice and could pose a risk of cross infection for people who lived at the home.

All these issues meant people were not protected from the risk of infection because appropriate guidance had not been followed. These issues were a breach of Regulation 12 of the Health and Social Care Act 20018 (Regulated Activities) Regulations 2010.

We saw systems were in place to reduce the risks to people's safety. Any concerns about a person's safety were identified and reported. All of the staff we spoke with were aware of how to recognise poor practice and how they would report it. Staff we spoke with confirmed that they had undertaken safeguarding and Deprivation of Liberty

Requires Improvement

Is the service safe?

Safeguards (DoLS) training. The registered manager told us this was in need of refreshing for all staff. Since our inspection the registered manager confirmed DoLS training had been booked for eleven staff for September and October 2014.

Some staff we spoke with could not demonstrate they understood the principles of the Mental Capacity Act. Mental capacity assessments had not been completed for all people who lived at the home who lacked capacity. We saw in one person's notes that they lacked capacity to make decisions, however there was no evidence of a capacity assessment or best interest decision being discussed. We asked the unit manager why these had not been completed they told us, "No we haven't done them". This meant the staff potentially made decisions that might not be in the person's best interest and did not involve family, or health care professionals in those decisions.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLs) and to report on what we find. At the time of our inspection the manager told us that there was no one who had their liberty, rights or choices restricted in any way.

We saw the recruitment process included taking references from previous employers and obtaining a Disclosure and Barring Scheme (DBS) check. This ensured staff at Meadowbrook Care Home were safe to work with people.

Requires Improvement

Is the service effective?

Our findings

We spoke to staff about training they had received. One person told us, "I've done lots of training". They went on to tell us, "I don't know enough about DoLS training, I want to look it up, it's the same as capacity isn't it?". The registered manager told us that they had arranged training relating to specialist areas. For example multiple sclerosis. They went on to say a trainer in brain injury was booked to come into the home in August to provide some training to staff. This meant people were supported by staff who had the knowledge and skills to support them.

Staff told us and the registered manager also made us aware that meetings with individual staff to discuss their work and annual reviews had slipped while they had covered at another of the groups home for seven months. The registered manager said they had put plans in place to address this but this had not yet happened due to staff sickness. This meant that staff did not have the support of senior management or the opportunity to discuss their work practice and their professional development which could impact on people who used the service.

We observed lunchtime in the main dining room. This was not a pleasurable experience for everyone. For example we heard one person say, "I cannot eat this it's too hard". The person was not offered an alternative and the meal was taken away. Another person asked for a yoghurt and the staff responded, "I'll see what they have in the kitchen". They brought back strawberries. One person who lived at the home told us, "Food is excellent" another told us, "The home does its best". We saw people were offered drinks throughout our inspection.

We also observed lunch on Garrett Anderson unit. Three of the four tables had table cloths. This meant some people did not experience the same experience as others at lunch time. There were no condiments for people to use if they wished. This meant people did not have a choice to add them to their meal or not. Some people had left the table to walk around. The dining area was restricted due to a wheelchair and two walking aids that had been situated in there. We noticed one person sat in their armchair to eat their meal but made no attempt to eat it. A care worker who was assisting another person to eat their meal spoke to the person in the armchair and then removed their meal. We asked what the care worker would do to ensure the person had something to eat. They told us, "We'll make them a coffee and try them with some pudding". We later saw the person eating with their relatives. This meant the relatives ensured the person had eaten.

We spoke with the chef who told us special diets were catered for at the home and they checked with people that they enjoyed their meals. We saw referrals had been made to the speech and language therapist which ensured that people received specialist assessments when required.

All records showed referrals to other professionals such as the doctor. We saw people had appropriate access to healthcare professionals when they required it. For example the tissue viability nurse had been called to people if their wound was assessed as requiring further professional specialist advice. We spoke to a general practitioner who visits the home weekly. They told us, "It's generally a happy ship here". This meant that staff supported people to maintain good health and had access to healthcare services when they required.

We looked at people's health risk assessment records we saw how people's individual health risks were managed. These included people's risks for bed rails, falls, malnutrition, weight loss, mobility and pressure area care. The home was visited by a doctor who attended the home every Wednesday. This meant that the risk of people's health being critically affected was reduced or eliminated

Requires Improvement

Is the service caring?

Our findings

We spent time observing the interactions between the staff and the people they cared for. We saw staff did not always offer support in a sensitive way. During the lunch time meal staff referred to people as "sweetie, darling and lovey". This meant potentially people were not addressed with respect. We saw very little interaction by staff with people at lunchtime. Staff appeared that they had to get the meals served and completed before they moved onto the next task. People told us the staff were always kind and polite. One person told us, "The staff always help me with my personal care in a way that doesn't embarrass me". Another person told us, "The staff cover me up when they need to so I'm not on show when they wash me". We saw that people's mail was delivered to them unopened, we also saw privacy screens used when people were hoisted from wheelchair to armchair.

One person told us, "I like to stay in my room and do what I like to do. I can come and go as I please, there's no rules here". Another person told us, "My family visit me and we sit and chat in my bedroom". This showed people had their own privacy when they needed it. Everyone had their own bedroom which were personalised and individual. We saw family and friends could visit whenever they wished. We spoke with relatives who told us staff were welcoming when they visited. People were able to maintain relationships with relatives and friends who were important to them.

People told us staff listened to them and would help them when they needed assistance. One person told us, "I can always say what I think and I think they listen to what I have to say". Another person told us, "You can chat to any of them and they will listen".

We saw the way staff assisted people to move round the home. They managed the process well and explained to people what they were going to assist with before they did. Staff provided the appropriate reassurance. This meant that staff consulted people about the support they provided and respected people's privacy and dignity. People were reassured by staff who were skilled to provide the right support in a caring way.

People we spoke with were complimentary about the care staff. People we saw looked cared for and comfortable. One person who was cared for in bed was comfortable and looked well groomed. We saw staff had put the radio on in their room as stimulation for the person who was unable to move out of the room. This meant the person was not left in silence with no stimulation.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us they did not feel listened to when they had raised concerns. One person told us, "I have asked them for one of those recliners for [relative] when they are sitting in the lounge. I was told they hadn't got enough. I think if [relative] was sitting in one of those they would feel more secure and stop keep trying to get up". Another told us, "We've asked time and time again [relative] is not left in a wheel chair and when we arrive they are in the wheel chair". This meant the service had not listened to people's concerns or suggestions.

People's needs were assessed before they moved into the home. Care plans contained information that was individual to each person taking into account people's needs, choices, likes and dislikes. One person told us, "Someone came to visit me from here before I moved in and we talked about the help I needed". Staff were provided with information about how to support people. One staff member told us, "I look at the information so I know what the person needs". The staff we spoke to demonstrated a good knowledge of the people that lived there including their likes, dislikes and medical needs.

Care plans we saw confirmed the registered manager and staff had a consistent approach to evaluating people's needs on an individual basis. We saw this was personalised and responsive to individual identified risks, wishes and needs. Although care plans we looked at were individual there was no evidence that they had been drawn up with anyone's involvement whether it be the person who used the service or their representative. This meant the care plan may not be an accurate reflection of a person's needs and in accordance with their wishes.

The provider employed an activities co-ordinator and we were told the provider was in the process of recruiting a further activities co-ordinator. On the day of our inspection a meeting for people that lived at the home was due to take place. We asked the activities co-ordinator if this had happened they told us that it consisted of going round talking to people. They reported people had not raised any concerns. They were unable to do a full meeting because they told us they had been asked to take part in an interview for the second activities co-ordinator with the registered manager.

In the afternoon we saw a sing a long take place in Garrett Anderson unit. People appeared to be enjoying the event. During our inspection we saw one person completing a word search. Apart from the one person we did not see anyone else following their own hobbies or interests. The registered manager told us about recent trips out and we saw photographs of events including a singer and animal man who had visited the home on display. The registered manager told us they wanted to introduce coffee mornings on Garrett Anderson unit where staff could make observations and pick up on things said. This had not been put into place at the time of our inspection visit. We saw a weekly activity plan in reception and we noted there were no events planned for weekends. One person told us, "There are very few activities" another told us, "Not a lot goes on for you".

We observed that there was not much attention to the individual hobbies and activities for people who lived at the home. Staff were task driven to attend to people's care needs with little extra time to provide any social interaction. One person told us, "There are very few activities". Another person told us they did not see much of the activities co-ordinator. This indicated that people did not always receive any support to follow individual hobbies and interests.

The walls in Garrett Anderson unit had been decorated with objects that would stimulate discussion and enable people to touch the items. The home kept chickens and budgerigars but these were tended to by staff. We were told there were no current people who lived at the home that wanted to care for the pets. One person on Garrett Anderson unit had chosen to bring their pet cat into the home with them. This meant the person's choice had been respected.

We saw the provider home had a complaints policy and this was displayed in the reception area of the home. People we spoke with knew who to talk to if they had a concern. Records we looked at showed the senior management team had dealt with complaints in a timely manner and had recorded details of the investigation and outcome. We noted two complaints about the gardens and grounds and the garden area around Garrett Anderson unit. These complaints were raised in September 2013 and May 2014. However, we spoke with the registered manager about this issue because we had noticed the garden by Garrett Anderson unit on the day of our inspection did not

Requires Improvement

Is the service responsive?

look cared for. This meant people did not enjoy a pleasant garden area. We noted a complaint about staffing levels in August 2013 and a complaint about an offensive odour in someone's room in June 2014. These were suggestive of issues we highlighted on the day of our inspection. This meant that the complaints had not been managed well and the provider had not learnt from complaints because the issues still remained.

Requires Improvement

Is the service well-led?

Our findings

The registered manager told us they had not been at the home for seven months because they had been covering at another home. CQC had not been informed of the absence of the registered manager and the interim arrangements that were in place during their absence. Failure to notify CQC of an absence was a breach of Regulation 14 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager told us some areas of the home required developing. These included improving face to face training opportunities, staff support meetings and annual reviews, improving the environment and improving the focus of the dignity champions to include people who used the service in dignity work.

Staff we spoke with were clear about their roles and responsibilities at the home. They knew who to report concerns to if they had any. However, there had been a breakdown in communication on the day of our inspection because none of the staff reported two people had not arrived for duty and neither was the registered manager aware from their own check of staff on duty that day. This meant the home did not have sufficient numbers of staff on duty on the day of our inspection.

Staff morale was low at due to staffing shortages, sickness. Staff told us they did not feel supported. The registered manager acknowledged that these issues were having an impact on staff at all levels.

Some staff told us that they did not feel supported by senior management at this time. One person told us they felt, “Unsupported by the management, not listened to and never felt so disappointed in the home”. One staff member spoke of unit meetings and, “Very little is done about what we mention”. Another staff member told us, “A lot of people are unhappy here, people aren’t as happy as they used to be”. We spoke with the registered manager about the low morale throughout the home. They told us they shared information with staff as they were informed and was aware of the anxiety that this was causing.

A key achievement for the home in the last twelve months is that the home had been accredited a PEARL dementia care initiative to silver level. PEARL means positively enriching and enhancing resident lives. One staff member told us, “There are not enough staff to deal with the needs of the residents, particularly when meeting the criteria of PEARL and providing a meaningful day for residents”. This meant that staff did not always feel the criteria of the initiative was always being met and people did not receive a positively enriching and enhancing life. We did not see any evidence to show how this initiative had improved care for people who were living with a dementia type illness.

We saw records of meetings held with people who lived at the home and their relatives. People told us they can attend if they choose to. The last minutes of meetings recorded people’s satisfaction with the food, ideas for trips out and an update on the recruitment of new staff. No complaints were received at the meeting.

The provider had an internal audit system to regularly assess and monitor the quality of service that people received. This included regular health and safety risk assessments and talking to people who lived at the home. The registered manager told us that this contributed to their head office care and quality audit programme. We looked at some of the records and found that audits had been routinely carried out. Monitoring system for accidents and incidents had been completed. Although there was a system in place to monitor quality at the home it had not identified issues that we found at the inspection. For example staffing levels, low staff morale and infection control shortfalls.

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 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	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **There were not sufficient numbers of staff to ensure people received the care and support they required.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **People were not protected from the risk of infection because guidance had not been followed.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 CQC (Registration) Regulations 2009 Notifications – notice of absence **The provider failed to notify CQC of the registered manager absence.**