Little Meadows

Little Meadows

Inspection report

1 Poplar Avenue
Cross Heath
Newcastle Under Lyme
Staffordshire
ST5 9HR

Tel: 01782711669

Date of inspection visit:
20 November 2019
22 November 2019

Date of publication:
18 March 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Little Meadows is a small residential care home providing accommodation and personal care to 12 people at the time of the inspection who may have dementia, mental health needs or physical disabilities. The service can support up to 20 people.

People's experience of using this service
People's health and safety had been put at risk due to the poor oversight of the quality of care and safety of the building. Risks were not always assessed and planned for, so people were put at risk. People were not always supported or monitored in relation to their health conditions and health professional advice was not always sought. People were not always protected from the risk of infection. We could not be sure people were having their medicines as prescribed. Lessons were not always learned when things went wrong as there was not always oversight of these.

There were sufficient staffing numbers, however as the manager was having to work care shifts, this was impacting upon their time to manage and have oversight of the service. Staff had received some training although there were concerns relating to supporting people in relation to their health conditions and medicines. There were no training records available to confirm staff had received up to date training.

Staff understood their safeguarding responsibilities but as there was a lack of oversight for some incidents, we could not be confident that every incident was investigated.

People were not always supported to partake in meaningful activities of their choice. People were not always supported to plan for their end of life wishes, although no one was receiving palliative care at the time of the inspection.

People were supported to have enough to eat and drink, although there were concerns regarding the storage and management of food.

People were not always treated well due to the concerns we found in the service. Despite this, people were supported to remain independent. People were involved in decisions about their care.

People and relatives were able to complain and these were investigated and responded to. People were supported to access information in a way that suited them.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The service was rated good overall. It was requires improvement in the well-led key question (published 24 June 2017). There had been multiple manager changes since the last inspection and the provider had no

quality assurance oversight of the home so the rating has now deteriorated to inadequate overall.

Why we inspected
This was a planned inspection based on the rating at the last inspection. We found significant concerns during this inspection in relation to all key questions, resulting in an overall rating of inadequate.

Enforcement
We have identified breaches in relation to keeping people safe and managing risk, and the oversight of the service.

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
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, 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 of 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?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Little Meadows

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team
The inspection site visit was carried out by one inspector on the first day and two inspectors on the second day.

Service and service type
Little Meadows is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. Although there was a manager in place, they had not completed their application to register with us. The previous registered manager had only recently left so the new managers application with us was still in progress. The provider is 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. Inspection site visit activity started on 20 November 2019 and was ended on 22 November 2019.

What we did
We looked at information we held about the service including notifications they had made to us about important events. A notification is information about events that by law the registered persons should tell us about. We also reviewed all other information sent to us from other stakeholders for example the local authority and members of the public. We assessed the information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements

they plan to make. We used all this information to plan our inspection.

During the inspection, we spoke with four people, one relative, two care staff, the manager and the previous registered manager who was supporting the service part time and the main partner who owned the care home. We also spoke with one visiting health professional. We reviewed four people's care records some of which included medicine records and daily notes. We looked at policies and procedures and records relating to the management of the service, including audits, meeting minutes and surveys and two staff recruitment files.

After the inspection, we requested additional evidence that could not be supplied on the day of our visits, such as evidence of building safety checks and the outcomes of complaints.

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 good. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- People's medicines were not always safely managed.
- One person's medicines had run out due to a delivery issue. The home had repeated the request but had not chased this so the person had missed nine doses of the medicine. This left them at risk of experiencing symptoms of their health condition and becoming unwell.
- One person had a dose of their medicines omitted by staff as they felt it was not safe to administer them. They had not sought medical professional guidance about this. One of the person's medicines prescription stated it should not be stopped unless a doctor advises to stop it.
- Some medicines were prescribed to be given 'when required', or PRN medicine. There was no additional guidance to help staff identify when people may need their PRN medicine which meant people could be at risk of not always having it consistently and when they needed it.
- Checks on the storage of medicines were not always regular and did not always check the minimum and maximum temperature that medicines had been exposed to, which put them at risk of not being effective.

Assessing risk, safety monitoring and management

- Risks were not always assessed and planned for. For example, one person experienced seizures. There had been documented seizures in their daily records and it was a known health condition. There was no plan in place to guide staff about how to recognise a seizure or what action to take if they had one. Staff gave us differing accounts of the action they would take. This put the person at risk of experiencing inconsistent or unsafe care.
- Some people could experience behaviours of agitation and distress. There was limited detail in their plans about how they may display these behaviours, what may cause them, and the action staff should take to support them. People could be at risk of experiencing inconsistent care as there was limited guidance.

Learning lessons when things go wrong

- Lessons were not always learned when things went wrong.
- People were experiencing falls and there was not always oversight of these. Incident forms were being completed, but they were not always detailed and had not always been checked by a senior or manager to ensure appropriate action was taken to keep people safe at the time of the incident and to reduce ongoing risk to people.
- Some people had experienced falls in their rooms when no staff were present. Radiator covers to protect people from the risk of harm when these were hot, were not available in their bedrooms. This meant if a person fell against a radiator, they may be at increased risk of experiencing burns. One person had been found on the floor against the radiator in the summer months. No action had been taken to reduce the

ongoing risk to that person when the radiators may be turned on.
● A person had displayed some behaviours of agitation and distress and there had been no learning from these incidents. The person's plan had not been updated following these incidents to ensure staff had consistent guidance to follow.

Preventing and controlling infection
● People were not always protected from the risk of infection.
● The home had been rated one out of a possible best rating of five, during a food hygiene inspection in February 2019. We checked to see if action to make improvement had been taken and continued to find issues with food safety.
● Food was being stored in the fridge without any covering and with no date label, so we could not be sure how old it was. Other items had been labelled but had gone significantly past the manufacturer's guidance for how long it should be open for. This put vulnerable people at risk of having food which was potentially not fit for consumption. Placemats in the dining room were sometimes dirty prior to meals being served.
● Whilst there were domestic staff who cleaned the home regularly, two people had carpets in their rooms which smelled unpleasant. Staff had tried to clean them, but the smell remained and the provider had not changed these carpets.

People were not always being protected from the risk of harm and the provider failed to demonstrate how they kept people safe. The above constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Whilst people did not have to wait for support, there were staffing pressures as the manager was having to cover caring shifts, so they were unable to actively manage the service when needed. This meant the oversight of the service was not always effective due to staff available.
● Staff were overall recruited safely, however procedures could be more robust in relation to checking employment history. Past employment references providing employment dates did not always match information provided by applicants and this had not been checked. Another staff member had listed a reference that was not noted in their employment history.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe. Staff knew the different types of abuse and understood their responsibilities to report concerns.
● However, as incident forms were not always reviewed and care notes not monitored, we could not always be sure appropriate action was taken to keep people safe at all times and to reduce ongoing risk to people. Despite this, we saw referrals were made to the local safeguarding authority as required.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People were not always having their health conditions sufficiently monitored and plans were not always in place to support people with their health conditions.
- For example, two people were having the regularity of their bowel movements monitored. Records showed they went several days without a bowel movement. One person had been given laxative medicine to help them go to the toilet, but this had still not resulted in them going to the toilet. Health professional advice was not sought in relation to this. People can be at risk of becoming unwell if they do not go to the toilet often enough. There was also no plan in place to guide staff of what action to take in the event of people not going to the toilet enough.
- Another person was at risk of experiencing seizures and this was not planned for and input from medical professionals had not been sought to help staff know what to do in the event of a seizure. The person was regularly experiencing seizures, and this had still not prompting the development of a plan and guidance for staff. Staff gave us differing answers as to how they would support the person at the time of a seizure which could put their health and life at risk. Records showed there had been a delay in contacting emergency services during one suspected seizure and it was not known if this was a safe amount of time to contact them.
- Another person did not have a plan in place regarding their catheter. This meant they were at risk of inconsistent care. There had been a recent delay of four days in having this changed by another health professional and although the manager was aware of this, it had still not resulted in the catheter being changed. People can be at risk of developing infections if they do not have their catheter changed regularly enough.
- One person had refused one of their medicines for a number of weeks and this had not been escalated to or reviewed by another health professional to check whether this may impact the person's health. There was a lack of guidance for staff to help them recognise when the person may have needed it.
- Despite this, people and relatives told us they had access to other health professionals. One person said, "Staff get a doctor or the practice nurse and they come to see me here."

There was a failure in ensuring robust plans were in place and risks mitigated to help keep people safe and to guide staff in delivering effective care. The above constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs

● The home was going through a period of redecoration. However, the home was not fully adapted and suitable for people living there. Staff feedback included, "It [the decoration] needs updating to be honest."

● The home was not dementia friendly, despite people living there who had dementia. There were no posters or boxes on people's bedroom doors to help them identify their own rooms. Best practice suggests that people find it easier to identify their own room if there are recognisable items to direct them there.

● People had not been involved in the ongoing redecoration of the service. The provider was very dismissive of getting people involved and they felt it would not be appropriate for people living in the home to have any say in how their home and environment was decorated. The provider's language in response to this was derogatory towards people and their health conditions.

● Radiators did not have covers on them which put some people at risk of injuring themselves. Safety checks on the building, such as water temperatures, were not always carried out.

● There was moving and handling equipment available, such as hoists, wheelchairs and walking frames available for people who needed them.

Staff support: induction, training, skills and experience

● The manager explained that the training provider they used had recently updated their system, so all training records for staff had been lost in the upgrade. The provider had no other way of monitoring staff training, so they could not confirm staff were up to date with their training.

● Relatives and staff told us staff had training. One relative said, "Everyone [staff] seems to know what they are supposed to do."

● Staff told us they had received training. However, as there were issues in staff knowing how to respond to some health conditions and issues with medicines, we could not always be sure staff training had been effective. Staff, whilst being caring in their approach, did not always record and monitor incidents of behaviour of distress and agitation so did not have effective oversight of these. People were at risk of continuing to experience these episodes.

● Staff told us they had some supervision and felt supported. One staff member said, "[In the supervision] We discuss residents, bring up my concerns, how I feel I'm working. Yes, it's useful, I feel as though I can tell them [manager] how I feel."

Supporting people to eat and drink enough to maintain a balanced diet

● People were supported to eat sufficient amounts of food and drink of their choice. However, we found there were issues with safe food storage so we could not be sure people were always being provided with safe food.

● Despite this, people gave us positive feedback about the food. One person said, "Its good food." Another person said, "It is much better than it used to be. They will get you whatever they can."

● People had their food intake monitored where necessary and people had their weight checked to ensure they remained healthy. People had generally maintained or gained weight. One person told us about the extra support they got to maintain their weight.

Ensuring consent to care and treatment in line with law and guidance

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 this is in their best interests

and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA.

● People were having their capacity assessed, however it was not always decision-specific. DoLS applications were also being made, however, they were not being completed with sufficient detail. Sections of the formal application form prompt services to explain why they are making the application and how people were being supported which needed to be considered under DoLS. However, these were sometimes blank. This meant professionals considering the application would not always have enough information to make a decision and to know if people were being protected.
● Despite this, staff understood what capacity meant and people had their consent checked before being supported.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Some people were spending time and sleeping in unpleasant smelling rooms, this showed they were not always being well treated. People were also at risk of being served inappropriately stored food on dirty placemats and administered inappropriately stored medicines.
- When we provided feedback to the provider regarding our inspection findings, they referred to people in demeaning terms and were not caring in their responses to our concerns. Their comments about people demonstrated they did not have a good understanding and were not respectful of people's diverse needs.
- Despite this, people and relatives felt staff were kind and caring towards them. We observed caring interactions between people and staff.
- One person told us they had religious beliefs and they felt able to request support around this if they needed it, although they did not feel the need to visit any places of worship.
- The manager explained to us that they asked people about their religion and other protected characteristics, such as sexuality, during the time the person was being assessed and moving into the home.

Supporting people to express their views and be involved in making decisions about their care

- People were involved in decisions about their care, for example their food and drink options and where to spend their time. For example, some people chose to spend time in their room and they confirmed to us it was their choice.

Respecting and promoting people's privacy, dignity and independence

- People and relatives told us they were treated with dignity. We observed staff speak with people appropriately. One person said when asked whether they felt treated with dignity, "Oh yes, they [staff] talk to me."
- People were supported to be independent, such as being encouraged to eat their own meals and we saw there was adapted crockery for some who needed it, so they could eat independently.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not always supported with their health needs and were not always supported to partake in activities of their choice.
- One person told us, "They do have activities on, but they aren't interesting to me." A relative also said, "I think there could be more [to do]. I don't think a lot does go on. They've got in a pattern where they sit and go to sleep."
- We observed this to be the case and people would often sit and sleep, so they were not always engaged in meaningful activity.
- People and relatives felt positively about staff and felt they knew people well.

Improving care quality in response to complaints or concerns

- There was no systematic way of recording and monitoring of complaints. When we initially asked to see complaints and their outcomes, this could not be provided. However, we requested evidence of this following our first visit and evidence of complaints that had been investigated and responded to were provided.

End of life care and support

- The service was not supporting anyone who was nearing the end of their life. We discussed with the manager how they would support someone who needed palliative care. The manager said, "We would get outside professionals in, GP and district nurses to support."
- There were no specific end of life plans or future wishes plans in place so there was a risk people not being supported in a way that met their preferences when the time came or when they may be no longer able to discuss their wishes.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Initially the manager was unaware of the AIS, however they explained to us they would sit with people and read through their plans if they needed to. When asked if they were able to provide care plans in alternative formats, they said, "At the minute we don't do it, it's just standard. If someone was to ask that, we'd try and

find a way." They were aware of people's communication needs, such as glasses and hearing aids.

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 requires improvement. At this inspection this key question has 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

- Systems failed to identify concerns and areas that needed to improve. There were significant failings in ensuring the environment was safe for people and in the oversight of people's care.
- Radiators had no covers and there was no system in place to check their temperature or mitigate risks to people. Hot water outlets had not been checked to ensure the correct temperature. As a result, there was a risk people could be scalded. There is national guidance in place for the maximum temperature hot water should be within care home.
- The provider was unable to provide evidence of gas and electrical safety checks at the time of the inspection. Following our feedback, these were put in place.
- The provider had failed to replace carpets in two people's bedrooms, despite them having a strong smell.
- The provider had no oversight of the service, either directly or by engaging any external support, so they could not be sure the home was safe, effective, caring, responsive or well-led. When we asked the provider for evidence or information, one of their responses was, "I haven't the slightest idea to be honest with you."
- People who had behaviours of agitation and distress did not always have incidents effectively recorded or sufficient oversight of these to improve their plans and staff approaches to their support.
- Systems in place to monitor medicines were not effective; the storage of medicines was not always being checked appropriately. Oversight of the administration and records was not effective as people had missed medicines and guidance was missing.
- Insufficient action had been taken to ensure all improvements were made following a poor food hygiene rating.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- The provider admitted they did not feel they could make the improvements necessary within the service, they said, "I don't think I am capable of doing it."
- The manager was having to work care shifts, so they did not always have the time to manage and have oversight of the service. Systems were not fully implemented to check the quality of people's care. The provider was not supportive and did not always act upon feedback from management.
- The provider was not person-centred and did not refer to people in a kind manner when we discussed our inspection feedback.

Continuous learning and improving care

● There was poor oversight of staff training, as there was no longer any evidence staff had received training.
● There were minimal systems in place to monitor accidents and incidents and they were not always reviewed to improve people's experience of their care or learn from incidents.

The provider had failed to ensure robust systems were in place to monitor and improve the quality of people's care. The above constitutes a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There was no systematic way of gathering people's feedback in order to check they were happy and to identify ways to improve their quality of care.
● People and relatives were not proactively engaged to encourage feedback and thoughts about the service they received. One relative said, "I've never been asked for a meeting." No surveys had been carried out. The home was being re-decorated, and people had not been involved in any decisions about the aesthetics of their home environment.
● There were some staff meetings however, staff were not asked for their opinion through surveys. Staff did say they felt able to approach the manager if they needed support.

Working in partnership with others:
● The manager was receptive to feedback and were willing to work in partnership, however the provider was dismissive of feedback during the inspection, although some concerns were later acted upon.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were not always being supported appropriately with their medicines. Risks to people's health and wellbeing were not always assessed and planned for. Plans were not always in place for people's health conditions. There were concerns with food hygiene.

The enforcement action we took:

We urgently imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of oversight of the service. The safety of the building was not always being monitored. Accidents and incidents were not always reviewed.

The enforcement action we took:

We cancelled the provider's registration so they can no longer deliver the regulated activity.