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# Meadow House Residential Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

We carried out an unannounced inspection of Meadow House on 25 July 2017. Meadow House provides accommodation and personal care for up to 24 people, some of whom live with a cognitive impairment. Accommodation is arranged over two floors of a converted Victorian building with stair lift access to the second floor. At the time of our inspection 21 people lived at the home.

At the time of the inspection the registered manager was having a period of planned absence from the home and the deputy manager was providing cover in an acting manager role. 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.

This service was last inspected in July 2016 when we found the provider had not ensured there were sufficient staff available at all times to meet the needs of people; there was a lack of proper and safe management of medicines for people and there was a lack of systems and processes in place to assess, monitor and improve the quality and safety of the service. At this inspection we found that although some action had been taken to address these issues additional improvements were required.

Not all staff had received the training they required to support their role and meet the needs of people. The system in place to monitor the training that staff had received was not robust in identifying staff training needs.

Staff and the acting manager had received training in respect of MCA and were able to demonstrate an awareness of the principles. However they did not always able to apply this to the people they supported. For example appropriate systems were not in place when people were given their medicines covertly and consent from people was not always obtained before providing care and support.

People and their families told us they felt the home was safe. There were suitable systems in place to ensure the safe storage and administration of medicines. Medicines were administered by staff who had received appropriate training and assessments. However, the auditing system to check medicine stock was not robust.

Not all staff had developed caring and positive relationships with people. Some people felt that staff did not always speak to them nicely or provide them with choices about their care.

There were enough staff to meet people's needs. Staffing levels enable staff with the time to engage with people in a relaxed and unhurried manner. There were safe and effective recruitment practices in place.

The risks relating to people's health and welfare were assessed and these were recorded along with actions identified to reduce those risks. People's care plans were personalised and provided sufficient information

to allow staff to protect people whilst promoting their independence. Environmental risks were assessed and managed appropriately.

People were supported to have enough to eat and drink. People were provided with appropriate support during mealtimes and supported to be independent. Healthcare professionals, such as chiropodists, opticians, GPs and dentists were involved in people's care when necessary.

Staff knew people well and responsive to people's needs. Care plans were personalised and focused on individual needs and preferences. People were provided with a range of activities.

There was an opportunity for families to become involved in developing the service and they were encouraged to provide feedback on the service provided both informally and through six monthly questionnaires. They were also supported to raise complaints should they wish to.

People had mixed views on the management of the service, although all families felt that home was well-led. The acting manager understood the responsibilities of their role. Staff were aware of the provider's vision and values, how they related to their work and spoke positively about the culture and management of the home.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

## 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.

People received their medicines at the right time and in the right way to meet their needs. However, the auditing system to check medicine stock was not robust.

Not all staff had the knowledge and understanding of how to identify safeguarding concerns.

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate checks had been completed.

People and their families felt the home was safe. Most of the staff were aware of their responsibilities to safeguard people.

The acting manager had assessed individual risks to people and had taken action to minimise the likelihood of harm.
Environmental risks were assessed and managed appropriately.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Not all staff had received the training they required to support their role and meet the needs of people.

Staff and the acting manager did not always able to apply the principles of the Mental Capacity Act (MCA) to the people they supported. There was a lack of understanding around the administration of cover medicine and consent was not always obtain before providing care and treatment.
People were supported to have enough to eat and drink.

People had access to health and social care professionals to make sure they received effective care and treatment.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

Not all people felt that staff treated them with respect or spoke with them in a kind and caring way and this was observed during the inspection.

Staff understood the importance of respecting people's privacy and took appropriate action to ensure that people's privacy was respected.

Staff encouraged people to be as independent as possible.

People were encouraged to maintain friendships and important relationships.

## Is the service responsive?

**Good**

The service was responsive.

Staff knew people well and were responsive to people's needs.

Care plans were personalised and focused on individual needs and preferences.

People were provided with a range of activities.

The acting manager and provider sought feedback from people using the service and had a process in place to deal with any complaints or concerns.

## Is the service well-led?

**Requires Improvement**

The service was not always well led.

At this inspection we found some improvements had been made in the areas of concern previously highlighted during the inspection completed in March 2016. However, further improvements are still required around medicine management; ensuring systems to monitor staff training are robust; ensuring staff are managing their time effectively to allow more engagement and acting on times when people were not being treated respectfully.

Staff were supported by a manager who encouraged an open, honest and transparent culture in the work place.

People, their families and staff had the opportunity to become

involved in developing the service.

# Meadow House Residential Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 was unannounced and was carried out on 25 July 2017 by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The home was last inspected in March 2016 when it was rated as 'Requires Improvement'.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with nine people using the service and engaged with five others, who communicated with us verbally in a limited way. We spoke with four visitors and two health professionals. We observed care and support being delivered in communal areas of the home. We spoke with three members of the care staff, the cook, the activities coordinator and the acting manager.

We looked at care plans and associated records for eight people using the service, staff duty records, three staff recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

Requires Improvement

# Is the service safe?

## Our findings

People told us they felt safe at Meadow House. One person said, "Yes, I'm safe here" and another person told us, "Oh yes, I don't need to worry". Family members felt that their relatives were safe and that they did not have any concerns regarding their relative's safety. One family member said, "I am confident that [my loved one] is safe".

At the previous inspection in March 2016 we found that medicine administration was not always managed in a safe way. We also found that the provider had not taken steps to ensure there was sufficient staff available at all times to meet the needs of the people. At this inspection we found action had been taken and some improvements had been made to ensure people were safe. However, further improvements are still required around medicine management and the service needs to further embed and sustain the improvements into practice that have already been made.

Medicines were only administered by staff who had received appropriate training and had their competency assessed by the registered manager. Most people told us they received their medicines safely. One person told us, "They [staff] sort out my medicine for me". Another person said, "They [staff] are quite good, but I have to remind them to give me my medicine". Staff supported people to take their medicine in a gentle and unhurried way and remained with them to ensure that medicines had been taken.

Systems were in place to ensure the safe storage of medicines, the ordering of repeat prescriptions and disposal of unwanted medicines. This was supported by an audit system to check the medicine stock in the home and to ensure all medicines were accounted for. However, on checking the stocks of four medicines we found that the system in place was not robust. From the information provided we were unable to calculate the total number of tablets that should be in the home for individual people. This meant that errors in medicine administration may not be easily identified and people may run out of medicine unexpectedly which would result in them not having access to medicine as needed. This was discussed with the acting manager who agreed that they would review the current auditing system and stock check process.

There were systems in place to manage medicines and ensure that people were receiving medicines as prescribed. The Medicines Administration Record (MAR) chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine. On viewing 15 people's MAR charts, no gaps were identified; this indicated that people had received their medicines as required.

There was guidance in place to help staff know when to administer 'as required' (PRN) medicines, such as pain relief and medicines to help reduce people's anxiety. We saw that PRN medicines had been given to people and the reasons why this had been administered had been clearly recorded. Safe systems were in place for people who had been prescribed topical creams and these contained labels with opening and expiry dates. This meant staff were aware of the expiration date of the item when the cream would no longer be safe to use. Prescribed topical creams were kept in people's rooms along with guidance for staff about

which creams had been prescribed and when and where these should be applied.

People and their families told us there were sufficient staff to meet people's needs. One person said, "There seems to be enough staff". Another person told us, "It's good as far as it goes. I'd like them to answer (the call bell) quicker, a bit quicker for calls of nature". A third person said, "They come quickly, a couple of minutes and they're here". During the inspection staff were visible and responded quickly to people's needs. The staffing level in the home provided an opportunity for staff to interact with the people they were supporting in a relaxed and unhurried manner on task focused actions such as supporting people with the bathroom or getting them a drink.

Staff we spoke with confirmed there were enough staff to provide appropriate care without being rushed in their duties. Staff told us that although there had not been an increase in the staffing levels since the previous inspection, the level of support the people living at the home required had reduced. Staff said that this had resulted in people's needs being met more effectively and in a timely manner.

Staffing levels were determined by the acting manager who used a dependency tool to support them with this. This dependency tool took into account the level of support people using the service required and was reviewed weekly or more frequently if required. The acting manager told us the tool did not consider the size or layout of the building, but they took account of this by listening to feedback from people and staff and observing care and response times. There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime and agency staff.

The provider had a recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff and records viewed confirmed these processes were followed before new staff started working at the home.

Three of the four staff we spoke with had the knowledge and confidence to identify safeguarding concerns and actions required to keep people safe. Staff told us how they would safeguard people if they thought someone was experiencing abuse. One staff member explained that they had received safeguarding training and were aware of the different signs to look for in relation to abuse. They went on to say, "If I had any concerns I would inform the manager or whistle blow if I needed to." Another staff member said, "I would report my concerns to the deputy or manager. If I needed to I would go directly to CQC." The acting manager explained the action they would take when a safeguarding concern was raised and records confirmed this action had been taken.

People were protected from individual risks. The acting manager had assessed the risks associated with providing care to each person; these were recorded along with actions identified to reduce those risks. People had risk assessments in place in relation to; medicines, moving and handling, falls, nutritional needs and skin conditions. Risk assessments were personalised and written in enough detail to protect people from harm. Staff were knowledgeable about people's individual risks and the steps required to keep people safe. For example, one person, who was at risk of falling, had a risk assessment in place in respect of the support staff should offer to help them mobilise. During the inspection we observed staff monitoring this person and offering support in line with their risk assessment. Staff were able to explain the risks relating to people and the action they would take to help reduce the risks from occurring. Where an incident or accident had occurred, there was a clear record, which enabled the acting manager to identify any actions

necessary to help reduce the risk of further incidents.

Environmental risks were assessed and managed appropriately. The acting manager had assessed the risks associated with the environment and the running of the home; these were recorded along with actions identified to reduce those risks. They included the use of electrical equipment, the laundry and handling and the control of substances hazardous to health (COSHH). No infection control concerns were identified and people were protected as they were living in a clean environment.

There were appropriate plans in case of an emergency occurring. Personal evacuation and escape plans (PEEPs) had been completed for each person, detailing the specific support each person required to evacuate the building in the event of an emergency. Staff were aware of the fire safety procedures and the action they would take if an evacuation was necessary.

Requires Improvement

# Is the service effective?

## Our findings

People had mixed views on the effectiveness of the service. One person said, "They [staff] are always there for me, they are really helpful". Another person told us, "I think its ok; they [staff] know what I need from them". However, some people living at Meadow House felt that the staff did not have the skills and knowledge to carry out their roles and responsibilities effectively. One person felt that the staff did not understand their specific health condition. Other people's comments, when asked if they felt the staff were well trained included, "No, I've got to be honest" and "No, not really. They don't know how to speak to people". Although one person said, "They seem to be (trained properly). I don't need much help. I do need them to help wash me and no one makes you feel embarrassed".

People were supported by staff who had received an induction into their role, which enabled them to meet the needs of the people they were supporting. Each member of staff had undertaken an induction programme, including a period of shadowing a more experienced member of staff who assessed their suitability to work on their own. However, new staff did not always complete essential training when they started working at the home or receive training which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. It aims to ensure workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. The acting manager told us that they planned to incorporate the Care Certificate into their induction programme.

The provider had a system to record the training that staff had completed and to identify when training needed to be updated. This included essential training, such as medicines training, safeguarding adults, fire safety and first aid. On reviewing this system, it appeared that staff training had not always been received or updated as required. For example, only eight of the 16 care staff had received safeguarding and Mental Capacity Act training; a number of the staff did not have up to date moving and handling and only one staff member had first aid training. The acting manager was able to provide additional evidence following the inspection that highlighted all staff had up to date moving and handling training and that eight staff had received first aid training. The acting manager told us that they would review and update the system used to reflect the training that had been received.

Staff had access to other training which focused on the specific needs of people using the service such as: dementia awareness, pressure area care and end of life care. Staff understood the training they had received and told us how they applied it to their practice. For example, they explained how they would support a person to mobilise and how they supported people to be independent. The provider supported staff to obtain recognised qualifications such as Care Diplomas and National Vocational Qualifications. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

The system in place to ensure that staff received regular supervisions was not robust. The acting manager told us that staff should receive supervision every six weeks however staff records and the supervision planner did not demonstrate that staff had received supervision as required. Supervisions should provide an

opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop.

The acting manager told us that plans were in place to "Share the supervision responsibility with other senior members of staff". They felt that this would then ensure that all staff were provided with supervision in a timely way. Following the inspection additional information was received with demonstrated that plans were in place to ensure that all staff were to receive regular supervision.

Although staff did not receive regular supervision all the staff told us they felt supported by the management team and senior staff and that they could raise any concerns straight away.

Staff assessed people's abilities to make decisions in line with the Mental Capacity Act (MCA) 2005. The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Although staff and the acting manager had received training in respect of MCA and were able to demonstrate an awareness of the principles they did not always able to apply this to the people they supported. For example appropriate systems were not in place when people were given their medicines covertly. This is when essential medicines are placed in small amounts of food or drink and given to people without their knowledge that they are receiving medicines. We were told by staff that one person living at the home could have their medicines administered covertly if required. When this was discussed in detail with the staff we were told that this had been agreed verbally by the person's doctor. There were no clear guidelines in place around giving medicine covertly to the person and correct documentation had not been completed in line with the current legislation that protects people's rights.

Some people told us staff did not always obtain their consent before providing care and treatment. People's comments included, "No, they just do it" and "No, they just say what they are going to do". However, we were told by one person that, "They [staff] always ask me first". During the inspection we observed a staff member provide medicines to a person, they did not always explain to people about the medicines they were giving in a way the person could understand or sought people's consent. This observation was highlighted to the acting manager who agreed to discuss this with staff.

The failure to gain the consent of the relevant person when providing care and treatment is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

With the exception of when a staff member provided medicine to a person we saw that staff sought people's consent before providing care or support, such as offering to provide support to help them mobilise. We observed staff seeking consent from people using simple questions, giving them time to respond. One staff member told us, "I will always ask before doing anything". Another staff member said, "I will ask people what they want assistance with". Daily records of care also showed that where people declined care this was respected.

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the necessary requirements and DoLS applications had been made to the supervisory body where relevant. Staff were aware of the people that these restrictions applied

to and the support they needed as a consequence.

People told us they enjoyed their meals and that they were offered a choice of what they ate and drank. People's comments included, "Yes, you get choices. They [staff] would probably give you other choices if you didn't like the food offered", "The food is alright. You can have what you want", "The food is lovely, I enjoy it" and "The food is excellent". However, one person felt that there was a lack of healthy options available to them and told us, "There's no yoghurts or fruit". Another person also said, "There's not always enough to drink. They [staff] say; 'it's finished' what does that mean?"

During the inspection we saw that people were provided with a choice of cold drinks throughout the day. However, there were some inconsistencies around people's access to hot drinks. For example, when people asked for hot drinks responses from staff would vary. On two occasions we heard staff tell people, "It's not time yet" and "the trolley will be around in half an hour". At other times we saw hot drinks were provided on request. This meant that people were not always provided with a drink of their choice when requested.

At meal times people were given a choice of where to have their meals. All people living at the home were able to eat independently, but staff supported people by cutting up food or providing them with specialist cutlery or equipment if required to enable independence. All requests for support were quickly attended to by staff, with patience and good humour.

When people's food and fluid intake was reduced or poor this was closely monitored by the care staff supported by the use of individual food and fluid intake charts. Staff checked these at the end of each shift and where issues and concerns were highlighted appropriate action was taken. Action included requesting guidance from health professionals and making changes to the menu.

People had nutrition care plans in place, which included information about people's food and drinks preferences, allergies, levels of support needed and special dietary requirements. One person's care plan highlighted that they required a pureed diet and we saw that this was provided. Both care staff and kitchen staff were aware of people's dietary preferences and needs and were able to describe these as highlighted in the care plans.

People were supported to access appropriate healthcare services when required. Their records showed that people were seen regularly by doctors, specialist nurses and other health care professionals if needed and also had access to chiropodists and opticians. All appointments with health professionals and the outcomes were recorded in detail. Staff were aware of people's health needs and care that was required to support and manage these needs. For example, staff were required to monitor one person's blood sugar levels daily. The person's care file provided staff with clear and informative guidance of how and when this should be done and the actions staff were required to take if the blood sugar levels were outside the normal range.

Requires Improvement

# Is the service caring?

## Our findings

We received mixed views on the care people received. Most people and their families told us that they felt the staff were caring. One person said, "Caring, yes, they're fantastic. I get on well with them. They help in every way they can. They're very, very good". Another person told us, "Yes, some of them (are caring)". A third person told us, "They seem to make sure everyone's OK". A family member said, "They [staff] do seem to care, I have no concerns".

However, other people felt they were not always cared for with dignity and respect and some expressed dissatisfaction with how they and others were spoken to by staff. Three people felt that staff did not always talk to them nicely. One person said, "They [staff] say, sit down, sit down. That's the way they spoke to me, I won't have it. I told them, if they try it now, I ignore them". A second person told us, "They [staff] say 'Go in there!' no 'please'. Some of them are OK, some forget themselves". During the inspection we observed a person being told by a staff member to sit down and wait for their tea in a manner which seemed to be overly forceful and abrupt. Additionally, we heard a person ask a staff member if they could have a hot drink. The staff member agreed to get this, but then spent time talking to other staff about non work related issues and reading the daily newspaper. This person asked twice more before the drink was provided.

The failure to treat people with dignity and respect is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All staff interactions with people seemed mainly task focused, for example, to help a person to the bathroom or get them a drink. During these interactions (with the exceptions highlighted above) staff spoke to people nicely, did not rush people and provided the care that was required. However, staff did not take the time to just sit with or talk to people, or attempt to engage them in something they had a particular interest in. The lack of non-task focused engagement between staff and people was discussed with the acting manager who confirmed that this was something that had been noted by the registered manager and was discussed at the last staff meeting which took place five days prior the inspection. The staff meeting minutes confirmed that a discussion had taken place around this. The acting manager agreed that this would be addressed again with staff.

Staff told us they understood the importance of respecting people's choice. They spoke with us about how they cared for people and offered them choices in what they preferred to eat, if they wished to participate in activities and where they wanted to spend their time. However, people had mixed views on whether their personal choices were respected. A person told us, "You can't stand up or go anywhere in the home". Another person said, "I am given a choice, I only like ladies in the bedroom and I only have ladies in the bedroom". Within the daily care records we saw that people had been offered choices and where care had been declined this had been respected.

People's privacy was respected when they were supported with personal care. Staff were able to describe the practical steps they took to preserve people's dignity and privacy when providing personal care. This included ensuring doors and curtains were closed and making sure people were covered. We saw all staff

knocking on doors, and asking people's permission before entering their bedrooms. We observed staff assisting a person to move from the lounge to use the bathroom; this was done discreetly and respectfully. One person said, "Yes, they close the door". A member of staff told us that when supporting people, "I always close the door, make sure the curtains are drawn and cover people up when helping them". Confidential care records were kept securely and only accessed by staff authorised to view them.

People were encouraged to be as independent as possible. One person told us, "The staff help me if I need it". A staff member said, "I will always ask people, what help they need". Comments in care plans highlighted to staff what people could do for themselves and when support may be needed. For example comments included, 'Encourage [name of person] to wash their hands and face', and '[name of person] prefers to maintain their own personal hygiene and will express themselves verbally if they want help from staff'. Another care plan stated, '[name of person] likes to mobilise independently but staff must supervise to ensure safety'. During the inspection we saw that the person had access to their walking frame at all times and were supervised when walking around the home. This showed that staff understood people's needs as described in their care plans. Where appropriate, adjustments had been made to the environment to support people to remain independent, including handrails.

People were supported to maintain friendships and important relationships; their care records included details of their circle of support. This identified people who were important to the person. The families we spoke with confirmed that the acting manager and staff supported their relatives to maintain their relationships. One family member said, "We [family] can visit at any time".

Good

# Is the service responsive?

## Our findings

People and their families told us they felt the staff were responsive to their needs. One person said that, "Action would be taken if they needed something". Another person told us, "They would get the doctor if I wasn't well". One family member said, "I know they would act if [my loved one] was unwell".

People experienced care that was personalised and care plans contained detailed information specific to each person. Care plans included information about people's preferences, likes and dislikes, described how people wished to be cared for and contained specific individual information to ensure medical needs were responded to in a timely way. One care plan stated, '[Person] has difficulty following instruction and understanding; staff to use short sentences and a gentle approach'. Another care plan highlighted, '[Person] prefers solitude and one to one conversation'. Records of daily care confirmed people had received care in a personalised way and in accordance with their care plans. Daily records were detailed and informative which provided staff with clear and up to date information about people's needs. Staff were able to describe the care and support required by individual people. For example, one staff member was able to describe the support a person required with personal care and described how this was undertaken. We saw people being supported by the staff as described in their care plans.

Some people living at Meadow House had care needs that required close monitoring such as, diabetes, specialist nutritionals needs, continence needs or skin complaints. Appropriate person centred care plans and risk assessments were in place which provided staff with clear guidance as to actions to take if concerns arose. Risk assessments and care plans were also supported by the use of support tools and monitoring charts to allow staff to pick up on and respond to people's changing needs quickly. For example, where one person was at risk of weight loss we saw that this was closely monitored through the use of a food and fluid chart and the person was regularly weighed. We saw that appropriate action had been taken in a timely way when people's needs changed. Actions included, requesting input from healthcare professionals.

Staff were kept up to date about people's needs through handover meetings which were held at the start of every shift. Information was provided to staff during these meeting which included information about changes in people's emotional and physical health needs and where people had declined assistance with personal care. During this handover meeting staff shared ideas and knowledge of how best to provide support to individual people.

People, and where appropriate their families, were involved in discussions about developing their care plans, which were centred on the person as an individual. When people moved to the home, they (and their families, where appropriate) were involved in assessing and planning the care and support they needed. A person told us how they were assessed before moving to the home by the registered manager who talked with them about their needs. The acting manager told us they, "are very clear about what needs they can and can't manage and when they assess people they will consider the skills of the staff and the people who already live at the home". Comments in care plans showed that family members were involved in discussions about care and kept up to date with any changes. The management team reviewed care plans monthly or more frequently if required. Families told us they spoke to staff regularly about their loved one

and were kept fully informed of any changes in their needs. One family member said, "Yes, we always get a phone call (if loved one is unwell)".

People were given the opportunity to participate in a range of varied activities which were provided by an activities coordinator employed by the service. The activities coordinator actively encouraged people to participate in games and activities through the day including singing, games, reading and arts and crafts. On the day of the inspection we saw people were given the opportunity to take part in a musical activity conducted by the activities coordinator and an external entertainer. Six people took part in this with obvious enjoyment. They were invited to choose percussion instruments which they played and sung along to the songs. Some people were supported to dance or to move to the music in their chairs. The music was chosen carefully with the audience in mind and reflected what they had enjoyed in previous sessions (hymns had been added). At the end of the session one person said, "That was good, wasn't it"?

Although the activities coordinator was enthusiastic about her role and aimed to meet people's needs, it was apparent that, on the whole the activities were not always valued and many people did not want to take part in them. Four people told us that they did not enjoy the activities offered and felt there was not enough to do. People's comments included, "There's not enough stimulation for people", "It's a bit boring, but it's alright. All there is to do is watch television. They do things like singsongs and bingo, but I don't like them" and "There are singsongs or playing cards. I'm not interested". The activities coordinator told us that they sometimes found it frustrating that people agreed to go out on trips and then changed their minds. They told us they, "tried to draw out people's interests through knowledge of their past life and interests." The activities coordinator also said they were flexible and although they planned activities they were prepared to "see what the mood is like and adapt plans accordingly". All of the people that took part in activities spoke positively about the activities provided.

People were supported to go on outings, such as to the seaside approximately twice per month and local school children would visit the people living at the home. Summer fetes and garden parties were held and people and their families were invited. Staff were responsive to people's religious beliefs and they were supported to maintain these if they wished. A local church group visited the home monthly and people were provided with communion if required.

The management team sought feedback from people's families on an informal basis when they met with them at the home, during telephone contact and via email correspondence. People and their families felt able to approach the registered manager at any time. One person said, "They [staff] will ask me how I feel about things." A family member told us, "They [registered manager] will always keep us updated". Residents meetings were held approximately every six weeks to discuss all aspects of care, update people on any changes in the home and to get people's view on the service provided. During these meetings people and their families were given the opportunity to talk about any concerns or issues they had and to share ideas about the development of the service.

The registered manager and provider also sought formal feedback through the use of quality assurance survey questionnaires sent six monthly to people, their families, professionals and staff. We looked at the outcome records from the latest two completed surveys for October 2016 and June 2017. Most responses to these surveys were positive. Where concerns or issues were raised, we saw that action had been taken. For example, in the survey completed in October 2016 a person had commented that they would like to be more involved in choices about the home decoration. In the survey completed in June 2017 it stated that 'People are happy the home is getting redecorated and they are involved in picking the colours for the lounges.'

The provider had a policy and arrangements in place to deal with complaints. They provided detailed

information on the action people could take if they were not satisfied with the service being provided. The information on how to make a complaint also included details of external organisations, such as the Care Quality Commission and the Local Government Ombudsman. Records showed the provider had not received any formal complaints since our last inspection. The acting manager told us any minor concerns which were identified by people, staff or relatives were dealt with immediately. Relatives told us if they had any concerns they would speak directly to the registered manager or a member of staff who were always very responsive to their comments. They were aware of how to complain should this be required.

Requires Improvement

# Is the service well-led?

## Our findings

People had mixed views on the management of the service, although all families felt that home was well-led. One person said, "I think they know what they are doing". Another person, when asked if they felt the home was well led, told us "No, it's not organised, the staff are so busy". A family member said, "Yes, our queries are always answered, they never try to hide anything". A healthcare professional who visited the service on the day of the inspection told us, "I am here to visit a person who I have never met. I was not introduced to the person, couldn't find any staff and I couldn't get hold of the person's paperwork or medicine record".

At the previous inspection in March 2016 we found that there were a lack of systems and processes in place to assess, monitor and improve the quality and safety of the service which was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found some action had been taken and systems and processes were now in place. However, these had failed to ensure that effective changes were made to improve the quality and safety of the service. For example, further improvements were still required around medicine management; ensuring systems to monitor staff training are robust in recognising staff training needs; ensuring staff are managing their time effectively to allow more engagement with people and identifying and acting on times when people were not being treated respectfully.

The lack of effective systems and processes in place to assess, monitor and improve the quality and safety of the services was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other quality assurance systems in place were effective. The acting manager carried out regular audits which included infection control, the cleanliness of the home, care planning and health and safety. There was also a system of audits in place to ensure that safety checks were made in respect of water temperatures, the medicine cupboard temperatures and fire safety. Other formal quality assurance systems were in place, including seeking the views of people and their families about the service they received. Where issues or concerns were identified, an action plan was created and managed through the regular meeting processes.

There was a clear management structure, which consisted of a registered manager, deputy manager (who was currently acting manager in the registered manager's absence), senior care staff and care staff. Staff understood the role each person played within this structure. The management team encouraged staff and people to raise issues of concern with them, which they acted upon. One staff member told us that, "both the registered and acting manager are accessible, I feel well supported". Another staff member said, "I would be very happy to go to the manager, I can talk to them at any time". A person said, "There's usually someone around to talk to when I need them". The provider had suitable arrangements in place to support the registered and acting manager, for example regular meetings. The acting manager told us that support was available to them from the provider.

The provider was engaged in running the service and their vision and values were built around 'Caring for

the individual'. The acting manager said that they aimed to, "Provide people with individualised care in a caring and safe environment". Care staff were aware of the provider's vision and values and how they related to their work. Regular staff meetings provided the opportunity for the acting manager to engage with staff and reinforce the provider's values and vision.

The acting manager told us they were aware of, and kept under review, the day to day culture in the service, including the attitudes and behaviour of the staff. This was done through observations of care provision and working alongside staff. Where concerns were noted these were addressed by the acting manager immediately (if required), during one to one meetings with staff and during staff meetings. Observations and feedback from staff showed the home had an open culture. Staff confirmed they were able to raise issues and make suggestions about the way the service was provided and these were taken seriously and discussed. There was a duty of candour policy in place, this required staff to be open with people and relatives when accidents or incidents occurred. The acting manager was able to demonstrate where incidents or accidents had occurred, these were discussed with people and their families where appropriate and put in writing.

Meadow House had up to date and appropriate policies in place to aid with the running of the service. For example, there was a whistle-blowing policy in place which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns, including the local authority or the Care Quality Commission if they felt it was necessary.

The acting manager understood their responsibilities and was aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. The rating from the previous inspection report was displayed in the reception area and on the provider's website.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect |
| Treatment of disease, disorder or injury | The failure to treat people with dignity and respect is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent |
| Treatment of disease, disorder or injury | The failure to gain the consent of the relevant person when providing care and treatment is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | The lack of effective systems and processes in place to assess, monitor and improve the quality and safety of the services was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |