Meadowbank Care Home Limited

Meadowbank Care

Inspection report

44 Braywick Road
Maidenhead
Berkshire
SL6 1DA

Tel: 01628781186
Website: www.meadowbankcare.com

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on the 17 March 2016 and was unannounced.

At our last comprehensive inspection of 18 April 2013 we found the service was not meeting the requirements of the regulations in place at the time in respect of safe staff recruitment. We followed this up at an inspection on the 31 July 2013 and found there were still issues outstanding with staff recruitment practice. We took compliance action and the provider submitted an action plan to address this in September 2013. We carried out a further inspection in February 2014 to check if appropriate action had been taken. We found the provider had made the necessary improvements and that the service met the requirements of the regulations in respect of staff recruitment.

Meadowbank Care is registered to provide care for up to twenty two older people, some of whom may live with dementia. Eighteen people were being cared for at the time of our visit.

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

We received consistently positive feedback about the service. "The standard of care is excellent" and "Absolutely excellent" were some of the comments made to us by people who lived in Meadowbank or their relatives. The only issues of concern expressed were in respect of the timing of the evening meal and bed time which were thought to be too early for some people and the frequency of activities outside of the home.

There were safeguarding procedures in place and staff received training on safeguarding vulnerable people. This meant staff had the skills and knowledge to recognise and respond to safeguarding concerns.

Risks to people were identified and managed well at the service so that people could be as independent as possible. A range of detailed risk assessments were in place to reduce the likelihood of injury or harm to people during the provision of their care.

We found set staffing levels were adequate to meet people's needs effectively. The commitment and team work of staff meant people were kept safe and ensured their needs were met appropriately.

Staff had been subject to a robust recruitment process. This made sure people were supported by staff that were suitable to work with them.

Staff received appropriate support through structured induction and supervision. Although formal supervision was only approximately two to three monthly, all the staff we spoke with said they felt able to

speak with the registered manager or senior staff at any time they needed to. There were also regular team meetings held to discuss issues and to support staff.

We looked at records of training for all staff. We found there was an on-going training programme to ensure staff gained and maintained the skills they required to ensure safe ways of working.

Care plans were in place to document people's needs and their preferences for how they wished to be supported. These were up to date and subject to review to take account of changes in people's needs over time.

Medicines were administered in line with safe practice. Staff who assisted people with their medicines received appropriate training to enable them to do so safely.

The service was managed effectively. The provider regularly checked quality of care at the service through audits and by giving people the opportunity to comment the service they received and/or observed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were sufficient staff available to meet people's assessed care needs.

Risks to people had been appropriately assessed as part of the care planning process and staff had been provided with clear guidance on the management of identified risk.

People were supported with their medicines in a safe way by staff that had been appropriately trained.

Is the service effective?

Good

The service was effective.

People received safe and effective care. Staff were supported to achieve this through structured induction, regular supervision and training.

People were encouraged to make decisions about their care and how it was provided. Decisions made on behalf of people who lacked capacity were made in their best interests.

People received the healthcare support they needed to maintain their health and well-being.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect and protected their privacy.

People were supported by staff who engaged positively with them whilst they provided care and support.

Staff knew people well and understood people's different needs and the
ways they liked their support provided. Staff gave people choices; however, some people felt the evening meal and bed-

time were too early.

Is the service responsive?

Good

The service was responsive.

There was a detailed care planning process which helped staff provide people's care in the way they wanted them to.

The service responded appropriately when people's needs changed. This ensured their needs continued to be met and that they could remain as independent as possible.

People were supported, when they wanted to take part in activities and social events in order to provide stimulation and entertainment. Some people told us they would like to have more frequent trips outside of the service.

Is the service well-led?

Good

The service was well-led

The registered manager and staff worked well together as a team.

Staff, relatives and people who used the service were able to talk with the manager and senior staff when they needed information, advice or support.

There were effective quality assurance systems in place to both monitor the quality of care provided and drive improvements within the service.

Meadowbank Care

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 was planned to check 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.

This inspection took place on 17 March 2016 and was unannounced. The inspection was carried out by one inspector 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.

Before the inspection we reviewed the Provider Information Record (PIR) for the service and previous inspection reports. The PIR is a form that asks the provider to give some key information about a service, what the service does well and improvements they plan to make. We also reviewed notifications and other information about the service we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

We contacted five healthcare professionals, for example, GPs, to seek their views about people's care. We spoke with 12 people who lived in Meadowbank Care and also to three family relatives and friends of people who lived in Meadowbank Care who were visiting the service.

Some people were unable to tell us about their experiences of living at Meadowbank Care because of their dementia. We carried out observations over lunch to help us understand the experience of people who could not talk with us.

We spoke with the registered manager and seven staff members.

We checked records about how people's care was provided. These included six people's care plans, medicines records, four staff files containing recruitment checks and details of induction for new staff and supervision and training spread-sheets for all staff.

Good

Is the service safe?

Our findings

People were supported by sufficient staff with the skills required for them to be able to do so safely. On the day of our inspection we found there were enough staff to provide people with the support they needed. Staffing levels were assessed taking into account the number and dependency level of people.

When we looked at staffing rotas and spoke with staff we found there were, in most cases, the planned number of staff to meet people's needs. When there were short notice absences of staff, we were told staff, including the management team, worked together to minimise any disruption to people's care routines. Staff displayed great commitment to Meadowbank and the people they provided care and support for. "Staff are all very helpful" was how one person put it. One healthcare professional told us that in their opinion; "There always seem to be ample staff to help all residents".

People's needs were being met. We saw staff managed busy times of the day well to ensure people's needs were met appropriately. For example, we carried out observations over lunchtime and found people received the support they required in a timely manner. People we spoke with told us staff were available when they needed assistance and we heard calls bells were answered promptly.

People were protected by the service's recruitment practice. There were appropriate recruitment processes in place. This meant people were supported by staff with the right skills and attributes. The four recruitment files we looked at contained the required documents; for example, a check for criminal convictions, written references and confirmation of their physical fitness to undertake care work.

People were protected when they needed support with their medicines. We looked at the service's medicines records and spoke with staff responsible for the administration of medicines. We found people's medicines were managed safely and in line with the provider's medicines policy. There were robust processes in place to ensure people received their medicines as prescribed. We saw medicines were given at the correct time and those medicine administration records (MAR) charts we saw were completed accurately to show the medicines people had received. The temperature of medicines storage were recorded.

Staff who undertook medicines administration were provided with appropriate initial and refresher training. We saw staff had undertaken a competency assessment before they administered medicines on their own. In their PIR the provider indicated there had been three medicines errors in the previous 12 months. We were told the competency assessment was re-done if any concerns were identified about the ability of staff to administer medicines safely.

Medicines which required additional controls because of their potential for abuse (controlled drugs) were stored securely. When a controlled drug was administered, the records showed the signature of two staff were recorded as required.

The service had policies and procedures, in place and being followed, in respect of safeguarding people

from abuse. These provided guidance for staff on the procedure to follow if they saw or suspected abuse. Staff had received training to help them to recognise and respond to signs of abuse. Staff were confident about the actions they would take if they felt someone was subject to abuse. Staff confirmed they had regular updates on safeguarding training.

Staff were advised of how to raise whistle- blowing concerns during their training on safeguarding people from abuse. This showed the home had created an atmosphere where staff could report issues they were concerned about and protect people from harm.

People were protected from avoidable risks. Risk assessments were in place to identify risks to people's health, safety and welfare. These set out how identified risks could be eliminated or reduced, to reduce the likelihood of injury or harm to people. These included, for example, the risks of falls and developing pressure damage. Risk assessments had also been written to assist in moving and handling people safely.

The building was well maintained. There were certificates in place which confirmed it complied with gas and electrical safety standards. Equipment to assist people with moving had been serviced and was safe to use.

The building was secure, with the principal access to the grounds electronically controlled and with an intercom system. There was a signing in and out book for visitors and staff. This meant people were protected from the risks associated with unrestricted access to the home.

Appropriate measures were in place to safeguard people from the risk of fire. Staff had been trained in fire safety awareness and first aid. Records showed fire drills had been carried out and. there were fire extinguishers and fire alarm test records in place. We also saw records of the testing of portable electrical appliances which had been undertaken.

Accidents and incidents were recorded appropriately at the home and appropriate action taken to prevent further injury to people.

Good

Is the service effective?

Our findings

People told us they felt their needs were met appropriately. "They know how I like things done and that is how they do it". A healthcare professional told us; "Meadowbank staff are capable and caring from what I see of them." One relative told us; "I am impressed by staff, very caring and welcoming, more than meets my expectation."

The staff we spoke with demonstrated a good understanding of people's needs. A significant number of the staff had worked at the home for several years and this had enabled them to build up a good understanding of individuals' needs. The people who lived in the home, who we spoke with, said staff were approachable if they had a problem.

All the health and social care professionals we received feedback from said they felt the staff were competent to carry out their roles. One told us that Meadowbank had made use of the visiting GP service to help manage winter pressures and avoid unnecessary hospital admissions.

People's healthcare needs were monitored and any changes in their health or well-being prompted a referral to their GP or other healthcare professionals. For example, people were referred to the dietician and speech and language therapists if staff had concerns about their wellbeing. Care plans identified any support people needed to keep them healthy and well. Staff maintained records of when they had supported people to attend healthcare appointments and the outcome of these. The records showed people routinely attended appointments with healthcare professionals, for example, dentists, opticians and hospital specialists. GPs visited the home regularly from the local surgery. This provided consistency for the people concerned and enabled the home to plan when people could have a routine consultation. Additional visits by the GP or access to other health services were arranged on an 'as required' basis. In feedback, GPs indicated they felt referrals made were not unreasonable or premature. One noted; "Visits are calm, appropriate and well-organised".

People received care and support from staff that were appropriately trained and supervised. We spoke with seven members of staff and with members of the management team. They were all positive about the training they received. Staff told us they had received a full induction when they started working. An induction checklist was completed for each new staff member.

Staff training records showed they were up to date with the training determined to be essential by the provider; for example moving and handling, safeguarding and infection control. The registered manager showed us the systems which helped them ensure staff were up to date with the appropriate training for their role and provided us with details of all the training provided and planned for staff.

All of the staff we spoke with said they had received some one to one formal supervision with a manager. People's experience of the frequency of formal supervision varied, some thought it was monthly and others three or six monthly. This variation in frequency was also identified in supervision records seen. However, all of the staff we spoke with all told us they felt supported and that they could approach the registered

manager or the provider at any time they needed to. They also confirmed they attended regular team meetings and we saw minutes of these.

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 in order 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

When we talked with staff about this, we found they had a good knowledge and understanding of the Mental Capacity Act 2005 (MCA) and had received relevant training. People were given choices in the way they wanted to be cared for. People's capacity was considered in care assessments in line with legal requirements, so staff knew the level of support they required while making decisions for themselves. If people did not have the capacity to make specific decisions around their care, staff involved their family or other healthcare professionals as appropriate to make a decision in their 'best interest' as required by the MCA.

When we spoke with staff we found they understood the importance of gaining consent from people before providing any care. Throughout the inspection, we observed staff spoke clearly and gently and waited for responses.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there were any restrictions to their freedom and liberty these had been authorised by the local authority as being required to protect the person from harm. We found that the registered manager understood when an application should be made to the relevant authority and how to submit one. In their PIR the provider informed us that five people were subject to Deprivation of Liberty restrictions and care records included appropriate records to support this.

We saw people had access to a regular supply of fluids. Where necessary people's food and fluid intakes were monitored and recorded to ensure they were appropriate for the maintenance of their health and well-being. People's care records also included details of any allergies or food intolerances, for example to gluten or personal lifestyle choices such as vegetarians.

We observed lunch and saw people had choice of where they ate. This could be the dining room, other communal areas of the home or in their own rooms if they preferred. The people we spoke with about food and staff assistance with meals said this was provided appropriately. We saw staff did not rush people when they were helping them eat and mealtimes appeared to be quite sociable occasions.

Good

Is the service caring?

Our findings

People felt the staff were caring. "Can't fault the home or the staff" and "Staff are all very helpful". Relatives had very positive views of the service and staff; "Very grateful- the staff are falling over backwards to support and help…" ,"We chose this home over several others and do not regret it", "standard of care is excellent".

We observed caring and compassionate support by staff, who understood people and knew their personal preferences. People appeared very relaxed in the company of staff, laughing and joking with them. We observed interactions between residents which demonstrated a sociable atmosphere in the communal areas of the home and especially at mealtimes.

When people asked for assistance, for example with going from a communal area to their rooms or to the toilet facilities staff responded very quickly and with patience. Personal records were stored and kept securely to prevent inappropriate access to them. Staff had received training during their induction and afterwards in the need to promote people's dignity and maintain their privacy. Where people needed to be supported to move, this was done in a way which promoted people's dignity, staff spoke with people throughout the whole process. Those relatives we spoke with did not raise any concerns about the preservation of people's privacy and dignity during their frequent visits.

People were able to express their views and were involved in making decisions about their care and support. They were able to say how they wanted to spend their day and what care and support they needed. People were able to make choices about their day to day lives for example if they wanted to spend time with others in one of the lounges, or if they preferred to spend time
alone in their rooms.

People were also involved in the running of the home. Resident and relatives meetings were held on a regular basis. These provided people with the forum to discuss any concerns, queries or make any suggestions. Minutes showed people spoke about, for example, activities, food options and staffing. Where people made suggestions, the provider and registered manager acted upon these wherever possible to do so.

Staff training included the implications for their care practice of providing care to people at the end of their lives. In their PIR the provider informed us there were at that time nine people with 'Do not attempt resuscitation (DNAR) forms/agreements in place. Thirteen people had information in their care plans which set out their advanced care preferences. When we looked at cards and letters of appreciation, we found a number which expressed gratitude and appreciation for the standard of care provided to relatives at the end of their lives. We were told by the provider that they would always try and meet people's wishes to remain in what was their home, rather than be transferred to hospital. This was unless their medical needs could not be appropriately met within the home, even with external specialist input.

People had access to advocacy services when they needed them. Advocates are people independent of the

service who help people make decisions about their care and promote their rights. We were told that where advocacy was required, most people had members of the family who did this on their behalf. There were however details of independent advocacy services available should anybody require them.

Good

Is the service responsive?

Our findings

People had their needs assessed before they moved to the home. Information had been sought from the person, their relatives and other professionals involved in their care. Information gained through the assessment was then used to draw up an individual care plan.

Care plans were personalised for each individual. They detailed daily routines and preferences specific to each person. There were sections in care plans about supporting people with different areas of daily living, for example, their health, dressing, washing, continence and mobility.

Care plans showed evidence of regular reviews taking place, involving the person concerned, their family where appropriate as well as key staff with knowledge of the person. This meant any changes to people's circumstances, for example, to their mobility or weight could be identified. This meant people whose needs had changed continued to receive appropriate support.

People received care and support from staff who knew them well. The relationships between staff and people who received support demonstrated dignity and respect at all times. We spoke with housekeeping staff about how care was taken of people's laundry. Staff showed concern for people's well-being in a caring and meaningful way, and they responded to their needs quickly. People told us they were happy with the care they received. "Staff are all very helpful" and "I am so grateful for the care staff give my mother" were two typically positive comments made to us.

Staff knew about people's individual communication needs. People could move freely around the home and choose where to spend their time. Staff respected people's choices to be in their rooms if they wished. There were areas in the building where people could sit and talk with visitors and family.

From what people, their relatives and staff told us and from what we observed during the inspection, including a lunchtime observation, people were in most cases offered choice. They could, within reason, determine how their care and support was provided. Staff were able to tell us in detail about people's needs and how they were met.

However, we found there was some dissatisfaction with one particular area of the home's operation and how it affected people's ability to choose. We were told by both people who lived in the home and relatives that the time of the evening meal was too early and that the choices offered at that time were rather restricted. Some relatives told us that there was also a knock-on effect from having an early evening meal, in that people were then being assisted to get ready for bed earlier and that effectively this could curtail the evening visiting time.

We discussed this with the registered manager who undertook to review the evening routine. They indicated this was not intentionally intended to restrict people's choice of when they ate or went to bed and that some people preferred to do both earlier rather than later. We were sent details, following the inspection, of an opportunity to discuss this which had been sent by the provider to relatives including an open day on the 29

March 2016 and an invitation to make contact by letter, telephone or e-mail if preferred.

We received positive feedback from healthcare professionals about the way the home responded to changes in people's health and wellbeing. Staff were very positive about the regular GP visits which took place and confirmed they provided information and any assistance required during them.

People's cultural and religious needs were taken into consideration, for example, services were held at the home led by local churches. Activities were arranged to reflect different cultural celebrations, important national events and other special occasions, for example Christmas and New Year.

There were procedures for making compliments and complaints about the service. Information about this was displayed prominently in the home. In the PIR, the provider recorded that in the last 12 months there had been 10 complaints managed under their formal complaints procedure, all had been resolved within 28 days of being made. The PIR gave details of action taken to address the complaints; for example the menus in the service had been changed and a full-time activity co-ordinator had been appointed in September 2015.

We observed activities being undertaken, staff actively involved people in decision making about what was happening, and offered choice. People told us whilst they valued the activities programme, they would welcome more opportunities for trips out of the home. We were told this was something the registered manager and activities co-ordinator were already looking at to expand over the coming months.

We had a very interesting discussion with the activities co-ordinator who outlined a very varied and imaginative activities programme. This was very well-documented and included individual activities records for each person. There was physiotherapy each Tuesday, individual service users had the opportunity, for example to help peel vegetables or do ironing or gardening. This helped them retain skills and feel they were actively continuing with activities which had been and still were important to them. One to one sessions were carried out; some of these included helping people retain and practice basic skills, for example writing and 'maths'. There was also a "coffee club" and various craft activities like knitting and art. The activity co-ordinator confirmed they had access to sufficient resources and that the service were members of recognised activity resource/training organisations.

The activity co-ordinator was very positive about the support they received from the registered manager and provider, for example through specialist training events and conferences.

Good

Is the service well-led?

Our findings

When we spoke with people who used the service, relatives and staff they were very supportive of the registered manager. Throughout our visit we observed that staff, visitors and people who used the service were comfortable approaching the registered manager. We saw staff consistently treated people with dignity, respect and compassion. There was a relaxed and informal 'feel' to the home.

The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). They had submitted notifications to us, in a timely manner, about any events or incidents they were required by law to tell us about. We used this information to monitor the service and ensure they responded appropriately to keep people safe. The provider was aware of the new requirements following the implementation of the Care Act 2014, including the duty of candour. This is where a registered person must act in an open and transparent way in relation to the care and treatment provided.

The home worked in partnership with health and social care professionals to promote people's well-being. We received positive feedback about the liaison and co-operation between the service and primary health community services.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. There were regular quality assurance audits undertaken which looked at how the service performed as a whole. We were provided details of an action plan drawn up between the service and the local authority to address any issues and monitor performance.

Records were well maintained at the service. Records or information we asked to see were provided promptly. Staff had access to general operating policies and procedures on areas of practice such as safeguarding, restraint, whistle blowing and safe handling of medication. This meant staff had ready access to the detailed guidance they required.

We found there were good communication systems at the service. Residents' meetings were held regularly. These provided an opportunity for communication between people who use the service and staff about concerns or improvements that were being made. One person told us the registered manager did respond to comments made and that they were; "Absolutely excellent". We saw minutes and action plans following a resident's meeting held on the 1st February 2016 and a relative's meeting held on the 3rd March 2016. These included, for example, confirming choice of hot meals at the evening meal and details of outings outside the service for residents.

Staff and the registered manager shared information in a variety of ways, for example face to face, during handovers between shifts and in team meetings. There was a clear management structure and staff knew who to contact in the event of any emergency or concerns. Staff felt able to raise concerns and they were confident concerns would be acted on. One told us "The manager is very approachable".

Staff gave positive comments when asked if they felt supported. One staff member told us they were able to

speak up and voice their views and raise any concerns. Another told us "We have regular staff meetings and daily handovers of care." Staff commented on how well they worked together as a team. We found staff interacted with the registered manager and each other to support with everyday tasks to ensure people were cared for in a timely manner.