A & I Care Home Ltd

The Meadows Residential Care Home

Inspection report

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15 February 2017

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Ratings

Overall rating for this service	Good
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 13 and 14 September 2016. A breach of a legal requirement was found because an incident was not raised as a safeguarding alert or reported to the Care Quality Commission as abuse or an allegation of abuse as required under the Regulations. This may have placed people at risk of unsafe care. After the comprehensive inspection, the provider submitted an action plan detailing what they would do to meet the legal requirement in relation to the breach.

We undertook this focused inspection on15 February 2017 to check that the provider had followed their plan and to confirm that they now met the legal requirement. This report only covers our findings in relation to the requirement. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Meadows Residential Care Home on our website at www.cqc.org.uk.

The Meadows Residential Care Home provides care and accommodation for up to 24 older people who may also have dementia care needs. At the time of our inspection there were 24 people living at the service.

The owner was also the provider. The provider, his wife and daughter were part of the management team and were active in overseeing the service. The registered manager had been in post since January 2014. 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.

At our focused inspection on 15 February 2017, we found that the provider had not followed all of their plan of action, dated 20 November 2016, and that the legal requirement had not been fully met.

The provider failed to raise a safeguarding alert and notify CQC on one occasion, however they had sent through seven notifications appropriately and as required.

Incidents and accidents were recorded appropriately.

The service had updated its' notification policy and staff had read it.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service well-led?

Requires Improvement

The service was not always well led.

We found the provider had taken action to improve the safety of people using the service, however, they failed to raise a safeguarding alert with the local authority and notify the Care Quality Commission.

The service had sent through seven notifications appropriately and as required.

Incidents and accidents were recorded appropriately.

The service had updated the notification policy and staff had read it.

We could not improve the rating for well led from requires improvement because the provider had not fully complied with the regulation. To improve the rating requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

The Meadows Residential Care 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.

We undertook an unannounced focused inspection of The Meadows Residential Care Home on 15 February 2017. This inspection was carried out to check that improvements to meet the legal requirement planned by the provider after our 13 and 14 September 2016 inspection had been made. The service was inspected against one of the five questions we ask about services: Is the service well led. This was because the service was not meeting some legal requirements.

Prior to the inspection, we looked at all the information we held on the service including the last inspection report, the provider's action plan which set out the action they stated they would take to meet the legal requirement, notifications of significant events and safeguarding alerts. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also contacted the local authority's safeguarding team for feedback.

The inspection was undertaken by a single inspector. During the inspection, we spoke with the registered manager and the provider. We looked at the care plans for three people, statutory notifications and incident and accident records.

Requires Improvement

Is the service well-led?

Our findings

At the inspection on 13 and 14 September 2016, we saw the service had not raised an incident as a safeguarding alert or reported it to the Care Quality Commission (CQC). This meant we could not be sure people were being protected from harm.

Prior to the inspection on the 15 February 2017, we reviewed the information we held about the service. We saw that since the last inspection the service had sent notifications to inform CQC of four deaths, one Deprivation of Liberty Safeguards (DoLS) application and two safeguarding alerts in September and October 2016. However, on 01 February 2017, the local authority informed us of a safeguarding alert that the service had not yet notified us about. When we spoke with the registered manager, they indicated this was because they were waiting for a root cause analysis of the incident to be completed. We explained the requirement for notifications to be completed in a timely manner and this resulted in the registered manager sending a notification through to CQC immediately.

At the inspection on the 15 February 2017, the provider and the registered manager told us they were clear that the registered manager must submit any notifications as required by the Regulations without delay, and we saw that in all but one instance the service had submitted notifications as required.

At the inspection, there was evidence the provider had made a number of improvements as detailed in the action plan dated 20 November 2016. They had created a compliance / notification policy regarding notifications to CQC and we saw that staff had signed the document to indicate they had read it. Additionally, we saw a new file had been created to record all notifications made to the local authority, CQC and the police. The registered manager and provider told us they had notified CQC appropriately of all other issues and sent through notifications. Since the last inspection, the service had made seven notifications to CQC.

We looked at the care plans of the three people where a safeguarding issue had been raised and saw the provider had taken appropriate action and involved other professionals to minimise harm to people using the service. We also looked at the service's incident and accident records to check incidents and accidents were being recorded and referred on to the appropriate agency if required, and we were satisfied incidents and accidents were well recorded with a follow on plan of action.

We saw safeguarding alerts, incidents and accidents and complaints were being audited monthly.