Meadows Edge Care Home Limited

Meadows Edge Care Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on 02 June 2015 and was unannounced.

Meadows Edge is registered to provide accommodation and personal care for up to 40 older people or people living with a dementia. There were 38 people living at the service on the day of our inspection.

The service has had no registered manager for 12 months. 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 last inspection in May 2014 we asked the registered provider to take action to make improvements to the care and welfare of people, medicines management, supporting staff, safe storage of records and how they ensured the quality of the service was being maintained.

Summary of findings

The provider did not send us an action plan to tell us how these improvements would be made. On this inspection we found that the registered provider had not made all of the required improvements.

At this inspection we found that the provider was not meeting our legal requirements for, medicines and governance. You can see what action we told the registered provider to take at the back of the full version of the report.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect themselves or others. One person living at the service had their freedom lawfully restricted under a DoLS authorisation.

Staff understood safeguarding issues and knew how to recognise and report any concerns in order to keep people safe from harm. However, people's safety was not always maintained, because staff did not always follow safe medicine administration and storage procedures and people were at risk of not receiving their medicine. Also, the provider did not always ensure that the service was consistently clean and that safe infection control procedures were adhered to. Furthermore, people were at risk of using equipment that was not clean or not fit for purpose.

People were cared for by staff who were supported to undertake training to improve their knowledge and skills to perform their roles and responsibilities. People had their healthcare needs identified and were able to access healthcare professionals such as their GP or psychiatrist. Staff knew how to access specialist professional help when needed.

People and their relatives told us that staff were kind and caring and we saw some examples of good care practice. However, we found that people were not always treated with dignity and respect. People were not always enabled to follow their hobbies and pastimes and people were not supported to maintain their independence.

The registered provider did not have systems in place to monitor the effectiveness of the care and treatment people received.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Staff did not always follow correct procedures when administering medicine.

Staff undertook risk assessments and knew how to keep people safe.

Requires Improvement

Is the service effective?
The service was not always effective.

Staff did not always complete their shadow induction period before they worked unsupervised.

People were cared for by staff that were supported to undertake further training to carry out their roles and responsibilities.

Requires Improvement

Is the service caring?
The service was not always caring.

Staff did not always work in ways that maintained people's dignity.

Staff treated people with kindness and compassion if they were distressed and upset.

Requires Improvement

Is the service responsive?
The service was not always responsive.

Staff did not ensure that people were occupied in meaningful activities.

People had their care needs assessed and personalised care plans were introduced.

Requires Improvement

Is the service well-led?
The service was not always well-led.

The provider did not have systems in place to monitor the quality of the service.

Staff and people found the acting manager approachable and felt able to raise concerns with them.

Requires Improvement

Meadows Edge 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 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.

The inspection took place on 02 June 2015 and was unannounced.

The inspection team was made up of three inspectors.

Before the inspection we looked at previous inspection reports and we reviewed other information that we held about the service such as notifications, which are events which happened in the service that the registered provider is required to tell us about, and information that had been sent to us by other agencies. We used this information to help plan our inspection

We looked at a range of records related to the running of and the quality of the service. This included staff training information and staff meeting minutes.

During our inspection we spoke with the acting manager, the deputy manager, a registered nurse, the housekeeper, four care staff, the cook and the activity coordinator. We also spoke with six people who lived at the service, two visiting health and social care professionals and three visiting relatives. In addition, we observed staff interacting with people in communal areas, providing care and support.

We looked at the care plans or daily care records for eight people. A care plan provides staff with detailed information and guidance on how to meet a person's assessed social and health care needs. In addition, we undertook a Short Observation Framework for Inspection (SOFI) at lunchtime. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.'

We also asked the local authority and commissioners of healthcare services for information in order to get their view on the quality of care provided by the service.

Requires Improvement

Is the service safe?

Our findings

During our inspection in May 2014 we found that the registered person did not protect service users against the risks associated with the unsafe use and management of medicines. This meant that people were at risk of harm from the unsafe use and management of medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered provider did not send us an action plan to set out how they planned to address the areas highlighted. At this inspection we found that improvements had not been made.

For example, we looked the medicine administration records (MAR) charts for 13 people, stock level recording records and relevant care documents and found that people were not receiving their medicines safely. There were unaccounted for gaps in the MAR charts when medicines had not been given, one person had the wrong dose of antibiotics written on their MAR chart by nursing staff meaning that the person only took half the prescribed dose, and another person's medication was out of stock and they went without their medicine for 24 hours. There were no guidance or information sheets for medicines prescribed on an as required basis to give staff clear instruction on how to give these medicines in a safe and consistent way to meet a person's individual needs.

Furthermore, the stock balance record of medicines received, did not match the stock levels in the service. This made it unclear if people received their medicine correctly. When a person had their medication through a slow release skin patch, records were not kept to identify the rotation of skin sites to be used. This left the person at risk of skin rashes and irritation. Medicine allergies were recorded on MAR charts and identification sheets in their medicine file, but there were discrepancies between them. Therefore, people were not always protected against the risk of receiving medicines that they were allergic to.

We found that the registered person had not protected people against the risks associated with the unsafe use and management of medicines. This was in breach of regulation 12 (2) (f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager told us that they had taken a proactive approach to make improvements to the standards of cleanliness in the service and had requested that the local authority infection control team undertake a full audit of the service. This had been scheduled for the week following our inspection. Three staff had taken on the role of infection control champions and would be attending the local infection control link practitioner's network run by the local authority. The link practitioners would train the remaining staff in infection control best practice.

However, the head housekeeper told us of the challenges they faced in maintaining a good standard of cleanliness in the service, due to broken and faulty equipment. We looked at all areas of the service and found evidence that standards of cleanliness were not maintained throughout the service. For example, each bedroom was deep cleaned once a week, but some carpets were so badly soiled that they would not come clean and had a lingering offensive odour. In addition, we found that the laundry was dirty and the linen bins were damaged and soiled inside and clean and dirty laundry were stored side by side increasing the risk of cross contamination. Furthermore, toilets, a hoist sling and seat cushions for shared use were soiled. This meant that the registered provider did not protect people from the risk of cross infection from contaminated equipment.

A range of risk assessments had been completed for each person for different aspects of care such as nutrition, moving and handling and falls. Care plans were in place to enable staff to reduce the risk and maintain a person's safety. There were safety and health information leaflets available on how to keep a person living with dementia safe or how to reduce the risk of falls. There were systems in place to support staff when the acting manager was not on duty. Staff had access to contingency plans to be actioned in an emergency situation such as a fire or electrical failure. We saw that people had a personal emergency evacuation plan that detailed the safest way to evacuate them from the service.

People told us that they felt safe living in the service. One person said, "They come to you straight away when called, and handle you properly. They are nice to us." In addition, the relatives we spoke with felt their loved ones were safe living in the service.

Staff were aware of safeguarding issues and knew how identify risks and signs of abuse and how to report their concerns. One staff member said, "If I saw abuse or neglect I would escalate my concerns to the manager or the county

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Is the service safe?

council or CQC." Another staff member said, "The manager told us that we can always speak to her in private or leave an anonymous note." The acting manager investigated safeguarding concerns raised by the local safeguarding authority (LSA) and shared lessons learnt with all staff. The acting manager told us that they interviewed relevant staff and provided feedback to people and their relatives and sent a report to LSA.

There was a robust recruitment processes in place that ensured all necessary safety checks were completed to ensure that a prospective staff member was suitable before they were appointed to post. We found no evidence that the registered provider had a system to calculate the dependency level of people to inform safe staffing levels. However, the acting manager told us that they had recognised that there were significant shortfalls in staffing levels as some staff worked extra shifts. Therefore, they had appointed 15 new members of staff to post. In addition the head housekeeper told us how low staffing levels at the weekend were a challenge to competently cover their duties. Staff and relatives commented that staffing levels had improved since the acting manager had been appointed. A staff member told us, "The new manager is addressing the issues of staffing." And a relative said, "The staff levels have improved as more staff are coming in."

Requires Improvement

Is the service effective?

Our findings

During our inspection in May 2014 we found that the registered person did not have suitable arrangements in place to ensure that staff had received appropriate training and appraisal for their role. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered provider did not send us an action plan which set out how they planned to address the areas highlighted. At this inspection we found that some improvements had been made and the provider was no longer in breach of the regulation.

We were informed that staff had undertaken training in key areas such as moving and handling, fire safety and mental capacity. However, we were unable to find evidence to support how many staff had attended each event as training records were not kept up to date. The acting manager told us that all care staff were supported to work towards a nationally recognised qualification in adult social care. In addition nursing staff had undertaken additional training in specialist subjects such as the care of a person who received their medicines through a syringe driver. Other staff had attended a training session the day before our inspection to enable them to understand what it was like for a person living with a visual impairment. We found that future training sessions had been identified to support staff to deliver best practice in areas such as infection control and tissue viability.

There was an eight week induction programme in place, however new staff were not properly supervised. For example, we saw a new member of staff supporting someone with swallowing difficulties to eat their meal but they had not been shown how to assist this person beforehand.

A programme of supervision and appraisal had recently been introduced. To date all nursing and care staff had completed a pre-appraisal form, but had not yet received an appraisal. In addition, some staff had attended a group supervision session in March 2015 on nutrition. The comments on the pre-appraisal form were positive about the opportunities staff wanted to have to make improvements to the service. For example, training in the care of a person living with advanced dementia and taking on extra responsibilities as a senior carer.

We spoke with the acting manager and nursing and care staff about their understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The MCA is used to protect people who might not be able to make informed decisions on their own about the care or treatment they receive. Where it is judged that a person lacks capacity then it requires that a person making a decision on their behalf does so in their best interests. It was unclear how many staff were knowledgeable about these processes as training records had not been maintained. We saw there was a policy to guide staff in undertaking MCA assessments, but the acting manager was unable to provide us with a DoLS policy to support staff in the DoLS process. We found that staff were aware that two people were cared for under a DoLS authorisation and the conditions of that authorisation. We found that all the assessments and reviews were undertaken in their best interest.

People told us that staff asked for their agreement before they received care and treatment. One person said, “They talk to me in a way I can understand and they tell me what they are going to do before they do it.” Furthermore, staff told us that they always asked a person before they gave them personal care. One staff member said, “I always tell them what I’m doing before I do it.” Where people lacked capacity to give their consent to care and treatment, staff had undertaken a two stage capacity assessment and had acted in the person’s best interest. For example, assessments had been undertaken for people to receive their medicine and have personal care. However, not all capacity assessments were up to date and some had not been reviewed since 2012. This meant that there was a risk that capacity assessments did not reflect a person’s current ability to make informed decisions about their care and treatment.

We observed the lunch and tea time meal experience and saw that most people were offered a choice and alternatives to the menu where available. However, we did note that where a person required a soft diet that they were not offered a choice and were given the same pureed meal for lunch and tea. People, were offered a choice of drink with their meal and jugs of fruit juice were available throughout the day in the lounge.

Where a person was unable to take food and drink orally they received all their nutrition and hydration needs and medication through a special tube inserted directly in to

Requires Improvement

Is the service effective?

their stomach. Care staff told us that they were supported by a dietician and the person's GP to manage this process effectively. Furthermore, there was an out of hours contact number if staff encountered any problems with the feeding tube.

We spoke with the cook who told us that people had their nutritional needs assessed when they first moved into the service and their food and drink preferences were recorded. However, when a person's nutritional status changed the kitchen copy of their nutritional record was not amended. This meant that the information kitchen staff had was not up to date and there was a risk that a person could receive food that was no longer appropriate for them.

People had access to healthcare services such as their GP, speech and language therapist and dietician. During our inspection several people were seen by the community nursing team and an occupational therapist. We found where a person had special health care needs the service ensured people were seen by an appropriate health professional. For example, where a person was exhibiting challenging behaviour, they had been referred to their community psychiatric nurse for a review and a multiprofessional meeting had been held to discuss how best to care for this person in their best interest. Relatives told us that they had confidence in the staff ability to respond to their loved ones needs if they became unwell and also keep their family informed.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were caring and when they undertook personal care they maintained their privacy and dignity. In addition, some people told us that they were well looked after by care staff. One person said, "We are looked after very well." We received mixed responses from the relatives we spoke with about the care their loved ones received. One person's relatives said, "She seems content and the staff do their best for her." However, another person's relative told us, "I haven't seen carers go out of their way to be particularly caring."

Some members of care staff did not speak with people when attending to their needs and some aspects of care were task orientated. For example, we watched a member of staff remove protective tabards from several people after lunch and did not interact or communicate with them in any way. This meant that people were not respected as individuals. We observed another person occupy themselves after lunch by stacking together the plates and glasses on their table. A staff member approached them, smiled, removed the cups and plates and did not speak with the person. The person then sat at the table on their own hugging a soft toy. This meant that there was a lack of communication and respect based on the preceding evidence. Although several people had difficulty communicating and expressing their needs verbally, we saw no evidence of staff using alternative forms of non-verbal communication.

Staff told us that dignity was regularly discussed with all staff. One recently appointed member of care staff said that dignity had been covered in their induction. In addition, a registered nurse told us that any concerns that a person was not being treated with dignity were discussed with the staff involved. We observed staff knock on a person's bedroom door and on a toilet door before they entered. One housekeeper told us that they always respected a person when they were in their bedroom. They said, "I knock the door and ask if they want their room cleaned." However, we also found that staff did not respect people's right to privacy. We overheard care staff shouting to each other through a toilet door while a person was using the toilet.

Our observations of how people were treated by staff were mixed. We saw examples of good caring practice such as when a staff member was sat with a person who was upset and agitated and gently spoke with the person to calm them down. They later told us, "Communication is important, just chat to them. If they have no verbal communication, sit square on and make sure you have eye contact." Another person had a birthday, and staff helped them to celebrate with a cake and staff and people sang happy birthday to them.

However, we saw that there was a risk of social isolation for some people. For example, several people were cared for in bed, but we did not see staff spend time with them other than when they provided personal care. One person was sat at a table on their own facing a wall at lunchtime. Staff told us that the person could become aggressive. There were no support mechanisms in place to give this person a sense of belonging.

We were informed by care staff that where able people were supported to express their views and were actively involved in making decisions about their care, treatment and support. However, most of the people that we spoke with could not recall being involved in planning their care. Where people were unable to express their views on their care and treatment we found evidence in their care file that staff had discussed their care with close family. One relative that we spoke with said that they had been involved in writing their parent's care plan. In addition, care plans had been reviewed and staff had recorded when a person was unable to sign their agreement.

We found that people had care plans developed to meet their individual needs. For example, one person expressed concern that people may wander into their bedroom uninvited. They had a personalised risk assessment and care plan to have their bedroom door locked.

There was no information available for people or their relatives to access on the role of an advocate. An advocate can be appointed to support a person through complex decision making, such as permanently moving into the care home. The acting manager told us that they would order leaflets from the local advocacy service.

Requires Improvement

Is the service responsive?

Our findings

During our inspection in May 2014 we found that the registered person had not taken proper steps to ensure that each service user is protected against the risks of receiving care and treatment that is in appropriate or unsafe. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered provider did not send us an action plan to set out how they planned to address the areas highlighted. At this inspection we found that improvements had been made and the registered provider was no longer in breach of the regulation.

People had their care needs assessed and personalised care plans were introduced to outline the care they received. For example, where a person had a fall there was a body map identifying the areas that the person had injured so as staff could monitor their recovery.

However, we observed procedures where staff did not follow best practice guidance. For example, we saw where a person was transferred from a wheelchair to an armchair that the wheelchair brake was not engaged and the wheelchair rolled away before the person was lowered into it. This incident happened despite care staff having received safe moving and handling training. We saw where a person was at risk of falling out of bed that a mattress was positioned on the floor at the side of their bed to break their fall. However, care staff did not ensure that the person would fall the shortest distance as their bed height was not set at the lowest level. Furthermore, if the person wanted to summon help their call buzzer by their bed was broken and a second buzzer was tied round the handle on their wardrobe door and out of their reach.

There were measures in place in the open plan lounge and dining room to help orientate people and keep them up to date with events. For example, there was information on meal times and a board with the date, season and weather.

The main ground floor corridor had been renamed memory lane and had several pictures of times gone by to stimulate people to reminiscence about their past life. There was an area of the lounge that had several items relevant to domestic and parenting activities to help people living with dementia occupy their time. We saw one person caring for a doll and found that other people enjoyed vacuuming with the housekeepers, folding laundry or setting the tables for lunch. We saw that three people had a daily newspaper. Supporting a person living with dementia to care for a doll or undertake domestic tasks can lead to improvements in communication and a reduction in episodes of distress.

The activity coordinator had been in post for two months. They spoke with enthusiasm about their plans to improve people's wellbeing through activities. They had introduced a folder with information on people's life and social histories to help them plan activities around individual likes and preferences and had started to keep a daily record of how people had spent their time. We saw that most activities were focussed on the individual pastimes rather than group events. For example, some people had personalised their place mat for the dinner table with pictures and drawings that were significant to their past.

After lunch most people sat in the lounge sleeping in their chair, watching a quiz on television or listening to the radio. The activity coordinator sat with some people individually and chatted with them. The activity coordinator told us that there were no evening or weekend activities for people to engage in. We observed that when the activity coordinator went off duty and care staff prepared for the tea time meal that several people became unsettled and agitated as they did not have anything to occupy them or staff to engage with.

There was nowhere for people and their relatives to sit outside and the grounds were unsafe for people to walk in due to trip hazards. For example, there was a broken man hole cover and piles of rubble in the grounds and construction materials were lying about in a central courtyard. In addition, there were no quiet areas for private conversation other than people's bedrooms.

Information on how to make a complaint was on display at the main entrance. However most people did not access this area of the service. People told us that they would talk with staff if they had concerns, but no one that we spoke with had made a complaint. There was no evidence of a complaints log being maintained.

Requires Improvement

Is the service well-led?

Our findings

During our inspection in May 2014 we found that the registered person did not have systems in place to effectively monitor and assess the quality of services that people received. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered provider did not send us an action plan to set out how they planned to address the areas highlighted. At this inspection we found that improvements had not been made.

For example, the registered provider did not always notify CQC of events notifiable under regulation, such as when a person had a standard DoLS authorisation approved or when the previous registered manager had left the service. In addition, there was little evidence that the quality of the service had been monitored as the registered provider was unable to provide us with any audit undertaken since our last inspection. The recently appointed acting manager had developed audit tools for medicines and care plans but these had still to be piloted. The room cleaning checklist used by housekeeping staff was not up to date and laundry cleaning schedules had not been completed since March 2015.

There was evidence that the lack of audit meant that faulty equipment was not identified and staff and people were put at risk of injury. For example, a mechanical hoist and sling that were in regular use were not compatible with each other. Care staff had to manoeuvre the hoist manually as the mechanism was faulty. We found that the hoist was old and not fit for purpose. This meant that the registered provider did not monitor that staff had access to moving and handling equipment that was fit for use.

We found that the registered person did not have systems in place to effectively monitor and assess the quality of services that people received. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection in May 2014 we found that the registered person did not ensure that records in relation to the care and treatment of each service user were kept securely. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered provider did not send us an action plan which set out how they planned to address the areas highlighted. At this inspection we found that improvements had been made and records were stored in a locked office when not in use. This meant that the registered provider was no longer in breach of the regulation.

A relatives meeting was held in May 2015. Fourteen relatives attended and all received a copy of the minutes. One relative told us, “The manager is trying to make changes, activities have increased.” Furthermore, we saw results of a questionnaire completed by people and their relatives in May 2015. Overall people and their relatives responded positively and were happy with the service and said the care was good. However, one person commented that they were “constantly disrupted by wandering residents who do not leave.”

We were informed that the atmosphere among staff had improved since the acting manager came into post. Senior carers had taken on a more senior and responsible role. Staff told us that they had all recently attended a meeting with the acting manager and deputy and had discussed all the areas of the service that that required improvement. Staff that were unable to attend were provided with a newsletter that briefed them on the proposed changes to the service. Feedback from staff was positive and staff spoke positively about the acting manager. We received comments such as, “Very approachable and appreciates what we do.” And, “Enjoying changes with new manager, an asset to the team.”

Staff were aware of the whistle blowing policy and knew how to raise concerns about the care people received with their acting manager, local authority and CQC.

The acting manager had forged links with the local further education college and a young person on an apprenticeship programme and volunteers had been identified to support people in activities, such as reading and painting.

The service had no registered manager for 12 months and the deputy manager worked permanent night duty. This meant that the service was without visible leadership during this time. The acting manager told us that they intended to register as manager with CQC.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not protected people against the risks associated with the unsafe use and management of medicines.

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not have systems in place to effectively monitor and assess the quality of services that people received.