Mr Farhad Pardhan

Meadowview Nursing 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?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out our unannounced inspection on 6 and 9 of December 2016.

Meadowview Nursing Home supports up to 42 people who require personal and nursing care. This includes people living with dementia. At the time of our visit there were 32 people using the service.

There was a manager in post who had applied to the Care Quality Commission (CQC) to become the 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.

At our inspection 27 January 2016 we found systems to monitor and improve the quality of the service were not effective. At this inspection we found systems were still not effective as they had not identified the issues we found during our inspection.

Where risks to people had been identified they did not always receive care and support to manage the risk. Records did not always contain up to date and consistent information to ensure people received support to meet their needs.

People did not always receive support that was person-centred and in line with guidance in their care plans. People had limited access to activities that interested them.

Everyone we spoke with was positive about the manager and the changes they had made. Staff felt supported and listened to by the manager, who promoted a positive, person-centred culture.

Staff were caring and showed compassion when supporting people. Staff knew people well and supported people to develop friendships.

Medicines were managed safely and people received their medicines as prescribed.

There were sufficient staff to meet people's needs. Staff received training and support to ensure they had the skills and knowledge to meet people's needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible in line with the principles of the Mental Capacity Act 2005 (MCA).

People enjoyed the food. Where people were at risk of weight loss this was monitored and action taken to improve people's well-being.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. We are considering what action we will take.

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.

Medicines were stored safely and people received their medicines as prescribed. There were sometimes delays in obtaining people's medicines.

Risks to people were identified and there was guidance to enable staff to support people to manage the risk.

Systems for monitoring the safety of equipment were not always effective.

Is the service effective?

Good

The service was effective.

People were supported in line with principles of the Mental Capacity Act 2005 (MCA).

Staff were supported and had access to regular supervisions. Staff completed regular training to ensure they had the skills and knowledge to meet people's needs.

People received food and drink to meet their needs. People's weights were monitored and action taken when needed.

Is the service caring?

Good

The service was caring.

People were supported by staff who showed kindness and compassion.

Staff encouraged people to maintain their independence.

People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive support in line with their care plans.

Care records were not always consistent and up to date.

People were supported to develop meaningful relationships.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems to monitor and improve the service were not always effective.

The manager promoted a person centred culture that put people at the centre of all the service did.

The manager had developed an action plan identifying areas for improvement in the service.

Meadowview Nursing 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.

This inspection took place on 6 and 9 December 2016 and was unannounced.

The inspection was carried out 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.

Prior to the inspection we looked at previous inspection reports and notifications. A notification is information about important events which the provider is required to send us by law. We also contacted health and social care professionals and the commissioners of the service for feedback about the service.

During the inspection we spoke with five people who use the service and seven relatives. We spoke with the provider, the manager, the deputy manager, the clinical lead, a nurse, four care staff, the chef, the activity coordinator and the laundry assistant. We observed staff interactions with people and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at nine people's care records, medicine administration records (MAR), four staff files and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Where risks to people were assessed and management plans in place we found guidance in people's care plans was not always followed. For example, one person was identified at risk of choking. The person had been referred to speech and language therapy (SALT). The SALT guidance stated the person should not have a cup with a lid or a straw due to the risk of choking. We saw this person had a cup with a lid. The person's care plan also stated the person should be supervised when eating. The person sat in the dining room and no member of staff was present during the meal.

We spoke to the manager about this person and they took action to ensure the person had drinks in cups without a lid or straw. The manager advised us that the care plan had been reviewed and now stated the person required 'distant supervision' as stated in the SALT guidance. This did not give clear guidance to staff in relation to whether the person could be left in a room alone when eating.

People's care plans did not always contain accurate, up to date risk assessments in relation to the use of equipment. For example, one person's care plan stated the person had bed rails with protective bumpers and a crash mat to reduce the risk of falls. We saw this person in bed during the inspection and the bumpers were not in place and the crash mat was at the side of a chair. This put the person at increased risk of harming themselves on the bed rail.

We spoke to the deputy manager who told us the person threw the protective bumpers off and that the crash mat was no longer required. Following the inspection we spoke to the manager who told us they would consider what action they would take to minimise the risk of harm to the person.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People and relatives told us they felt safe. One person told us how staff had supported them to reduce the number of falls they had experienced. One relative told us, "This is the only home that has kept her safe". The relative told us this was the fifth home the person had lived in and the relative felt the person had been thoroughly assessed and was now safe.

Staff had completed training in safeguarding vulnerable adults and understood their responsibilities to identify and report safeguarding concerns. One member of staff told us, "I would raise it with the nurse in charge, if they do nothing then I would go to [deputy manager] and then the manager. If she did nothing then I would whistle blow. The resident s welfare is more important than me keeping my mouth shut". Staff knew the outside agencies they could go to in order to raise concerns. One member of staff said, "I can make an online safeguarding form. We can come to you guys (Care Quality Commission) or Oxfordshire County Council".

The manager had recently completed one to one sessions with some staff to ensure they understood their responsibilities to report concerns. This had resulted in one member of staff raising a safeguarding concern.

The provider had a safeguarding policy and procedure in place. The manager had raised concerns appropriately with Oxfordshire safeguarding team and notified the Care Quality Commission (CQC). Records showed that concerns had been investigated and appropriate action taken as a result.

Nobody we spoke with had any concerns about staffing levels. There were sufficient staff to meet people's needs. During the inspection we saw staff were not rushed. Call bells were answered promptly. When people needed support this was responded to in a timely manner. People who chose to remain in their rooms were visited regularly by staff. The manager had a dependency assessment tool for each person. This was reviewed monthly and was used to enable the manager to determine safe staffing levels. We saw these levels were maintained.

Medicines were managed safely. People's medicine administration records (MAR) included people's photographs, allergies and details of all prescribed medicines. Where people required a clinical observation prior to receiving specific medicines these were completed and recorded. Some people were prescribed 'as required' (PRN) medicines. There were protocols in place to ensure people received PRN medicines when they needed them.

Medicines were administered safely. The nurse checked all details on people's prescribed medicine against the details on MAR. Where people required PRN medicines the nurse checked daily records and with the person to establish whether they required the medicine. Once the nurse had observed people taking their medicines the MAR was signed to record the administration.

Medicines were stored safely. Temperatures of the clinical room and medicine fridge were checked and recorded daily. Medicines were stored in locked trolleys. When not in use the trolleys were secured in the locked clinical rooms.

Where people were prescribed topical medicines there was clear guidance for staff on what the topical medicine was for and when it should be administered. Topical medicine is medicine applied to the surface of the body. For example creams and lotions. Topical medicine records included body maps to guide staff where the medicine should be applied. Records showed that people's topical medicines were administered as prescribed.

There were systems in place to monitor the safety of the environment and equipment. This included checks of fire systems, gas installations, electrical equipment, hoists and pressure relieving mattresses. We saw that annual checks of water systems were made in relation to legionella. However, records showed the water temperatures had not been checked since June 2016. We spoke to the manager who told us they would ensure water temperature checks commenced immediately and would be completed monthly.

Good

Is the service effective?

Our findings

Staff were supported to ensure they had the skills and knowledge to meet people's needs. Staff received regular supervision and records showed supervisions were used as an opportunity to improve staff skills and knowledge and check competence. For example, one supervision record showed the member of staff had discussed the use of thickening agent in people's drinks and the use of a pain scale assessment document. Supervision records also showed staff understanding relating to policies and procedures was assessed. For example, one member of staff had discussed the whistle blowing policy and the record showed they understood their responsibility.

Staff were positive about the support they received. Staff comments included: "I feel supported. I get supervisions, they [managers] are very supportive"; "If I have a question they will listen and support me" and "[Manager] is very supportive. She listens to us".

New staff worked with more experienced staff to learn about people's needs. One new member of staff told us, "I always work with other members of staff. They tell me about resident's needs". The manager and clinical lead trained new staff on a one to one basis. More formal face to face training was arranged on a regular basis and covered moving and handling, safeguarding, infection control and dementia care. We saw that all staff had completed the provider's mandatory training. Staff were positive about the training they received. One member of staff told us, "It's very interactive. We get workshop exercises. It is very helpful".

People were supported in line with the Mental Capacity Act 2005 (MCA). 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.

The manager understood their responsibilities in relation to MCA and ensured people were supported in line with the principles of the act. Staff had completed training in MCA and understood how this impacted on the way they supported people. Staff comments included: ""It's when a person can't make decisions for themselves. They may lack capacity in things like personal care, however they may have capacity to make some choices"; "We have MCA to support people to make safe decisions" and "We have to make sure decisions are made in the person's best interest".

People were positive about the food. One person told us, "We get good meals". Relatives were confident people got enough to eat and that food was appetising. One relative said, "[Person] eats really well". The relative said this was a good indication as the person was not always a good eater.

There was a four week menu displayed in one of the dining rooms. This offered a choice of two main meals at lunchtime with a list of alternatives if people did not like what was on the menu. Although we did not see anyone offered a choice we were told people were asked earlier in the day what they would like. When asked if they were given a choice one person told us, "Sometimes".

Where people had specific dietary requirements we saw people received food and drink to meet these needs. For example, one person's care plan stated the person required a soft diet and thickened fluid we saw the person was supported in line with the guidance in their care plan.

People's weights were monitored and where people were identified as at risk of weight loss they were given fortified food and their food and fluid intake was monitored. We saw these records were completed regularly and monitored to ensure people were receiving sufficient food and drink.

People had regular access to health professionals. The GP visited the service on a weekly basis and people were reviewed on a regular basis and seen by the GP if their condition had changed or there were concerns about their health. People also had access to a variety of other social and healthcare professionals. This included: the care home support service (CHSS); podiatrist; speech and language therapy and diabetic nurse.

Good

Is the service caring?

Our findings

People and relatives were positive about the staff. They described staff as; "Marvellous", "Phenomenal" and "Always on the ball". One person told us "Staff are very sensitive". Relative's comments included; "It's nothing flash, but these people really care" and "Our experience of the staff is amazing. They are so caring in such a challenging environment. Everything gets followed through". One relative went on to tell us they felt staff looked after them as well as the person when they were visiting.

Relatives told us staff knew people well and used this knowledge to offer personalised support. One relative told us, "I came in here one morning and there was one of the carers dancing with her". This had clearly meant a lot to the relative to see the person enjoying themselves.

Staff were sensitive to people's distress and supported them in a kind and compassionate manner to try and alleviate their distress. For example, one person was struggling to eat due to breathing difficulties. Staff were attentive and caring throughout the person's distress. The person was given their medication immediately to relieve their symptoms and staff offered an alternative lunch of soup which the person could eat more easily.

We saw many cheerful and friendly interactions. Staff had developed positive relationships with people and clearly knew people and relatives well.

Staff understood how to treat people with dignity and respect. One member of staff told us, "I close curtains and the door. Don't expose people because it can be embarrassing and is unnecessary". Staff were discreet when supporting people in communal areas. For example, when supporting people to attend to personal care needs staff encouraged people to go to a more private environment.

Staff understood the importance of supporting people to maintain their personal appearance and respected people's personal belongings. One relative told us, "[Person] is always well dressed and her wardrobe is always tidy, with all her clothes in colours and types".

People were encouraged to maintain their independence. One member of staff told us, "I offer people a chance to do things for themselves. I don't just assume they can't do it. This supports people to do the things they are capable of. We mustn't take these things away from them".

People were involved in their care. Where people had representatives records showed these representatives had been included in the development of care plans and reviews of people's care needs.

People's confidential personal information was stored in a locked nurse's station and in the main office. The registered manager had identified that information need to be stored more securely and was putting in place improved storage to maintain the confidentiality of people's personal information.

Requires Improvement

Is the service responsive?

Our findings

At our inspection in January 2016 we found that people's records were not always accurate and up to date. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had not been made to all care plans.

People's records contained conflicting information. For example, one person's care plan identified the person required thickened fluids to a 'single cream' consistency. The record also contained a letter from SALT identifying the person required thickened fluids to a 'double cream' consistency. The date on the SALT letter was dated after the date on the care plan. We spoke to the deputy manager who was not aware of the SALT letter. The deputy manager told us the person was receiving fluids thickened to single cream consistency. Following the inspection the deputy manager advised us they had spoken to SALT and the person required fluids to a single cream consistency.

This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were assessed before accessing the service to ensure their needs could be met. Assessments were used to develop care plans that identified how people's needs would be met. However, people did not always receive care and treatment in line with their care plans. For example, one person's care plan stated they required specialist cutlery and plate guard to enable them to eat independently. We saw this person served their lunchtime meal without specialist cutlery. The person struggled to eat their food. We asked the deputy manager about the person's cutlery. The deputy manager told us, "He's (person) has got some somewhere". The deputy manager then went to the kitchen and returned with the specialised cutlery and gave them to the person.

People enjoyed the activities organised within the home. However, people told us there were not enough activities particularly when the activity coordinator was not on duty. One person said, "There's not a lot going on". One relative told us activities were "The only thing lacking in the home". A relative told us, "[Activity coordinator] does his best".

There was an activity coordinator employed in the home. On the first day of our inspection the activity coordinator was not on duty. People spent long periods of time in the communal areas of the home with little interaction. The television was on in both lounges. However, not all people were sat in positions where they were able to see the television. During the afternoon one member of staff entered the lounge and turned the TV to a different channel and turned the volume down without consulting any of the people sat in the lounge. During the afternoon one person was given a jigsaw puzzle; however there was no activity offered to other people sat in the lounge.

Staff did not always use opportunities to engage people in conversation or other activities. We saw staff standing in the doorway of communal areas observing people. However, they did not sit and speak with people at these times.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The activity coordinator was enthusiastic about their role and gave many examples of the activities people were offered. This included; reminiscence sessions using 1940's and 1950's flash cards; sensory session, which included using puppets; crafts and quizzes. They told us, "I make sure I see each resident every day I am here".
There was a monthly holy communion organised in the home and a monthly multi faith service organised by the Christian Fellowship. The activity coordinator had links with the local community and supported a 'friends of Meadowview' group who helped to organise events. For example, the service had hosted a summer garden fete.
People were supported to go for walks into the village and to the local pub. We saw there had been outings to a local wildlife park and garden centre.

People were supported to maintain and develop relationships that were important to them. For example, we spoke to two people who had recently moved to the home. They had developed a friendship which they told us had been supported and encouraged by the service. One of the people told us the friendship had made a big difference to their life. It was clear the two people enjoyed each other's company and spent the day together chatting and reminiscing. One relative told us, "It's good that he's met [person], he's a lovely man".

The provider had a complaints policy and procedure in place. People felt able to raise concerns and were confident action would be taken. We saw records of complaints. All complaints had been dealt with in line with the provider's complaints policy. Feedback from complaints had been used to improve the service. For example, there had been a complaint relating to the laundry service. The manager had introduced a new laundry system. The system was being monitored to ensure it was achieving the improvements required.

Requires Improvement

Is the service well-led?

Our findings

At our inspection on 27 January 2016 we found that systems for monitoring and improving the service were not effective. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that some improvements had been made. For example, there were improved monitoring of people's weights and food and fluid charts which had resulted in improvements in people's weights. There were improvements in relation to the recording of staff meetings and actions being taken as a result.

However, we found that the systems for monitoring and improving the quality of the service had not identified the issues we found during this inspection. For example, the care plan audit had not identified the inconsistencies found in people's care plans.

This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were positive about living at Meadowview Nursing Home. One person told us, "It is a very lovely home. I am very, very happy here".

The manager had been in post for six months. People and relatives were positive about the changes the manager had made. Comments included; "[Manager] has more bounce – so good, like a breeze" and "[Manager] has done a lot of decorative work in the home and made it more homely".

Staff were extremely positive about the manager and told us they felt valued and listened to. Staff comments included: "If you have any problems the manager will sort it. She's more efficient and on the ball"; "We are more organised and we keep on top of the care"; "Things have improved since the new manager came. She always attends morning handover and wants to know what's going on"; "Manager is very active and gets things done. She gets involved in the day to day task. She is very supportive and listens to us" and "I am massively supported by [manager]. She is a great mentor. So organised it is a breath of fresh air".

The manager promoted a person-centred culture that ensured people were at the centre of the service. The manager knew people and relative's well. For example, we saw one relative approach the manager. The relative was concerned about a person's condition. The manager responded immediately, showing a clear understanding of the person's condition and responding to the relative with understanding and compassion.

We spoke with the manager who was passionate about the service and ensuring people received good quality care. The manager recognised there were still many improvements to be made. The manager had developed a comprehensive action plan, identifying areas of the service for improvement. We saw that some improvements from the action plan had already been completed. For example, supervisions were being carried out regularly. The recording of supervisions included the areas of discussion and any learning points

from the supervision.

The manager recognised the importance of effective quality assurance systems and the action plan included the improvements planned to auditing systems.
There were systems in place to seek feedback from people and relatives. A quality assurance survey carried out in May 2016. The responses had been analysed to enable improvements to be made. For example, the entrance to the home had been made more attractive following the survey.

There manager had introduced feedback forms in the entrance of the home to encourage people to give feedback about the service.

Accidents and incidents were reported and recorded. Records showed what had happened and any action taken as a result of the accident to reduce the risk of a reoccurrence. For example, one person was referred to the care home support service (CHSS) following a fall. There were systems in place to monitor for trends and patterns relating to incidents.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider did not ensure care and treatment of service users was appropriate and met their needs.

The enforcement action we took:

We have served the provider with a notice of proposal to impose positive conditions to support improvement of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider did not ensure that care and treatment was provided to service users in a safe way. Risks were not always assessed to ensure service users health and welfare. The provider did not do all that was practicable to mitigate risks to service users.

The enforcement action we took:

We have served the provider with a notice of proposal to impose positive conditions to support improvement of the service.

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	Effective systems were not established and operated to ensure compliance with the regulations. The provider did not assess monitor and improve the quality and safety of the service. The provider did not ass, monitor and mitigate risks relating to the health, safety and welfare of service users. The provider did not maintain an accurate, complete and contemporaneous record in respect of each service user.

The enforcement action we took:

We have served the provider with a notice of proposal to impose positive conditions to support

improvement of the service.