Mr Farhad Pardhan

Meadowview Nursing Home

Inspection report

48 Rackend
Standlake
Oxfordshire
OX29 7SB

Tel: 01865300205

Date of inspection visit:
27 January 2016

Date of publication:
14 March 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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 inspection on 27 January 2016. This was an unannounced inspection.

The service had a registered manager who was responsible for overall management of the home. 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.

Meadowview is a care home providing accommodation for people requiring personal and nursing care. The service supports older people with a variety of conditions which includes people living with dementia. At the time of our visit there were 38 people living in the service.

Medicines were not always managed safely. People did not always receive their medicines as prescribed and staff administering medicines were not always competent to do so.

People enjoyed living at Meadowview Nursing Home. People and their relatives were complimentary about the registered manager and staff supporting them. There was a caring culture in the home and there was a relaxed, cheerful atmosphere. People spent their day as they chose and were able to take part in activities that interested them.

People were positive about the food and were supported to eat and drink in a respectful manner. People's specific dietary requirements were met and people were given a choice of food.

People had individual care plans which were written based on assessments carried out prior to them moving to the service. However, care plans were not always up to date and did not always contain up to date, completed risk assessments.

Systems in place to monitor the quality of the service were not always effective. Issues found during this inspection had been identified but had not been addressed.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not always managed safely.

Risks to people were not always identified and where they were there was not always information in relation to how risks would be managed.

There were sufficient staff to meet people's needs.

Is the service effective?

Good

The service was effective.

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

People had access to food and drink to meet their needs. People's specific dietary requirements were catered for.

When required people were supported to access health professionals.

Is the service caring?

Good

The service was caring

Staff were kind and caring and always explained what was going to happen to people before providing support.

People were treated with dignity and respect.

People and their relatives were involved in decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always completed and did not always contain accurate, up to date information.

People had access to activities that interested them. People were supported to spend their ay as they chose.

People and their relatives knew how to make a complaint and were comfortable to do so.

Is the service well-led?

Requires Improvement

The service was not always well-led

There were not effective systems in place to monitor and improve the quality of the service.

The registered manager was described as 'approachable' and promoted a caring culture in the service.

Accidents and incidents were monitored and action identified to reduce the risk of further events.

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.

The inspection took place on 27 January 2016 and was unannounced.

The inspection was carried out by two inspectors and an expert by experience (ExE). An ExE 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 notifications received from the provider. A notification is information about important events which the provider is required to tell us
about by law.

During our inspection we carried out a 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 also observed care practices throughout the day.

We spoke with four people using the service, six visitors and one visiting health professional. We looked at ten people's care records, medicine administration records, four staff files and other records showing how the home was managed. We spoke with the proprietor, the acting deputy manager, the lead nurse, a nurse, a senior carer, the activity coordinator, the chef and four care workers.

Inadequate

Is the service safe?

Our findings

Medicines were not always stored and administered safely. Medicines were not administered in line with the organisations medicine policy or national guidance. For example, we saw the nurse sign medicine administration records (MAR) before administering medicines. This potentially increased the risk of an administration error. Medicines that required extra security for example where medicines required two staff to sign and administer were not always managed safely. For example, we saw that one person's medicines were left unattended on the medicine trolley in the medicines room for 50 minutes. Records relating to the administration of this person's medicines had been signed indicating they had been administered to the person.

People did not always receive medicines as prescribed. One person required a pain relief patch to be replaced every 72 hours. The person did not receive the patch for four days due to the medicine being out of stock. This put the person at significant risk of experiencing pain.

Protocols identifying how medicines were to be given were not always up to date or being followed. For example, one person had a protocol relating to medicine prescribed for the treatment of diabetes. The protocol contained details relating to the medicine administration being dependent on the person's blood sugar level and the amount they had eaten. However records showed that medicines were not always being given in line with the protocol. There was no record of the persons food intake as required on the protocol.

There was an increased risk of error due to the lack of focus by the nurse on the task of medicine administration. We observed a nurse administering medicines. For example we observed that the nurse took two phone calls during the medicine round. On one occasion, the nurse was looking through MAR sheets whilst speaking on the phone. The nurse had not prepared for the administration of medicines and had to interrupt the administration of medicine to find a supply of clean medicine pots. It took approximately thirty minutes to dispense three people's medicines. We noted that the nurse was still giving out the morning medicines at 10:20am. This put people at risk of not receiving their medicines as prescribed.

During the observation we saw the nurse administer a medicine for a person, without looking at the medicine label. We looked at the label and saw the label had another person's name on it. The nurse was informed of this error. The nurse then found the correct medicine on a shelf in the medicine store room and dispensed another dose from the correct bottle. We spoke to the deputy manager and proprietor regarding these concerns and immediate action was taken to ensure the member of staff was not able to administer medicines until further training had been completed and competency assessed.

Risk assessments were not always up to date. For example, one person's personal safety risk assessment identified the person was no longer able to walk and required support of two carers and equipment to transfer. However, we saw this person walking about the home. Staff we spoke with told us the person had been unwell but was now recovered. The risk assessment and care plan had not been updated to reflect this change.

Risk assessments were not always completed. For example one person who had recently been admitted to the service from hospital did not have a falls risk assessment or skin integrity risk assessment in their care record.

Risk assessments had not always been completed in relation to people's diagnosed condition. For example, one person's care plan identified the person had epilepsy. There was no risk assessment or care plan to advise staff what action to take should the person experience an epileptic episode. Staff we spoke with were unable to tell us what action they would take if the person had an epileptic episode.

One person's door had been propped open using a bedside cabinet. The door was a fire door and in the event of a fire the door would have been unable to close. We spoke with a member of staff who took action to remove the cabinet.

This issue is a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People told us they felt safe. Comments included: "I feel very safe here"; "I am safe and well cared for" and "I'm safe and well looked after".

The home had a safeguarding policy and procedures in place and records showed safeguarding concerns had been recorded and reported in line with the organisations policy and local authority safeguarding procedures. However, one person's relative told us they had reported concerns about poor practice to a nurse. We spoke to the nurse who told us they had spoken to the member of staff and reported the incident to the manager. The nurse told us they had not made a record of the concern.

Staff had received safeguarding training and understood their responsibility to identify and report concerns relating to possible abuse. Staff told us they would report any concerns to the nurse in charge or the manager. Not all staff were able to tell us where they would report concerns outside of the organisations but knew where they could find the information. One member of staff told us they would notify Care Quality Commission (CQC) if they felt the service had not taken concerns seriously.

People told us there were enough staff to meet people's needs. Comments included: "If I need anyone they answer the call bell quickly, within a couple of minutes"; "The staff are fine. Always enough of them around"; "The call bell, they don't hang around" and "They don't take very long to come, very quick really".

Throughout the inspection call bells were answered in a timely manner. The atmosphere was busy but calm and staff had time to speak with people. Staff responded promptly to people who needed support. People had call bells to hand.

Staff told us they felt staffing levels were sufficient to meet people's needs. One member of staff said, "Staffing levels are pretty good". The acting deputy manager told us staffing levels had been increased to ensure people's needs could be met. The acting deputy manager used a dependency assessment tool to ensure there were sufficient staff to meet people's needs. We looked at the rotas for a four week period and saw that the assessed staffing levels were achieved.

Records relating to the recruitment of new staff contained relevant checks that had been completed before staff worked unsupervised in people's homes. This was to ensure staff were of good character. These checks included employment references and disclosure and barring checks (DBS). DBS checks enable employers to make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

One person in the home had recently been diagnosed with a terminal condition. The relative was extremely positive about the support both the person and relatives had received from the management team and the staff. The relative said, "There is extremely good communication, they explain everything". The relative told us one of the nursing team was supporting the person and relative to complete an end of life care plan to ensure staff were able to support the person in the way they chose.

Good

Is the service effective?

Our findings

People and relatives told us staff had the skills and knowledge to meet people's needs. One relative told us, "They know [person] very well. They explain everything to me".

Staff had completed training which included, fire safety, first aid, safeguarding and dementia. One member of staff told us the registered manager had arranged for them to attend updates to ensure they kept their skills and knowledge up to date. New staff completed an induction period which included training and shadowing of experienced staff.

Staff felt well supported. One member of staff said, "I like it here, they [management and senior staff] are very supportive". Staff told us they received regular supervision and there were regular staff meetings where staff were encouraged to raise issues and suggest ways to improve the service.

Staff attended handovers at the beginning and end of every shift to ensure they were aware of changes to people's conditions. Records of information shared during handovers showed any issues discussed and action planned and taken as a result.

Staff had a clear understanding of 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. Staff told us how they supported people to make as many decisions as possible for themselves. For example, one member of staff told us how they supported a person to choose what they would like to eat and what they would like to wear.

Where people were assessed as lacking capacity to make certain decisions and were being deprived of their liberty, appropriate Deprivation of Liberty Safeguards (DoLS) referrals had been made to the local authority supervisory body. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA .

People's care plans included information relating to people's capacity and where people were assessed as lacking capacity decisions had been made in their best interests. For example, one person was assessed as lacking capacity to decide whether to take their medicines. The person's family and GP had been consulted and a best interest decision had been made to administer the medicines covertly when the person declined to take them.

People were positive about the food and drink in the home. Comments included, "Lunches are very good but I don't usually get very hungry" and "We get lovely meals, there is a nice variety. Not too fancy or fussy".

Where people had specific dietary needs these were identified in people's care plans and staff were knowledgeable about people's dietary requirements. For example, one person's care plan identified they

required a pureed diet. We saw the person was provided with a pureed meal at lunchtime. The food was presented to look appetising and the person was encouraged and supported in line with their care plan.

The chef was knowledgeable about people's dietary requirements. People were offered a choice of two meals and extra portions of each choice was made to enable people to change their minds. If people did not like the choices available, an alternative would be prepared for them. Two people were identified as requiring finger foods and we saw these were provided. This meant people were receiving food and drink to meet their needs and preferences.

People had access to a range of health professionals. Records showed people had been referred to health and social care professionals when their needs changed or concerns identified. For example, one person had been unwell the evening before our visit. The persons GP had been contacted and blood tests taken at the GP's request. People's care records showed that people had been supported to access services from; opticians, dentist, community mental health team and care home support service.

Good

Is the service caring?

Our findings

People were positive about the caring nature of the staff. Comments included: "I'm safe and well looked after, there are no bossy staff and they always check with me first before they do anything to help"; "Everyone is very kind and good to us. They make sure we get all we want" and "I get on well with everyone. They are very sociable kind and willing. Staff are really lovely".

Relatives were complimentary about the care provided in the home. Comments included: "Staff are compassionate and value our priorities"; "The staff are brilliant. I'm kept well informed" and "The care [person] has had is amazing. Staff are so lovely and very supportive of me, huge empathy from all of them".

Staff had a caring approach to their work and clearly enjoyed supporting people. Staff spoke with kindness and compassion when speaking with people. During our inspection we saw many gentle and considerate interactions. For example, one member of staff sat with a person, gently holding their hand and reassuring them. The person responded with a smile and there was clearly an affectionate relationship between the member of staff and the person.

People were treated with dignity and respect. One person told us, "They always keep the door closed. They are very good". People were addressed by their chosen names and spoken to in a respectful manner. When speaking with each other about people, staff were respectful and showed empathy and understanding.

When people required support in a communal area of the home this was completed discreetly. Staff took great care to protect people's dignity and explained what was going to happen. For example, one person needed to be transferred from a wheelchair into a more comfortable arm chair in the lounge. The person required support from two care workers and the use of a hoist. Staff spoke to the person before commencing the transfer and explained what was going to happen at each stage. One member of staff reassured the person. Staff covered the person's legs with a blanket to ensure their dignity was protected.

People and their relatives were involved in decisions about people's care. One relative told us both they and their loved one had been involved in developing their care plan when they moved into the home. One person told us they had spoken to staff about the way they were supported to stand. The concern had been recorded and all staff were made aware of how the person wanted to be supported.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed prior to them moving into the home. Assessments were used to complete care plans detailing how people's needs would be met. However, we found care plans did not always include accurate or up to date information. For example, one person's care plan identified the person had given up smoking. A member of staff told us the person still smoked and was supported to go outside to smoke when they requested. There was no information in the person's care plan stating how the person was supported to smoke. There was no risk assessment associated with the person smoking. Care plans for people who had been admitted to the home from hospital for a limited period were not always complete. For example, one person had been admitted to the home on 13 January 2016, their care plan contained no assessments or care plans relating to health care, dependency, breathing, continence, dietary needs, mobility, and moving and handling.

We spoke to staff about the needs of people who had recently moved to the home. Staff told us they were given information at handover about the support people needed.

Some people's care plans contained consent forms that were not always signed and some forms were signed by relatives. There was no evidence to show the relatives had legal right to consent on the persons behalf.

Although records were not always fully completed and up to date, people's individual needs were met.

This issue was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People spent their day as they chose. Some people chose to spend time in their rooms. One person told us, "I'm happy here in my room. I get the paper in the mornings and watch TV in the afternoons. If I need anyone they answer the call bell quickly". We saw the person had their call bell in reach. One relative told us, "[Person] prefers to lie in until about 11:00am and to wake up naturally and also prefers bath rather than showers". The relative confirmed this happened.

There was an activity co-ordinator who organised a variety of activities in the home and outings to local places of interest. During our visit people were encouraged to take part in a musical quiz. The activity coordinator used the music to support people to reminisce. People enjoyed the activity and were smiling and singing to the music. We saw a monthly programme of activities was displayed, this included: discussion groups; quizzes and seated exercise. The activity coordinator took people on walks to the local village when weather permitted. Outings to a local zoo and stately home had been organised. People were positive about the activities offered Comments included: "I like singing"; "[Activity coordinator] is very nice and always gets me my paper" and "I love puzzle books but I join in the activities too. I can stay in my room if I feel like it. I will go to the dayroom today".

People's equality, diversity and human rights were respected. Staff had completed equality and diversity

training to ensure people's cultural and religious needs were met. The home organised regular multi faith services in the home and arrangements were made for people to receive Holy Communion if they wished. There was a complaints policy and procedure in place. People and their relatives knew how to make a complaint and were confident to do so. One relative told us, "There have only been minor matters and they always listen and sort them out". Records of complaints showed that complaints were investigated and responded to in line with the organisational policy.

Requires Improvement

Is the service well-led?

Our findings

There were not always effective systems in place to monitor the quality of the service. Auditing systems were in place; however audits were not always completed on a regular basis and did not always identify issues we found during our inspection. For example, no medicines audit had been completed since May 2015. Care plan audits were carried out. The care plan audits had not identified the issues found during the inspection. We could not be sure the quality of the service was being effectively monitored and improved.

Records were not always available to evidence the effective management of the service. For example there were no records relating to staff meetings. The service was not able to monitor whether issues had been identified and actions taken to address issues and improve the service.

At the time of our inspection the registered manager was absent from the service. There was an acting deputy manager and a lead nurse, however it was not clear who was responsible for the service on the day of the inspection. When issues were raised during the inspection it was unclear who would be responsible to take action to address issues. There were no clear lines of responsibility and accountability to ensure there was effective monitoring of the quality of service in the absence of the registered manager.

This issue was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There was a caring culture in the home. It was clear that the needs of people and their relatives were at the forefront of everything the service did.
People and their relatives were positive about the registered manager. One person told us "The registered manager is open and approachable". However one relative told us they were concerned as the registered manager was currently away and said to be leaving. The relative said, "It's all at sixes and sevens. I'm not sure who is taking the lead".

Staff told us the manager was approachable and were positive about working in the home. Comments included: "Very good. They [registered manager] look after us like parents"; "I'm very happy, [registered manager] listens to you": "I like it here, they are very supportive": "I go to [registered manager] with problems, she's very good"; "[Registered manager] is a good manager. I am well supported" and "[Registered manager] checks us and we must do things correctly. The owner is regularly in the home. He speaks to staff and residents as well".

Staff were aware of the whistleblowing policy and felt confident to report any concerns if necessary.

The service carried out quality questionnaires to gain the views and opinions of people and their relatives. Where areas for improvement were identified the service responded and put action plans in place to address the issues. For example, concerns had been raised regarding staffing levels. The home had been actively recruiting staff and one relative told us, "I have expressed concerns at the turnover of staff but they are getting on top of it now and there is a bit more stability. This is very important for residents".

There was a 'Friends of Meadowview' group for relatives to have input into the running of the home. The activity coordinator organised these meetings. It was unclear how often the meetings were held and one relative told us, "The last 'Friends' meeting was cancelled. I would have used that for feedback to them". There were no records of previous meetings held available on the day of the inspection.

There were systems in place to monitor accident and incidents and to look for trends with a view to improving safety. For example, all incidents related to falls were monitored. The system had enabled the identification that one person was at significant risk of falls at a specific time of the day. A best interest meeting had been held to discuss possible actions to be taken to reduce the risk of falls. The actions taken had reduced the number of falls from eight falls in one month to one fall in January.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not establish effective systems to monitor the quality of the service in relation to; assessing, monitoring and improving the service and maintaining an accurate and complete record in respect of each service user. Regulation 17 (1) (2) (a) (c)

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 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 in a safe way for service users. Risks to people were not always assessed and plans were not in place to mitigate the risks. The premises were not always used in a safe way. Medicines were not managed in a safe way. Regulation 12 (1) (2) (a)(b)(d)(g)

The enforcement action we took:

Warning notice