Meadows Edge Care Home Limited

Meadows Edge Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Meadows Edge Care home is a residential care home providing personal and nursing care to up to 45 people in 1 adapted building. The service provides support to old and younger adults and people living with dementia. At the time of our inspection there were 29 people using the service.

People's experience of using this service and what we found
We have made a recommendation the provider considers installing privacy screening to some of the bedrooms.

Important information was not always available in people's medicine records to ensure staff had the appropriate information to provide safe care and treatment.

We identified areas in the building that required maintenance to ensure they were not an infection, prevention control risk.

Individual risks identified in incident forms were not risk assessed. For example, when people had hit other people and staff when distressed.

The systems and processes to review incidents were not robust and did not evidence learning lessons.

Audits were not always accurate or reflective of what actions had been already taken. Medicine and maintenance audits did not show who was responsible to complete actions and if they had been completed.

Notifications were not always made to the Care Quality Commission when required.

Terminology and language used in care plans and other records was respectful and there were no indications of a closed culture. Care plans were well written with consideration for people's personal preferences and encouragement for staff to promote choice.

Health monitoring forms and communication tools were effectively used to monitor people when risks to their health had been identified.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (published 24 May 2023). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations. This service has been in Special Measures since 23 May 2023.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Meadows Edge Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding people from abuse, good governance and staffing at this inspection. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 safe.	**Inadequate**
Is the service well-led? The service was not well-led.	**Inadequate**

Meadows Edge Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 2 inspectors.

Service and service type
Meadows Edge Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Meadows Edge Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We requested feedback from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan our inspection.

During the inspection
We spoke with 3 people who used the service and observed interactions between people and staff during the inspection. We spoke with 4 staff members, these included 3 nurses and the head of finance. We looked at a range of information. This included 6 care records, all medicines administration records (MAR) and associated documents. We also checked 3 staff files, training records and information about the operation and management of the service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At our last inspection the provider had failed to ensure 'as required' (PRN) medicines were managed safely and that risks relating to the health, safety and welfare of people and the environment were robustly managed, monitored and assessed. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● Important information was not always available in people's medicine records to ensure staff had the appropriate information to provide safe care and treatment. For example, it wasn't documented on a person's medicine administration records (MARs) when they required medicine to be given through their feeding tube. This meant people were at risk of medicines not being given safely and in line with their assessed needs.
● Information was sometimes missing from people's MARs. For example, when people had no known allergies the box was blank, so it was not clear whether they had allergies or not. Although information was in people's care plans, information was not accessible within people's medicine records to ensure staff were safely supporting them.
● Stock checks had not been carried out for all medicines that were stored in the home. There were no stock checks for people's insulin. This meant there was no clear process in place to monitor stock levels of medicines to ensure they were available when required.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Preventing and controlling infection
● Incident forms did not contain all the information relating to the incident. Some information was in a separate form kept in a different folder so it was difficult to get an overview of what had happened and what actions staff had taken when people were distressed.
● Incidents were not reviewed to ensure lessons were learnt. Although actions were taken after incidents like referrals to external agencies, there was no effective process to discuss with staff how and why the incident happened or to identify any learning to prevent reoccurrence.
● Individual risks identified in incident forms were not assessed. For example, when a person showed signs of distress including attempting to bite others this had not been risk assessed to give appropriate guidance to staff. Furthermore, information on what people did when they were distressed was not always incorporated into care plans to ensure staff were aware of people's reactions and the risks associated with

them.
● We found environmental concerns that increased the risk to people. For example, screw heads were protruding from a wall and flooring around a toilet was in poor condition. The provider had failed to address these risks in a timely manner.
● The provider had not assessed the risks or considered the impact on people when renting out a house which was in the gardens of the care home and did not have separate access arrangements. We observed several members of the public walking and biking down a path where we had seen people walking around with staff. Additionally, car tyre marks were on the gardens towards the rented house which meant there was a risk to people and staff who used the grounds. We observed several bedrooms facing the rented house without privacy screening which meant people's dignity and privacy was potentially at risk.

We recommend the provider considers installing privacy screening to the bedrooms that face the rented house.

● We identified areas in the building to be poorly maintained including a heavily stained and worn carpet in the stairwell, cracked basins and scuffed paint on the walls. These areas were frequently used by people living in the home which mainly accommodated people who were unable to ensure their own safety. This posed a risk of harm due to poor environmental safety and impacted on effectiveness of cleaning.

The provider failed to assess and manage a range of risks which placed people at risk of avoidable harm and was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Falls monitoring was consistent. We saw examples where people were monitored closely following falls until the emergency services attended. There was evidence of analysis and actions taken to keep people safe.
● Communication tools were used effectively to monitor people when health risks had been identified. For example, when a person had a high temperature, these forms were used to make assessments and take actions, so people received timely support to keep them safe.

Visiting in care homes
● At the time of inspection there were no restrictions for visitors. The provider had an open visiting policy with no restrictions.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had not ensured appropriate systems and processes were in place to prevent the risk of abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

● Referrals had not always been made to the local safeguarding team when required. For example, when people who lived together at the service had harmed each other. This meant the provider was not working collaboratively to prevent abuse and neglect where possible.

Systems in place had failed to ensure people were protected from abuse and left them at risk of harm. This

was a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were supported in the least restrictive way. We saw in incident forms staff gave people space when they were distressed, allowing time for people to de-escalate in a safe environment.
● The use of as required (PRN) medicines to help people who were feeling anxious or distressed had reduced. People had regular reviews to ensure they were on appropriate medicines and referrals were made to external professionals when required to support people's health needs.

Staffing and recruitment

At our last inspection the provider had not ensured staff had received appropriate training to meet people's needs. This was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● Staff told us previously they would benefit from training in supporting people with mental health conditions. Although the provider had told staff they could complete any additional training, training in specific mental health conditions was not mandatory even though staff continued to support people with complex needs.

The provider had not ensured all relevant training was available for staff to ensure they could safely meet people's needs. This was a continued breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff received supervisions twice a year which was in line with the provider's policy. Additionally, 'flash meetings' were regularly undertaken to support staff and keep them informed of relevant information, although we found some of this was duplicated from each meeting which didn't support meaningful discussion or learning.
● People were supported by enough staff. We observed positive interactions between staff and people which supported happiness and wellbeing.
● Staff were recruited safely. This included ensuring staff had the right to work in the UK and Disclosure and Barring Service (DBS) checks. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection managerial oversite and the providers systems and processes that monitored quality and safety were not robust. This was a continued breach of Regulation 17 (Good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The provider did not have an established or effective system to review incidents and accidents, including when people experienced emotional distress. This meant the provider could not always mitigate future risks and identify staff training needs to promote more positive outcomes.
- The systems and processes to learn lessons were not always used. The provider told us 'flash meetings' were used to review incidents with staff. However, during our inspection, we reviewed a month of meeting minutes where incidents had happened and found nothing had been discussed.
- Risk assessments did not always record a summary or conclusion. For example, when people were assessed for the use of bed rails it was not clear whether they required them or not. Information was provided in the care plan; however, assessments did not signpost to where guidance was available for staff which meant it could be missed.
- Audits to check the quality of the service were not always accurate or up to date. For example, in a medicine audit, a member of staff told us an identified issue was still recorded as a problem 2 weeks after it had been resolved. Additionally, it was not clear on audits who was responsible to take actions or if any actions had been taken when issues had been identified.
- We could not be assured the provider was notifying the Care Quality Commission when required in line with regulatory requirements. During inspection we found an incident that had not been reviewed by the management team, therefore, there was an increased risk we had not been notified regarding other incidents. Providers must ensure notifications have been sent to the Care Quality Commission for all incidents that affect the health, safety and welfare of people who use services as soon as possible after the event. We will continue to monitor and follow this up.

The provider had failed to operate effective systems to ensure the quality and safety of the service. This was a continued breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

At our last inspection the provider failed to ensure people were receiving care and support that met their individual needs and reflected their preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Terminology and language used in care plans and other records was respectful and there were no indications of a closed culture.
● Care plans contained information about people's personal preferences and encouraged staff to ensure people were supported to make choices.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● We observed some positive interactions where staff were supporting people to make everyday decisions. This promoted people's self-esteem and independence.
● There was evidence the provider was open to working with external agencies to support good outcomes for people. For example, the service had sought input from healthcare professionals when appropriate.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider understood their legal responsibilities to act on the duty of candour.