

Meadow Court Limited

Meadow Court Residential Home

Inspection report

Meal Hill Lane
Slaithwaite
Huddersfield
West Yorkshire
HD7 5EL

Date of inspection visit:
23 February 2017
28 February 2017

Date of publication:
24 May 2017

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

We inspected Meadow Court Residential Home (known to the people who live and work there as 'Meadow Court') on 23 and 28 February 2017. The first day of the inspection was unannounced. This meant the home did not know we were coming.

Meadow Court is a residential care home for up to 37 people. It consists of one building with two floors. All bedrooms are single; 29 have ensuite facilities and eight have a sink but are located near a shared bathroom and toilet. On the ground floor there are two communal lounges, a TV room, a large conservatory and dining room. Both floors have shared bathrooms, toilets and shower rooms. The home has an enclosed courtyard area with seating.

At the time of this inspection there were 32 people living at the home; two of these people were using the service for respite care.

Meadow Court was last inspected in February 2016. At that time it was rated as 'Requires Improvement' overall. It was judged to be 'Inadequate' in the Safe domain, 'Requires Improvement' in the domains of Effective, Responsive and Well-led, and 'Good' in the domain of Caring.

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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 home had a registered manager, although they had recently become the activities coordinator and were in the process of deregistering as manager with the Care Quality Commission (CQC). The plan was for one of the directors of the registered provider company to apply to become the registered manager. The director was managing the home at the time of this inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People's care plans did not always contain measures to manage risks that had been identified. Some care plans we saw had not been updated after incidents had occurred.

Relatives had made decisions for people without the correct legal authorisation to do so. Staff knowledge, including that of the home manager, around the Mental Capacity Act 2005 (MCA) and how it was applied in a care home setting needed to be improved. These were concerns identified at the last inspection in February 2016.

People's care plans did not always contain the person-centred detail staff needed to support them effectively. Some people lacked care plans for a specific health condition and two people receiving respite care at the time of this inspection had no risk assessments or care plans in place.

Concerns with medicines identified at the last inspection had been resolved. Most aspects of medicines administration and management were well managed, although we did find some problems with topical cream charts and the recording of the medicines room temperature.

Most aspects of the building's utilities and facilities had been checked for safety, although we did identify some gaps. This included not checking water temperatures in the hand basins of people's rooms. We found water temperatures recorded for communal bathrooms exceeded guidelines from the Health and Safety Executive. Fire drills had not been undertaken.

Improvements had been made to the quality monitoring systems at the home, but more work was required to ensure care plans were up to date and all accidents and incidents that occurred were analysed together.

People told us they felt safe at Meadow Court and their relatives agreed. Care staff could describe how to identify the different forms of abuse and said they would report any concerns to managers.

Concerns with the recruitment process at the home identified at the last inspection had been resolved. People and their relatives told us there were enough staff deployed to meet people's needs, although they said they had to wait for support at times.

Information about falls had been analysed for trends and used to increase staffing at times of the day when people were identified as being at higher risk.

We found the home to be clean, tidy and odour-free. People and their relatives agreed.

Staff told us, and records showed they now had access to regular supervision. With the exception of MCA training, staff had received the training they needed to support people effectively. Care staff new to health and social care were enrolled on the Care Certificate.

Feedback from people and their relatives about the food served at Meadow Court was good.

People had access to a range of healthcare professionals to help meet their wider healthcare needs. Feedback we received from healthcare professionals who visited the home was positive.

Members of the management team had sought training on dementia-friendly environments and had made some changes to the home in accordance with what they had learned.

People and their relatives described staff as kind and caring. Care staff could describe people well as individuals.

People and their relatives were involved in designing and reviewing their care plans on a regular basis. We saw people had access to independent support with decision-making if they needed it.

We observed, and people told us, care staff respected their privacy and dignity. Staff also promoted people's independence.

Care staff could describe what good end of life care involved. Feedback from relatives of people who had received end of life care at Meadow Court was positive.

People told us they had access to a range of activities which they enjoyed. Our observations during the inspection supported this.

One formal complaint received since the last inspection had been addressed appropriately. People and their relatives told us they felt able to raise concerns with staff if they needed to.

People, their relatives and staff were given opportunities to feedback about the service at regular meetings. Feedback about the management team from people, their relatives and staff was positive.

Notifications had been made to CQC regarding any relevant accidents, incidents or events, as is required by the regulations. The ratings from the last inspection were not prominently displayed at the home when we arrived. This was because the entrance area had been decorated shortly before the inspection; we saw this was put back in place during the inspection.

We found breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

We found concerns around the way risks to people were assessed and managed.

Most aspects of medicines management and administration were managed well, however topical cream charts lacked detail and the temperature of the medicines room was not checked.

We observed sufficient staff were deployed to meet people's needs. People and their relatives told us there were enough staff although sometimes they were made to wait.

Most aspects of the building were checked regularly for safety, however fire drills had not taken place and water temperatures were not monitored effectively.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Concerns with obtaining the correct legal authorisation around consent and decision making in accordance with the Mental Capacity Act 2005 remained.

Staff had access to the supervision and training they needed to support people effectively.

People and their relatives gave us positive feedback about the food and drinks served at the home.

People had access to a range of healthcare professionals to help support their wider health needs.

Is the service caring?

Good ●

The service was caring.

People and relatives said staff were kind and caring. All the interactions we observed were supportive and friendly.

Care staff respected people's privacy and dignity. We saw, and records showed, staff promoted people's independence.

Care staff knew people well as individuals. People had access to advocates if they needed them.

Staff could describe the important aspects of end of life care. Feedback from relatives of people who had received end of life care at the home was positive.

Is the service responsive?

The service was not always responsive.

Care plans were not always person-centred or up to date.

We saw people had access to a range of meaningful activities. People told us they enjoyed the activities on offer.

One complaint received since the last inspection had been managed appropriately. People had been provided with guidance on how to complain.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Improvements had been made to audits completed at the home but there were still concerns with care plans and accidents and incidents to resolve.

People, their relatives and staff at the home were asked to feedback about the service at regular meetings.

Statutory notifications had been correctly submitted by the home manager. They were in the process of applying for CQC registration.

Requires Improvement ●

Meadow Court Residential 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 23 and 28 February 2017. The first day was unannounced. The inspection team consisted of two adult social care inspectors and one '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. The expert by experience on this inspection had been a carer for an older person and had supported adult social care inspectors on other inspections.

As part of the inspection we reviewed the information we held about the service and requested feedback from other stakeholders. These included Healthwatch Kirklees, the local authority safeguarding team and the Clinical Commissioning Group. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. They did not share any concerns with us. During the inspection we spoke with two healthcare professionals who were visiting people at the home; they both gave us positive feedback about the home.

During the inspection we spoke with 13 people who used the service, eight people's relatives, four members of care staff, the activities coordinator, the home manager, three directors for the registered provider company, the care manager, and a cook. We also received feedback from one other relative after the inspection.

As part of the inspection we looked at eight people's care files; this included their risk assessments and care plans. We also inspected three staff members' recruitment and supervision documents, the home's staff training records, six people's medicines administration records, accident and incident records, and various

policies and procedures related to the running of the service.

Is the service safe?

Our findings

People we spoke with told us they felt safe at Meadow Court. One person said, "I'm safe here and so are my things", and a second told us, "You just feel safe, I can't describe it. There's always somebody about." Relatives agreed; one told us, "Me and my family can leave here and know [my relative's] going to receive perfect care", and a second commented, "[My relative's] safe. [They've] got people around [them]."

We inspected care records to see how the home assessed and managed risk to people. Care records we saw contained various risk assessments for risks such as mobility and falls, skin integrity and poor nutrition; these had been reviewed on a regular basis. We found gaps in records as to how risk was managed for people and identified times when care plans to manage risk had not been updated following incidents.

For example, none of the people at the home had a care plan in place to tell staff how to support them safely to bathe or shower. We noted two people who had epilepsy did not have care plans detailing how staff should support them in the event of a seizure. One person's records showed they had got out of the bath unassisted when a bath seat was in place; a message had been sent to staff about this but the person's care plan had not been updated with the information. Records showed the person had also experienced an acute health episode a few weeks prior to this inspection which was recorded incorrectly as a different acute health condition on their personal care and physical wellbeing care plan. A second person had fallen numerous times when receiving assistance from care staff to transfer, yet their mobility care plan had not been updated to advise staff of this. A third person had been assessed by a speech and language therapist (SALT) who had produced guidance on how to support the person to eat and drink safely. We saw some of this information had been added to an evaluation of the person's eating and drinking care plan, but the care plan itself had not been updated. We also observed the SALT's advice was not followed fully when the person was supported to eat and drink. The same person had also trapped their foot in bedrails on their bed on two occasions in 2016. We saw messages had been sent to staff about this but their care plan had not been updated to include this particular risk. We brought these issues to the attention of the home manager. They told us care plans would be reviewed and amended as a priority.

We saw daily records which showed people were receiving care that was not described in their care plans. For example, daily records showed two people were being assisted to reposition to reduce their risk of developing pressure ulcers, but this requirement was not included in their skin integrity care plans. This meant staff providing care according to people's care plans would not be aware each person needed support to change position and therefore be at higher risk of developing pressure ulcers.

We checked the care plans of two people receiving respite care at the home at the time of this inspection. One person had been admitted to the home three days before the inspection and the other four weeks before the inspection. Neither had any risk assessments or care plans recorded on the electronic system. Risk assessments are used to identify potential risks to people and contain measures to help to minimise and manage these risks. We asked the home manager why these people had no risk assessments or care plans. They said the home did not routinely offer respite care and in such situations care staff recorded the daily care people had received but they did not complete risk assessments or devise care plans. Instead we

saw the home manager had sent out a short electronic message to staff which summarised each person's needs into a short paragraph. We saw one of the people on respite needed support to mobilise, with their personal care and with their medicines, all of which presented a risk to the person if not done correctly. This meant people were at risk because person-centred risk assessments and care plans had not been put in place to ensure their needs could be met safely.

Concerns with risk assessment and management were a breach of Regulation 12 (1) and (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At the last inspection in February 2016 we identified some concerns with medicines management. This included topical creams not dated upon opening so it was not possible to tell how long they had been in use. In addition, medicines prescribed 'when required' such as pain killers did not have care plans or medicines protocols to tell staff how and when to administer the medicine. We also found medicines audits had a 'tick box' format with no action plans to evidence improvements were made.

At this inspection we found there had been some improvements made to the management of medicines at the home. Topical creams we saw were dated upon opening and none were out of date. Most medicines prescribed 'when required' for people had detailed and person-centred medicines protocols in place, however, we did identify two which were missing. The home manager put these in place straightaway. There had also been a recent improvement to the format of the medicines audit; we saw it was now more detailed and thorough. This was a result of additional medicines training the home manager and care manager had recently attended.

We observed a medicines round during the inspection. We noted people were supported to take their medicines in a person-centred and respectful way, and were not rushed. People prescribed 'when required' medicines, were asked if they needed them. We saw the care staff administering medicines checked the content of people's blister packs to make sure all the medicines listed on the person's medicines administration record or MAR were present.

On all but one occasion the member of care staff signed people's MARs after they had witnessed the person taking their medicines, but on one occasion they left the person's tablets with them and still signed their MAR. When we queried this, the member of care staff said the person had mental capacity to take their medicines independently, but preferred to do so slowly and in their own way. As a result of our observation, the home manager contacted the pharmacy who supplied the home's MARs so they could add a 'not seen' code to the bottom of the MAR to record when people had been given their medicines but were not seen taking them. This meant the person could still receive their medicines in the way they preferred and the information recorded on MARs would be accurate.

We checked a selection of people's MARs and found there were no gaps in recording which showed people had received their medicines as prescribed. The application of people's topical creams was recorded on separate MARs which had body maps to show where the creams should be applied. We noted the level of detail included to direct staff was poor in some instances. For example, one person's prescribed moisturising cream MAR stated 'as directed to affected area'; staff had recorded their reasons for applying the cream on the reverse of the MAR, however, they had either written 'as directed' or 'legs and arms.' Another person was prescribed a pain-relieving gel. Their MAR for the gel said 'three times a day when required', the body map did not indicate where to apply the gel, and care staff had recorded the reason for application of the gel as 'as prescribed.' We discussed this with the care manager and home manager. During the inspection they added person-centred instructions and updated the body maps for each topical cream.

We inspected the medicines room and noted medicines were stored securely. This included controlled drugs, such as strong pain-killers, in use at the home. We checked the recording of controlled drugs and performed a stock check of a selection of medicines; they tallied with recorded amounts.

We saw records were kept of the temperature of the fridge used to store medicines, but not of the medicines room. Most non-refrigerated medicines must be stored at or below 25°C so it is important to make daily checks to ensure room temperatures do not exceed this level. We fed this back to the care manager and daily checks were instigated during the inspection.

This meant the majority of medicines were now administered and managed safely, although some concerns were identified and corrected during this inspection.

At the last inspection in February 2016 we identified a breach of regulation, as records could not evidence new members of staff were recruited safely. At this inspection we inspected the recruitment records of three staff members employed at the home. All of the documentation was in order. This included an original application form evidencing any gaps in employment, references from previous employers, and a Disclosure and Barring Service (DBS) check. The DBS helps services make safer recruitment decisions. This meant the recruitment process at the home was now robust and ensured staff employed were suitable to work with vulnerable people.

At the last inspection in February 2016 we identified a breach in regulation as there were insufficient staff deployed to support people safely at night and as a result there had been a high number of unwitnessed falls. The home manager also did not use a dependency tool to evaluate whether staffing levels were appropriate to meet the needs of the people living in the home.

At this inspection we asked people, their relatives and care staff if they thought there were sufficient care staff on duty to meet people's needs and keep them safe. Feedback was mixed. Comments included, "We didn't use to (have enough staff at the home). We get quick attention now", "They come quickly (when I press the buzzer)", "Yes, I can't complain", "They could do with more (staff). They are run off their feet sometimes", "There may be a short wait. I haven't had to do it all that often", and, "(Response to) the buzzer has never been a problem." Comments from relatives included, "[My relative] likes to go out walking and they don't have the staff to take [them]", "Yes, we can't complain (about staffing levels)", and, "I've no problems with the staffing I've seen." We spoke to some relatives who had waited a long time to be let into the home when visiting in the evenings, as care staff were busy assisting people who liked to go to bed early.

Comments from care staff who worked day and night shifts about staffing levels included, "I think we need an extra staff member in a morning. It can be hectic", "We generally do alright on the 3pm to 10pm shift", "We manage OK", and, "Yes (we manage), because the owner and manager live nearby. If we have any problems they come straight over."

The home manager showed us a dependency tool they had implemented shortly before this inspection at the home. We saw all the data around people's dependency in various categories had been added, as had the hours staff were rostered. The home manager had experienced technical difficulties generating outcomes from the tool, and had requested support from the tool developer. They told us, "If it (the dependency tool) tells me we need more staff at night, we'll have to do it." The home manager had also put in place a falls audit tool, which analysed falls for trends, in terms of where they had occurred and the times of the day. They had used this tool to identify an issue with more falls occurring at the busy time between 5pm and 9pm when most people wanted to go to bed, and in response had added an extra member of care staff during these times. The home manager said, "We're looking at everything with staffing levels – the

buzzers, the dependency tool and the falls." We also noted night and day staff overlapped for an hour between 8am and 9am so there were more care staff available to support people to get up.

We arrived early both days of this inspection and made observations of staffing levels and response times to call buzzers until early evening. We saw people received the support they requested and buzzers were answered in a timely way. Feedback from people, their relatives and staff, plus our observations showed there were sufficient staff deployed to meet people's needs and keep them safe.

We noted information about the accidents and incidents people had experienced was recorded on the home's electronic care records system. We saw detailed notes were made of the circumstances around these accidents or incidents, for example falls, however there was very little or no information included as to the action taken to prevent future occurrences. When we raised this with the home manager they showed us information on action taken in other parts of the electronic system; they could therefore evidence appropriate action had been taken. The home manager said they would ensure this information was recorded in the accidents and incidents section of people's electronic care notes so a full audit trail could be more readily available.

Two of the directors for the registered provider company were responsible for maintenance at the home. They could evidence regular checks had been made on most aspects of the building's facilities and utilities, including gas appliances and the electrical wiring. Regular servicing of the home's fire extinguishers and moving and handling equipment had also been done. The home had an up to date fire risk assessment in place and we saw actions from a Fire Enforcement Notice served by the fire service in March 2016 had been completed within the required timescales.

Records showed checks were undertaken of hot and cold water temperatures in main bath rooms, and flushing of water outlets was completed regularly. These are checks made to reduce the risk of Legionella outbreak. Some aspects of the home's water system were not checked for safety on a regular basis. This included water temperatures in the wash basins of people's rooms and in the communal toilets. We noted checks on the communal bathrooms had recorded water temperatures of between 46°C and 49°C. Health and Safety Executive (HSE) guidance states if hot water used for showering or bathing is above 44 °C, the risk of serious injury or fatality is increased. We shared the HSE guidance with the directors responsible for maintenance at the home. They made sure mixing valves were adjusted to lower water temperatures to a safer level by the end of the inspection and instigated a regular check of water temperatures in people's rooms.

At the last inspection in February 2016 we identified a breach of regulation because the home was cluttered with furniture, a carpet presented a trip hazard and people did not have personal emergency evacuation plans (PEEPs) in place. PEEPs summarise the assistance people need to evacuate the building in an emergency situation. At this inspection we noted the home was much less cluttered with furniture and the dangerous carpet had been replaced.

We also found PEEPs were in place for each person who used the service; they were kept in an emergency bag where they could be easily located. We found their format slightly confusing and discussed this with one of the directors responsible for maintenance. They told us the PEEPs had been shown to the local fire service who were happy with them, although they agreed they could be simplified. We saw this was done and the new PEEPs were in place by the end of this inspection.

We were concerned to find the home did not undertake regular fire drills so staff could practice what to do in an emergency situation. The directors in charge of maintenance told us, and records showed staff

completed fire safety training on an annual basis so we asked staff what they would do if the fire alarm sounded. Most could describe what action to take, however one member of care staff said they had no idea what to do. We discussed this concern with the directors responsible for maintenance. During the inspection a procedure for monthly fire drills was put in place and three drills were completed successfully at different times of the day between the first and second day of our inspection. They also sent out the home's fire evacuation procedure to all staff to read and sign to confirm they had read it.

Staff we spoke with at the home could describe how to identify the different forms of abuse and said they would report any concerns to managers. They also told us they had received safeguarding training and records at the home confirmed this. This meant staff at the home could demonstrate how to keep people safe.

People and their relatives told us they thought the home was clean and tidy. One relative commented, "I feel the hygiene standards are excellent." We checked communal areas, including bathrooms and toilets, and people's rooms and found the home was clean and odour-free. There had been a recent outbreak of diarrhoea and vomiting at the home which had resolved two days before this inspection. We noted staff at the home had liaised appropriately with the local authority and an action plan had been put in place and followed. Staff we spoke with could describe the measures taken during such outbreaks and we saw personal protective equipment was available for staff to use when supporting people with personal care. This meant the home put measures in place to try and protect people from infections.

Is the service effective?

Our findings

People and their relatives told us staff at the home had the skills and experience they needed to provide effective support. Comments included, "The staff don't need more training", and, "They (the staff) know what they're doing."

At the last inspection in February 2016 we identified a breach in regulation as the frequency of staff supervision was irregular and inconsistent, and the content of supervision sessions was not always detailed or constructive. At this inspection care staff we spoke with told us they now had regular supervision. One member of care staff said, "They make sure we're up to date with training and health and safety issues", and a second commented, "I like them. We explore my concerns and think of ideas." Records showed care staff had been receiving regular supervision sessions which covered areas such as training, infection prevention and safeguarding. Staff appraisals had also been planned. This meant care staff now had access to regular supervision.

Records showed care staff employed who were new to health and social care were enrolled on the Care Certificate. The Care Certificate is an introduction to the caring profession and sets out a standard set of skills, knowledge and behaviours that care staff follow in order to provide high quality, compassionate care. This had involved theory training and an assessment of staff' competency in practice. The home manager said, "They (the new care staff) work with team leaders until they feel comfortable and managers feel they're confident." Care staff employed with existing skills and experience in health and social care told us their induction consisted of training and shadowing other care staff.

We noted the induction process for care staff with existing health and social care experience was not documented in their personnel files. When we raised this with the home manager and director for the registered provider company who focused on administration, they could describe the induction process and told us each new employee had a 28 day probationary period. There was also a tick list which showed the different aspects which were covered with new employees and checks that were made. The home manager said these records would be added to staff personnel files going forward.

The home manager had a training plan which listed all the courses care staff had attended, what was outstanding and which courses had been booked in. We saw care staff had completed training on a range of core subjects, including first aid, moving and handling, safeguarding and infection control. Care staff we spoke with were positive about their access to training courses and said they felt able to ask for additional training if they needed it. This meant care staff now received the training and support they needed to support people effectively.

We noted one area where care staff lacked knowledge was around the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Training records showed not all care staff had attended training. The home manager told us, "I do know they need it." This was a finding at the last inspection in February 2016. Care staff we spoke with could not describe the process of how people's mental capacity was assessed and best interest decisions made, but did say they provided people with choices to help them make

decisions for themselves. We observed this was the case during the inspection.

The 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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards or DoLS. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Records showed the home was compliant with DoLS. Applications had been made to restrict people's liberty when it was needed to keep them safe and authorisations to do so from the supervisory body were kept on people's files. We noted one person had conditions on their DoLS authorisation around medicines administration. This had been recorded in their care plans and on their medicines record to ensure care staff complied with the requirements.

At the last inspection in February 2016 we identified a breach of the regulation relating to the need for consent. This was because relatives of people who lacked mental capacity had been asked by the home to make decisions for them even though there was no evidence they had been granted Lasting Power of Attorney (LPA) by a court. People with mental capacity can give people they trust LPA to make decisions for them if a time comes when they lose mental capacity.

At this inspection the home manager told us a letter had gone out to all relatives after the last inspection asking for evidence of LPA, but not all relatives had replied. We found evidence on the electronic care records system that the correct process for decision-making for those lacking or thought to lack mental capacity was not being followed. For example, consent had been sought from people's GPs if they were judged to lack capacity to make decisions around their medicines. This was done without a mental capacity assessment and not as part of a best interest decision. Records showed one person's family had made decisions around whether medical investigations should go ahead. The family members did not have LPA and there had been no assessment of the person's capacity to be involved in making the decision. There were no mental capacity assessments on this person's file for any aspect of the care and treatment provided by the home.

A second person had been put on a soft diet and syrup consistency fluids on the advice of a speech and language therapist (SALT) to make swallowing safer. There had been no consideration given to whether the person had capacity to refuse this change in the consistency of their diet. In some cases people prefer to eat the foods they like and accept their increased risk of choking. We found a third person's care records contained contradictory information. There was a room key risk assessment that stated they had mental capacity, a cognition care plan stated they needed assistance with more complex decision-making, their LPA care plan stated they had full capacity and a DoLS care plan stated they would be prevented from leaving the home unaccompanied because they had a medical condition and were hard of hearing.

We spoke with the home manager about the process for assessing people's mental capacity and making decisions of their behalf. They demonstrated a lack of understanding which had led to the issues described above, but were keen to learn the correct process and implement it at the home as a priority. Our observations around the home during the inspection showed people who lacked capacity to make some

decisions were supported by staff to decide what activities to take part in, what to eat and where to sit in the home. However, concerns with record-keeping evidenced the correct procedures were not being followed.

Concerns with MCA compliance was a continuous breach of Regulation 11 (1) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Feedback about the food and drinks served at Meadow Court from people and relatives was positive. One person told us, "The breakfast is always good", a second person said, "The food is lovely. I like veggie burgers and beans on toast", and a third commented, "We get snacks between meals." We observed three meals during the inspection and one of our inspection team ate a meal with people who used the service. Tables were set with tablecloths, napkins, cutlery and condiments. People who preferred to dine in their rooms received their meals there. Other people chose to eat in one of the lounges or in the reception area of the home. We saw people were given a choice of foods and were asked by care staff if they had eaten enough or wanted more. A trolley also went round regularly between meals to offer hot and cold drinks as well as cakes and other snacks. The home had installed a drinks making area in the dining room so people and their relatives could help themselves to refreshments whenever they chose to.

We looked around the kitchen and spoke with one of the cooks. They could explain how they modified foods for people with special requirements, such as texture or low sugar for diabetes. We noted the home kept records for the amount of food and fluids consumed by each person at the home. It is more usual for this to be done only for those people who have experienced weight-loss or who are at particular nutritional risk. The director for the registered provider company who focused on administration said they felt it was good practice as any issues with weight loss could be analysed immediately. This meant the home monitored people's nutrition and hydration to ensure their needs were met.

The most recent food hygiene inspection at the home in October 2016 had given a rating of five out of a possible five, which meant the standards of hygiene were good.

People's electronic care records evidenced they saw a range of healthcare professionals. During the inspection we noted representatives from various different services coming in to see people. We saw most of these wrote up their consultations with people on the electronic care records system. People's records evidenced they had seen dieticians, speech and language therapists, community nurses, GPs, social staff and tissue viability nurses, amongst others. One relative told us, "I have no doubt [my relative] is in much better physical and mental health than when [they] arrived." The home also had a video system they could use to seek face to face advice from clinicians at a local hospital. With the system people could be asked questions about how they felt and their symptoms. This was then used to triage the response to the person's condition. The hospital could arrange an ambulance if it was required. The home manager told us, "It's a clinical decision for us."

We spoke to two healthcare professionals during this inspection and they all gave us positive feedback about the home's communication around people's healthcare needs and willingness to follow advice and instruction. One healthcare professional told us, "If we give instructions or advice they follow it". After seeing a person for wound-care they commented, "Because they let us know straight away it's healing quicker." A second healthcare professional told us, "I genuinely feel I don't have to chase them up – they follow my advice. They do call in healthcare professionals when they need them. They're valid referrals." This showed us the home worked well with other services to meet people's wider healthcare needs.

Some of the people living at Meadow Court had a diagnosis of dementia so we asked the management team how the home had been modified to meet their needs. Two of the directors for the registered provider

company told us they had visited the internationally recognised dementia centre at the University of Stirling. They could describe various aspects of dementia-friendly environments, including colour schemes, grab rails, door colours, carpet designs and signage. We noted the newer carpets at the home were plain as is recommended, and an order had just been made for picture signage to help people navigate around the home. The home manager stressed the management team wanted to preserve the 'homely' feel of Meadow Court, with its traditional furniture, pictures and ornaments, but try to implement good dementia practice whenever possible. One relative told us, "I feel the staff at the home have worked really hard to settle [my relative] in and make [them] feel comfortable and have been very sensitive to [their] dementia and the difficulties it presents." This meant the home manager had investigated and implemented ways to make the environment of the home more dementia friendly.

Is the service caring?

Our findings

People and their relatives described staff at the home as kind and caring. Comments included, "They are absolutely friendly", "They're all brilliant and we have a laugh", and, "People are friendly."

During the two days of inspection all the interactions we observed between staff and people were friendly and supportive. People and care staff frequently shared laughter. We found there was a homely atmosphere at Meadow Court and people could decide what they wanted to do and when. One person told us, "I have breakfast at 8-ish. I stayed in bed an extra hour and could have stayed two if I wanted to", a second person said, "It's quiet and nobody bothers you and they don't lay down the law to you", and a third person commented, "I get a choice when I go to bed and get up." A care worker told us, "I always ask if it's OK to assist them. I always ask if they want help." We observed a care worker answering a call buzzer on the first morning of our inspection. We heard them ask a person in bed if they'd like to get up; the person said they were not ready. The care worker responded with, "OK, I'll give you a bit longer then." Minutes from the January 2017 staff meeting we saw stated, 'You must not assume what the resident wants, they should always be offered a choice.' This meant people could exercise choice over what they did and when.

Staff we spoke with could describe people's likes, dislikes, preferences and personal histories in detail. The activities coordinator was using one-to-one time with people to record detailed information about people's past lives, families and interests. The home manager said, "It helps us to identify activities for them." As part of this the activities coordinator had recently spent time with a person living with dementia and established they enjoyed looking at old photographs of the local area and reminiscing. We saw this had led to a request to the local library for books of old photographs; the home manager said, "[Name] has a sparkle when [they] look at the photos." This meant staff at the home used people's personal histories to individualise their care and activities.

Staff at the home described how they promoted people's independence during personal care and at mealtimes. We noted minutes from staff meetings included discussion around promoting the independence of people at the home. For example, minutes from the January 2017 meeting stated, 'Please encourage [name] to stand independently, [they] can do this and we do not want to take away [their] independence by doing it for [them].'

People told us care staff supported them to maintain their dignity and also respected their privacy. We saw people's rooms were personalised with their own belongings, furniture and photographs. We observed people were dressed appropriately for the time of year in clean clothing and had their hair brushed or styled. People we spoke with told us they were supported to bathe or shower once a week and were happy with this. Comments included, "I have a bath every week. It is enough for me. I could ask for one more often", and, "It's once a week I think. I like it that way." We saw care staff knocked on people's bedroom doors before entering and people told us they always did this. This meant staff at the home respected people's privacy and dignity.

At the last inspection we identified a breach of regulation as people's care plans did not always reflect their

personal preferences. At this inspection we found people and their relatives were involved in designing and reviewing their care plans. Records showed people with mental capacity to make decisions around their care were regularly consulted to see if their care needs or preferences had changed. Relatives of people living with dementia who were involved in their care also received copies of their care plans for comment. Relatives told us, "I get a copy of the care plan every month", and, "I receive a monthly care plan which is detailed and comprehensive." Minutes from the January 2017 staff meeting stated staff were to ask for feedback from people around their preferred foods, which activities they enjoyed or any concerns they had. This meant the home involved people in the review of their care plans on a regular basis.

Members of the management team could describe how and when to refer people to advocacy services. We saw information about accessing advocates was included in the home's service user handbook, which every person at the home had a copy of. One of the directors of the registered provider company gave an example of when they had referred a person to an advocate to help them manage their money. They told us, "I didn't think it was appropriate for us to do it." This meant people had access to independent support to make decisions when they needed it.

We asked the home manager how they promoted equality and supported people's diverse religious and cultural needs. The home manager showed us the pre-assessment form used to assess potential new admissions to the home included sections on people's religious and cultural needs; they told us, "We are aware of the different religions. We realise everyone is different and have their own beliefs and ways of doing things." The service had never supported a person with specific cultural dietary needs. The home manager told us if a person moving to the home needed this, there would not be a problem. They said, "We'd talk to the person and their family and do some research." The home manager described how they had sought the views of a person living at the home who did not celebrate Christmas to find out if they wished to be included in the exchanging of presents with everyone else. They said they wanted to make sure the person's wishes were respected but did not want them to feel left out. This meant the home respected people's cultural and religious diversity.

People's electronic care files noted whether or not a 'do not administer cardiopulmonary resuscitation' or DNACPR decision had been made with or for them. We saw the paper forms were kept in a file in the medicines room. Those we checked had people's correct name and address details on. The care manager told us they were stored in the medicines room so staff could access people's medicines records and DNACPR forms quickly if a person was to be taken into hospital urgently.

The home manager told us staff at Meadow Court provided end of life care to people when their needs could be met. Records showed the involvement of people's GPs and community nurses in the care of people approaching the end of their lives. Training records showed some staff had undertaken additional specialist training on palliative care; the home manager told us, "The district nurses come in if people are on a syringe driver. The staff are amazing at end of life care."

We asked care staff what they thought good end of life care involved. One member of care staff said "They need support and comfort. They may need turning or more personal care given", and a second told us, "It's about making them comfy and reassessing them." Feedback from relatives of people who had received care at the end of their lives at the home was positive. Comments from thank you cards included, "Words cannot express our grateful thanks for the wonderful care you gave [our relative] in the last years of [their] life", "[Our relative] was very happy at Meadow Court, which was a great comfort to us", and, "In particular your care and understanding during [their] last weeks which enabled [them] to pass away with great dignity." This meant the support people received at the end of their lives at Meadow Court was good.

Is the service responsive?

Our findings

People and their relatives told us staff at Meadow Court were responsive to their needs. Comments included, "They know what I need", "If I ask they do their best for me", and, "They know what they're doing here. They know exactly what you like and keep it in mind."

The home used an electronic care planning system to record people's risk assessments, care plans and daily care interventions. Areas covered included mobility, nutrition, cognition, communication, death and dying, oral health and skin care. The home manager told us they were responsible for creating, reviewing and updating people's care plans, and records showed they had been evaluated on a monthly basis. We noted some care plans were detailed and person-centred, whereas others contained generic statements or information that was inaccurate. For example, one person with epilepsy and swallowing problems had a death and dying care plan which said they had dementia. This meant people may not always receive the person-centred support they needed.

Daily records evidenced people were receiving person-centred care, care staff could describe people's needs and preferences in detail, and people told us they were happy with the care they received at Meadow Court.

Care staff who supported people recorded this on a different part of the system to people's care plans and risk assessments. During the inspection we asked care staff how they knew what people's needs were. All care staff we spoke with said people's needs were described in their care plans and that they read these when people were admitted to the home and when their needs changed. However, one care worker we asked for assistance with accessing people's care plans on the electronic system did not know how to do this; they told us they relied on a brief summary of people's care needs on a different part of the system. This meant not all care staff were regularly reading people's care plans. We discussed this with the home manager; they said they would ensure care staff received further training on the care planning system.

The home manager explained the process of considering new admissions to the home involved three members of the management team. Together they would review information about the person's needs supplied by the local authority and one or two would then go to visit the person to assess their needs using the home's own pre-admission assessment documentation. The home manager said part of the assessment process included consideration of the dependency of people already in the home and that people with more complex needs could only be admitted if they were sure meeting their needs would not compromise others, and vice versa. This showed the home had an effective system of admission assessment in place.

People and their relatives said there were regular activities provided at Meadow Court. We saw a timetable of activities planned for the week of our inspection included one-to-one chats, pamper time, adult colouring and a talk on bee-keeping. One person said, "I loved it when we had the owls. It was interesting", a second person commented, "We've painted pictures on plant pots then we glazed them", and a third person told us, "We have lots of entertainment." People and relatives said they enjoyed sitting out in the small courtyard garden when the weather was nice.

The registered manager for the home was in the process of deregistering with the Care Quality Commission and had switched roles to that of activities coordinator. They told us, "It's wonderful. I love it." They worked 8am until 5pm Monday to Thursday and told us, "I try to arrange outside entertainment on a Friday."

During the inspection we observed people taking part in a range of activities, including adult colouring, dominos, a quiz, a reminiscence discussion and scrabble. Newspapers were delivered and we saw people reading them. There was a large pull down screen in the dining room and we saw people enjoying a black and white movie with hot drinks and snacks. One room had been converted to a small TV room. A person who often used the room told us, "I can watch the programmes I like and no one is talking." Feedback from people and relatives, and our observations, showed people had access to a range of meaningful activities at the home and enjoyed taking part.

One formal complaint had been made to the service since the last inspection in February 2016. Records showed it had been investigated and responded to appropriately. We saw a complaints policy was in place and details of how to complain were contained in the service user handbook every person at the home had been provided with. People and their relatives told us they felt able to complain if they needed to. One person told us, "I'd tell one of the staff", a relative said, "I'd speak to either [the care manager] or [the director with responsibility for administration], but we don't have a complaint", and a second relative commented, "I feel as if I can go to anybody under this roof and tell them anything I want." This meant people and their relatives felt able to raise concerns if they needed to, which indicated there was a positive and open culture at the home.

Is the service well-led?

Our findings

People and their relatives told us they thought Meadow Court was well managed. Comments included, "As far as I'm concerned it is (well managed)", "What I've seen here is first class as far as I'm concerned", and, "Absolutely wonderful." Feedback from care staff at the home about the management team was also positive. One care worker said, "They're great. They're approachable", and a second told us, "They're absolutely lovely. I can speak to any of them."

The management team at the home had undergone changes since the last inspection. The registered manager was in the process of deregistering with the Care Quality Commission (CQC) and had become the activities coordinator. The management team in place consisted of four directors of the registered provider company who were part of the same family. One of the Directors had taken up the role of home manager and was in the process of applying to become registered manager. The other three directors had assumed responsibility for administration, finances and maintenance, respectively. People and relatives we spoke with did not understand the roles and responsibilities of the different member of the management team, but said they felt able to raise concerns with any of them. The home manager said once their position as registered manager was confirmed, they intended to hold a special residents' and relatives' meeting to explain the management changes at the home.

At the last inspection in February 2016 we identified a breach of regulation relating to good governance as there were concerns with the oversight the registered manager had over the quality and safety of the service. At this inspection we found a range of audits and other quality monitoring was in place. As discussed earlier in this report, the home manager was recording and analysing information on falls at the home and had used this to increasing staffing levels between 5pm and 9pm after a falls trend was identified. Other accidents and incidents at the home had not been analysed for trends at the home, although records showed they were overseen and followed up by the home manager individually. The home manager told us they would add all accidents and incidents at the home to the falls analysis spreadsheet so they could be reviewed together as a whole.

Records showed other regular audits at the home included wheelchair risk assessments, nutritional risk, infection control, and the checking of mattresses and pressure cushions.

As discussed earlier in this report, we identified issues with the content and quality of people's risk assessments and care plans, so we asked the home manager how people's care records were audited. The home manager explained they reviewed and evaluated all people's risk assessments and care plans on a monthly basis after care staff had discussed them with the individuals they concerned. The home manager conceded this might mean they could not identify inaccuracies in their own work and committed to implementing a care plan audit which involved the sampling of care plans by other members of the management team.

Concerns with care plans, their review, update and audit were a breach of Regulation 17 (1) and (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The home manager and care manager had been on medicines training in January 2017 which involved their creating an action plan for the improvement of medicines management at the home. We saw this action plan was detailed and progress had been made implementing the various changes required. For example, records showed medicines incidents were now reviewed and evaluated for shared learning purposes at team leader meetings. As discussed earlier in this report, we found some concerns with medicines management, and with the content of people's care plans. This meant whilst improvements had been made in the oversight of quality and safety at the home, there was still more to be done.

People and their relatives had been given opportunities to provide feedback about the service they received at regular residents' and relatives' meetings. People told us they could raise any concerns and were listened to. Minutes of the last meeting listed 14 attendees. Items discussed included the menu, future activities and those planned for the coming month, the summer fayre, and whether the home would benefit from a suggestion box. There had been no annual survey of residents and their relatives in 2016; the home manager told us this was planned for Spring 2017. This meant people and their relatives could make their own suggestions on how to improve the service.

At the last inspection in February 2016 we found general staff meetings were not held. At this inspection records showed general staff meetings had occurred on a quarterly basis. Minutes evidenced discussions around training opportunities, communication, infection control and any issues or updates with people using the service. Care staff we spoke with said they valued these meetings; one told us, "We can raise any issues we want. They (the management team) ask us for ideas." The home manager told us they had sent round a staff survey at the end of 2016 but response had been limited. This had been raised at a subsequent staff meeting; minutes recorded, 'If we do not know you are unhappy we cannot do anything about it.' This meant staff at the home were given opportunities to share ideas and feedback about their experiences of working at Meadow Court.

At the last inspection in February 2016 we noted the home's policies and procedures which had been purchased from an external company had passed their review date of June 2015 and were potentially out of date. At this inspection we found the same policies were still in place. However, one of the directors for the registered provider company explained they had signed a new contract with the external company for a new set of policies and procedures and, unlike last time, rather than this being a one-off purchase, the company would supply updated policies should any changes relating to nationally available good practice or legislation be required. The new policies were due for delivery at the time of the inspection.

One of the responsibilities of a registered provider is to report specific incidents to the Care Quality Commission (CQC). Notifiable incidents include safeguarding concerns, police call-outs and serious injuries. We checked the records for these types of incidents and found they had all been reported appropriately.

Under the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015, registered providers have a legal duty to display the ratings of CQC inspections prominently in both their care home and on their websites. The home did not have its own website. We could not see the ratings from our last inspection displayed in the home so we asked one of the directors for the registered provider company where they were. They told us the ratings had been displayed in the home's entrance foyer but were taken down six weeks prior to the inspection so the area could be decorated. We saw they put the ratings back up immediately.

We asked the home manager about the registered provider's vision and values for the service, and how these were communicated to the staff. They told us, "We're trying to offer the best care. We want people to feel like this is their home", and, "The staff see what we expect from the way we interact with people. We

won't tolerate staff who are not caring. We won't keep them on." The home manager explained these expectations were also discussed with staff in staff meetings and during supervision sessions. We noted the home manager and three other directors for the registered provider company were present at the home and available to speak with people, their relatives and staff throughout the days we were there.

We asked the staff about the service's vision and values and why they chose to work at the home. Comments included, "I like looking after people. Connecting with them and hearing about their past", "I love it. You feel good at the end of the shift. You've helped people", "I love it. I love the residents, I really enjoy helping people. We want to care for people's families like we'd want for ours", and, "It's family run and that passes on through the home." Feedback from people and relatives, and our observations, showed the registered provider's vision and values of care underpinned the care and support provided by staff at Meadow Court.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The home was not compliant with the Mental Capacity Act 2005. This was an issue identified at the last inspection. Regulation 11 (1) and (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People's care plans were not always person-centred or up to date. The audit process in place had failed to identify these concerns. Regulation 17 (1) and (2) (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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>We found issues with the way risks to people were assessed, managed and documented. People receiving respite care lacked risk assessments and care plans.</p> <p>Regulation 12 (1) and (2) (a) (b)</p>

The enforcement action we took:

We served a warning notice on the Registered Provider. They were told they must become compliant with the Regulation by 25 May 2017.