Kent County Council

Meadowside

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was carried out on the 13 and 15 September 2016 and was unannounced.

Meadowside is registered to provide accommodation and personal care for up to 20 people. It is a respite service, offering overnight stays for people with learning disabilities, who usually live with family members or carers.

People using the service had a range of physical and learning disabilities. Some people were living with autism and some required support with behaviours that challenged.

Downstairs there was a kitchen, dining room, activities area, lounge and several bedrooms and bathrooms. Upstairs there were more bedrooms and bathrooms, and a small lounge.

At the time of the inspection there were nine people staying at the service. Two people were there on a long stay placement, meaning they were living at the service until a more suitable place could be found.

The service had a registered manager in post. A registered manager is a person who is 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.

Some people needed support to communicate. Although they had communication books to assist them to make their needs known staff did not use them. We saw one person sign to staff that they would like a drink and staff did not act or understand what they wanted. There was a lack of accessible communication within the service so it was not always clear to people who would be supporting them. People with more complex needs were not given choices in a way they could understand, about what they wanted to eat.

Staff did not always treat people with respect. Staff discussed a personal, private matter in front of people.

Medicines were not always stored safely and at the correct temperature. Some medicines had specific storage requirements and these were not always adhered to. Thickener powder, used to thicken people's drinks if they had difficulty swallowing, was not stored safely. There was a risk that people could pick it up and accidentally swallow it.

Staff did not consistently record or monitor people's behaviours. We saw three different staff members react in a different way to one person's behaviour, as there was a lack of guidance for staff to follow. Sometimes staff did not complete incident forms when incidents occurred meaning further analysis was not done to look to reduce the chances of them happening again in the future. Staff did not update people's care plans and risk assessments when their needs changed.

Some people needed help with eating and drinking or moving safely. People's care plans explained how to manage these risks and ensure that people received the care they needed to minimise the risks from occurring. Other risks, such as those relating to unstable health conditions such as epilepsy were not assessed fully.

There was a number of staff off sick. People told us that they sometimes did not ask staff for assistance as they were aware of the high sickness levels. Some people needed one to one support but staff were engaged in other tasks so were unable to provide this level of care at all times. We saw some people becoming distressed and staff not responding immediately as a result.

People and their relatives told us they were not always able to go out as much as they would like. One person liked to go out but needed extra assistance from staff so did not go out as often as they would like. People were engaged in a variety of activities on the day of the inspection, including a music workshop and craft activities.

Due to the high levels of staff sickness, staff had not had regular one to one meetings with their manager or team meetings to discuss any issues and reflect on their practice. Staff received training on key topics such as safeguarding; however, some staff were due refresher training for topics such as behaviour support and medicine administration.

The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. One person had been staying at the service for several months and required continual support and supervision to stay safe. They were unable to consent to their care and treatment. The registered manager had not applied for a DoLS authorisation for this person. They contacted the local authority and applied for a DoLS on the second day of the inspection.

The registered manager told us that there had been several historical issues, relating to the premises and physical environment. Paint had been flaking from an entrance hall containing asbestos and the provider's maintenance department had been slow to respond. The registered manager told us they had been focused on ensuring the physical environment was safe and the quality of care had 'slipped as a result'. They moved their office to the front of the service so they were able to view what was happening on the second day of the inspection.

The registered manager and team leaders carried out regular audits on the environment and paperwork, but their checks had not identified the errors we found during the inspection. Annual questionnaires were sent out to people, relatives, staff and other stakeholders so they could give their views about the service. Easy read surveys were also available so that everyone had the opportunity to take part. The responses were collated and action was taken to address any ideas and suggestions made.

People's needs were assessed before they started using the service. People's healthcare needs were managed well. If people became unwell when using the service staff supported them to see a doctor.

Some people had eating and drinking guidelines in place from speech and language therapists (SALT). Staff followed these guidelines and food and drinks were served at the correct consistency. Staff ensured people had enough to drink during hot weather.

Staff were kind to people and there was affection between people and staff. When people needed to go to

the bathroom they were asked in a discreet manner.

The registered manager was aware of their responsibilities regarding safeguarding and staff were confident the registered manager would act if any concerns were reported to them. The registered manager was experienced in working with people with learning disabilities and providing person centred care. The CQC had been informed of any important events that occurred at the service, in line with current legislation. Staff were checked to make sure they were of good character and suitable to work with people.

People's relatives, staff and other stakeholders were regularly surveyed to gain their thoughts on the service. There was a complaints policy in place and people and their relatives said they knew how to complain if they needed.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the back 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?

Requires Improvement

The service was not consistently safe.

Thickener powder was not stored safely, placing people at risk.

There was a high number of staff off sick which impacted on the level of support provided to people. Appropriate checks were carried out on staff before they started to work with people.

Medicines with specific storage requirements were not stored correctly. Medicines were not stored at the correct temperature.

Staff did not consistently update people's support plans when changes in their behaviour occurred leading to a risk of inconsistent support.

Some risks relating to unstable health care conditions such as epilepsy had not been assessed fully.

Staff knew how to recognise and respond to different types of abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always able to choose what they wanted to eat.

Staff had not had the opportunity to meet one to one with their manager for some time. Some staff required refresher training in areas such as medicine administration and positive behaviour support.

One person had been staying at the service for an extended period of time and was unable to consent to their care. The registered manager had not made a DoLS application, in line with current legislation.

Staff sought advice regarding people's healthcare needs when necessary.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always communicate with people effectively. Staff did not use people's communication books and were unclear what people meant when they used signs to communicate.

Staff were kind to people and there was affection between people and staff.

People received the support they needed in a discreet manner.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's needs were assessed before they started to use the service; however people's care plans sometimes lacked the detail for staff to provide effective support.

People and their relatives told us they were not able to go out in the community as much as they would like. People were engaged in a music workshop and craft activities on the day of the inspection.

There had been no complaints in the past year.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The registered manager and team leaders carried out regular audits on the environment and paperwork, but their checks had not identified the issues we found during the inspection.

People did not always receive person-centred care. The registered manager told us they were committed to improving this.

The Care Quality Commission (CQC) was informed of important events within the service, in line with current legislation.

Annual questionnaires were sent out to people, relatives, staff and other stakeholders so they could give their views about the service.

Meadowside

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 13 and 15 September 2016 and was unannounced. It was carried out by two inspectors on the first day and one inspector on the second day.

The provider had not had the opportunity to complete a Provider Information Return (PIR) as they had not received this document before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

At the time of the inspection we spoke with the registered manager and two team leaders. We also spoke with five care staff and one relative. We spoke with one person using the service.

We looked at seven people's care plans and the associated risk assessments and guidance. We looked at a range of other records including four staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance surveys and audits. We observed how people were supported and the activities they were engaged in. Some people were unable to tell us about their experience of care at the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us

After the inspection we spoke with two relatives about the service.

We last inspected Meadowside on 18 September 2014 when no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they felt safe when using the service. One relative said, "I definitely feel that my relative is safe." A person said, "I feel safe because I get along with people, they don't judge me and I feel better for it."

Thickening powder was not stored safely at the service, placing people at risk. On the first day of the inspection thickening powder was stored on the counter of a small kitchen with a serving hatch open into the lounge. Staff told us this was so it was easily accessible to staff if people wanted a drink. The lounge and kitchen were open and staff were not always present so people had unsupervised access to the powder. We discussed this with the registered manager and they said that the thickener would be moved and stored somewhere more secure.

On the second day of the inspection we observed a staff member using thickener to thicken a person's drink at lunch time. They left the thickener on the table in front of them for the duration of the meal. Staff then left two people sitting at the table to clear away their plates. One person picked up the tub of thickener and brought it towards their mouth. They held the tub in their hands and played with it, bringing it up to their mouth several times before staff intervened and removed it from them. There was a risk they could have swallowed the thickener. We discussed this incident with the registered manager and they agreed it should not have happened.

Staff had identified some of the risks associated with people's care, such as mobility and eating and drinking. Each care plan explained how to manage these risks and ensure that people received the care they needed to minimise the risks from occurring. Other risks, such as those relating to unstable health conditions such as epilepsy were not assessed fully. One person's care plan contained basic information about the emergency medicine they needed to take if they had a seizure, but not what their seizures looked like or how often they occurred.

People's behaviours were not always managed safely. Staff did not consistently support and record people's behaviours. Guidance to show staff how to manage people's behaviour was not up to date and did not always reflect people's needs.

We saw one person displaying behaviours that challenged. The person was taking objects that did not belong to them and was refusing to give them back. When staff tried to intervene the person pushed them away. Three different members of staff tried to intervene and the staff all used a different approach without success. There was no guidance in place for staff to follow to tell them what to do should this happen. There was a lack of a consistent response by the staff and the behaviour continued. Staff did not document the incident so there was no learning from it and changes to the person's support.

One person told us about an incident when another person had set off a fire alarm. Although it had been documented in the person's daily notes and their support plan had been updated staff had not completed an incident report so that the incident could be looked into in more detail. We spoke with the registered

manager about this and they said, "I know we didn't do any analysis about what happened, as I didn't fill in my bit of the form. We should have done an incident form; it means we can monitor things fully."

Accidents, including falls were well documented and information was sent to the provider's health and safety department so they could investigate and take any necessary action.

Risks to people were not always assessed, managed and mitigated. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us there were high levels of staff sickness in the service. One staff member said, "Recently we've had some staffing issues. It's unusual, everyone is ill and it has an impact. We try to get the same agency (staff), but we're all doing extra too." The rota showed that shifts were covered with agency staff when needed and the registered manager said they often came in to cover shifts if no one else was available.

One person told us they were aware of the staff sickness levels and said, "Sometimes if they're short on staff I don't ask them to move my chair as they need two staff to do that. It would be unfair to take staff away from people who need them, but it means I'm stuck on my own sometimes." We spoke with the registered manager about this and they said there was always enough staff to move the person's chair. They said they would speak to the person and reassure them they could ask for assistance if needed. The registered manager was aware that the person had concerns regarding this and had previously sent an email to all of the team leaders telling them they must move the person's chair if they were asked.

The registered manager assessed people's needs on each stay and worked out the staffing levels accordingly. Some people were assessed as needing one to one support. There was enough staff on shift to provide this, however we observed some people who needed one to one support being left by staff as they had to go off to do other things including clearing tables and cleaning. Two people appeared to become distressed. One was hitting themselves, rocking in their chair, banging on a chair and pulling at people. The other person was pulling at staff's arms, going from staff to staff pointing and making noises. There was no staff available to reassure or talk to both people. The registered manager said they would review staffing deployment for each shift and ensure staff were focussed on people and not other tasks.

There was not enough staff to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not always stored safely and at the correct temperature. If medicines are stored at too high or too low a temperature their shelf life can be affected and the medicine may not work as intended. Room temperatures were not recorded consistently, so there was a risk medicine had been stored at a temperature that was either too high or too low. Staff had not recorded the temperature of the room where medicines were stored between 31 August 2016 and 6 September 2016 and 6 September 2016 and 10 September 2016.

When temperatures had been recorded, they were consistently 25C or above, which is above the recommended level. Staff had recorded they moved the medicines trolley to a cooler location and opened a window on several days but this had not lowered the temperature to a safe storage level. The registered manager contacted the provider's maintenance department and a temporary air conditioning unit was installed on the second day of the inspection to ensure the room temperature was lowered sufficiently.

Some medicines had specific storage requirements as they were liable to misuse. We found one medicine

stored in the medicine cabinet which should have been stored separately and locked away. Staff told us that they had checked the medicine label and it had not said that it required special storage. The registered manager confirmed it did require special storage and that staff should have been aware of this. Records showed when the medicine had been present in the service previously it had been stored correctly.

There were some creams stored in a cupboard in the medicine room and in a fridge that had been turned off. We spoke with staff and asked why these creams were there and they told us they had "No idea." When they checked, the medicine was out of date and required disposal. The registered manager told us that all medicine should either be disposed of or sent home with people at the end of their stay.

We recommend that the provider reviews their medicines policies, especially relating to storage of medicines.

The registered manager told us the provider's maintenance department had caused delays in addressing maintenance issues. Paint on a porch way that had asbestos had started to flake in July 2015, the registered manager had reported this and showed us emails they had sent requesting the works to be carried out on multiple occasions. The works were approved in April 2016 and had not been carried out until September 2016. A legionella risk assessment had been carried out on 4 July 2016 and recommended that new thermostatic mixer valves should be fitted urgently. These were being fitted on the day of the inspection, over two months later.

Staff carried out regular health and safety checks of the environment and equipment to make sure it was safe to use. These included ensuring that electrical and gas appliances were safe. Regular checks were carried out on the fire alarms and other fire equipment to make sure they were working properly. People had a personal emergency evacuation plan (PEEP) and staff and people were regularly involved in fire drills. A PEEP sets out the specific physical and communication requirements that each person has to ensure that they can be safely evacuated from the service in the event of an emergency.

Staff knew how to recognise and report different types of abuse. They had received safeguarding training and information about abuse. The Kent and Medway safeguarding protocols were on display in the office for all staff to refer to if needed. Staff told us they would report any concerns to the registered manager. One member of staff said, "I'd go straight to my manager or the team leader. I've done it before in the past, but I've not had to here. Here people are safe." Staff were confident that the registered manager would act on any concerns that were raised. The registered manager was aware of their safeguarding responsibilities. There had been no safeguarding issues in the past year, but the registered manager was in regular communication with people's care managers and informed them of any incidents that occurred.

Recruitment procedures were thorough to make sure that staff were suitable to work with people. Written references were obtained and checks were carried out to make sure staff were of good character and were suitable to work with the people. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Requires Improvement

Is the service effective?

Our findings

People were not always given choices about what they wanted to eat at meal times. One member of staff told us, "I'll be honest I don't think people get enough choice with food. We should offer more choices." A person told us, "It depends what food they've ordered in, but no, we can't always choose what we want to eat."

There was no information displayed about what food was available so people did not know what the choices were for lunch or dinner. One member of staff told us, "People are told on the day or the night before what is for lunch, it could be better." However, on the morning of the inspection we asked two people what was for lunch and they said, "I don't know what we're having today." and "No I don't know what is for lunch, I haven't asked."

Lunch was served in a large dining room. The kitchen was linked to the dining room by a serving hatch and food was served from there. Some people were able to go up and choose their meal. On the day of the inspection people could choose between haddock or sausages. However, some people with more complex needs were not shown the different options and remained sitting at their table. Staff decided for them what they were going to eat. One member of staff asked, "What is the sign for haddock?" No one responded and they did not sign to the person they were supporting what the different options were for lunch. The same thing happened when choosing dessert.

Menus were decided in advance by staff. We asked what involvement people had in choosing the menus and were told people discussed them during service user meetings. However, a service user meeting had not been held for some time. One member of staff told us, "Three or four times a year we'll change the menu and try and get input from service users. Ultimately we know people's likes and dislikes though."

The provider had failed to enable people to make choices about their support. People were unable to make choices regarding what they ate. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff showed concern for people's well-being. It was very hot on the day of inspection and staff were encouraging people to drink. One person was very reluctant to drink. Staff then offered the person jelly which has a high water content, which they ate. Staff then ensured that jelly was always available for that person. They also made a note to discuss this with the person's main carer at the end of their stay.

Some people had eating and drinking guidelines in place from speech and language therapists (SALT). Staff followed these guidelines and food and drinks were served at the correct consistency. People received the support and supervision they needed to eat safely. One person told us they enjoyed the food and that it was, "Five star, it is what I would cook for myself."

People and their relatives told us that staff were skilled in carrying out their roles. However, we found that staff were not appropriately supervised and had not all had the updated training they needed to carry out

their roles. Staff did not have the opportunity to meet with their manager regularly to discuss their personal development needs and reflect on their practice. The registered manager told us that due to staff sickness levels the opportunity for staff to meet and discuss any issues, both one to one and as a team, had not been offered as they needed to ensure there was enough staff to support people. On the second day of the inspection the registered manager had organised regular all staff and team leader meetings for the year ahead and said they would discuss arranging supervisions then. We will follow this up at the next inspection.

Staff had received training in key topics such as safeguarding and mental capacity, however some training including fire safety and nutrition and hydration was due for renewal in line with the provider's policy. Some staff were administering medicines to people, and their medicines training needed to be updated. The registered manager had identified this and booked staff onto additional courses. The registered manager told us that it could be difficult to book staff onto courses run by the provider. A range of training methods such as face to face and online training had been introduced to try and make it easier for people to complete some courses.

Some staff had not had training in positive behaviour support or how to deal with behaviours that challenged. People's daily notes showed that staff were regularly dealing with these types of behaviours and we witnessed several incidents during our inspection. Some of these incidents were not dealt with consistently and successfully by staff. We saw some people become distressed or displaying behaviours that challenged and staff did not talk to them or reassure them. At lunch time we saw one person trying to get staff's attention by banging their wheelchair and their chest. Staff responded by saying, "Learn to be patient" in an abrupt way.

Staff did not have the appropriate supervision, support and training to enable them to carry out their roles effectively. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff worked through induction training during a six month probation period, which included working alongside established staff. The provider had introduced the Care Certificate for new staff as part of their induction, which is an identified set of standards that social care workers work through based on their competency.

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 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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Some people were constantly supervised and so needed a DoLS authorisation to make sure the constant supervision was lawful. The registered manager had not applied for DoLS authorisations. One person had been staying at the service since March this year, and they were unable to leave without staff support. The registered manager had not considered whether he needed to apply for a DoLS authorisation for this person. After we pointed this out, the registered manager sought advice from the local authority and applied

for a DoLS authorisation.

The provider failed to ensure constant supervision and any deprivation of liberty was lawful. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they always assumed people had capacity. However, when people lacked capacity to make decisions capacity assessments had not been carried out.

People's healthcare needs were managed effectively. One person told us, "I can walk so much better now, staff are great at helping me when I'm unwell and always come with me to my appointments." If people became unwell, staff sought medical advice promptly. One person had been supported to attend a local hospital when there were concerns they had an infection and they were prescribed antibiotics. Staff were liaising with another person's care manager to arrange an optician's appointment, as they had not had an eye test for some time.

One person staying at the service was being supported by district nurses. They told us, "The staff here are great, the nurses help me, but they help me with everything else, I'm happy here." The person's mobility had increased since they had moved to the service.

Requires Improvement

Is the service caring?

Our findings

Relatives told us that staff were helpful and approachable. One relative told us, "It surprises me how they remember things about my loved one. They'll say, it's your favourite tea, sausages, and that's impressive. I'd forget if I was dealing with that many people." Another said, "The staff are very pleasant and they haven't changed a lot over the period of time [my relative] has been coming, that says good things about a place." We saw some staff behaving in a compassionate and kind way. However, we also saw that staff sometimes lacked the skills to engage with people in a caring manner and did not always know how to communicate with people effectively.

Staff did not always know the best way to communicate with people, which resulted in people becoming distressed or frustrated. Some people were unable to communicate verbally and used a variety of communication tools, including communication books to make their needs known. People's care plans contained information on how to use these books and how people communicated. However, on the first day of the inspection staff did not use communication books so people did not have the support they needed to communicate. We spoke with the registered manager about this and they said that staff should be using people's communication books regularly.

We observed one person signing that they would like a drink. They did this several times in front of staff, but staff did not react or offer the person something to drink. We asked the person (using sign language) if they wanted a drink and they smiled. We told staff we thought the person may be thirsty and the staff member gave the person a drink which they looked happy about. We asked one member of staff if they were aware of the different signs the person used and they said, "Your guess is as good as mine," implying they were unclear what the person meant.

There was a board showing photographs of some of the staff on shift in the front entrance. However, this had a limited number of photographs on it and some people's names were written rather than have a photograph. People took us to the board several times throughout the inspection and pointed at the photographs, smiling whilst doing so. There was an opportunity to make this more meaningful by showing photographs of the staff on duty each day so people would know who would be supporting them. There were no pictures displayed or being used to show what activities or foods were on offer.

The provider had failed to enable people to make choices about their support. Communication support was not provided for people on a consistent basis. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always treated with dignity and respect. One person was sitting on the arm of a sofa, and staff told them that they were being 'naughty.' This was said in front of other people. Staff also discussed a private, personal matter at lunch time, in front of people. We recommend that the provider supports staff to provide dignified and respectful care.

Staff treated people with kindness. They spoke to people about their interests, families, pets and what they

had been doing since they last stayed at the service. People were introduced to staff they had not met before and were encouraged to talk about themselves and their likes and dislikes. There appeared to be affection between some people and staff, people hugged staff and smiled.

When people wanted to use the bathroom this was offered discreetly. People were supported by staff of the same gender unless they chose otherwise. During activities, staff explained to people what they were doing and what was happening next so people felt more at ease. People's privacy was respected. Staff knocked on people's doors and waited for a reply before entering. Staff supported people to go to their room for their medicines so they could take them in private.

People had regular visits from family and friends which were supported and encouraged by staff. One person told us that since using the service they now had a girlfriend. They were excited about them coming to visit them. A staff member told us "(Relatives) say they're given a good welcome. The staff might be different but they're always greeted with a smiley face. That makes me proud to work here."

People's care plans, associated risk assessments and other records were stored securely and locked away so that information was kept confidentially. When we asked questions about people staff answered in a quiet voice so not everyone was able to hear.

Requires Improvement

Is the service responsive?

Our findings

People told us that staff were responsive to their needs. One relative said "I'm more than happy with the service [my relative] gets." Some people told us they were happy with the activities they were offered and one person said "It's really good as I can get out." Other people told us they were not always able to go out as much as they wanted.

Each person's level of need was assessed before they started using the service. The registered manager looked at a person's healthcare needs, mobility, behaviour, communication and the support they needed with personal care and eating and drinking to assess how much staff support each person required. Before people moved in they were invited to look around and have tea so they could meet everyone. Care plans and risk assessments were written, using information from people, their families or care managers.

If people had to stay at the service in an emergency, people's care managers sent the registered manager information about the person. Staff used this information until they got to know the person and were able to write a more detailed care plan.

People's care plans and risk assessments were not always updated between respite stays. One person's daily notes showed they had refused support with personal care during a recent stay. Staff had been concerned about their skin becoming sore and had completed an incident form about the action they had taken. The person's support plan and risk assessments not been updated accordingly so staff did not have up to date guidance on how to support the person with their personal care.

The level of information in people's care plans was inconsistent. Some plans detailed the support people needed, what they could do for themselves and their preferences, but others did not. Some care plans lacked detail, so staff did not always have the information they needed to support the person in the way they wanted. For example, one person's care plan stated the person needed 'full support with personal care' but did not detail how to provide the support or what they could do for themselves.

Information on what people liked to do was limited, as was guidance for staff about how to support people with activities. There was a lack of information about what people liked to eat or drink and staff were not always aware of people's preferences. One person did not like any of the food on offer for lunch and staff did not know what to offer them as an alternative.

One person had been at the service for seven months. Their care plan did not give staff the information they needed to support the person safely. Incident records showed that having a bath could cause the person anxiety. There was no guidance for staff about how to minimise this and support the person to have a bath without becoming anxious or about offering alternatives to a bath. The registered manager told us they were reviewing the person's care plan currently to add more detail.

People and their relatives told us they were not able to go out as much as they would like. One person commented, "I like to go out. I like to do more activities." A relative told us, "My loved one would like more

activities." One person had been out only three times in the previous two weeks, despite their care plan saying they liked to go out regularly and be active. Staff told us it was difficult to support this person when going out as there were not enough staff.

The provider had failed to ensure that people received care that met their needs and reflected their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the day of the inspection people were supported to go shopping locally and they visited a local café. When they returned the staff showed great interest in what they had done and purchased. One person talked about the activities they had taken part in and told us "I've been shopping and had dinner out in Weatherspoon's."

People were engaged in a variety of activities within the service. Some people took part in a music workshop and had an opportunity to try different instruments. People also took part in craft activities, including colouring and making cards. One person showed us the card they had made for a friend and said, "I chose all the stickers on here, look, I really hope they like it."

People were encouraged to continue to attend clubs, groups or day centres as they did before they came to stay at Meadowside. There was a day centre on site which some people enjoyed going to and they had been supported to build relationships with other people who attended.

People told us that if they had any concerns or problems they would talk to the staff. There had been no complaints in the past year. The registered manager displayed the complaints procedure in the entrance hall of the service. An easy read leaflet was available, that was written in a format people understood so they had information on how to make a complaint if necessary.

Relatives were regularly surveyed to ask for their opinions on the service. One relative told us "If I had a problem I feel they would sort it. What they say they do."

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us that the service was well-led. One relative told us, "They are very helpful and approachable. The manager is good; he has visited us at home to arrange things. The service works for us."

The registered manager and team leaders carried out regular monthly checks on the service. These covered areas such as the environment and records. Team leaders reviewed people's care plans every time people came for a new stay to check that they had been updated. However, these checks had not highlighted the issues we had found during the inspection.

The registered manager told us they did not formally check the quality of care that staff were providing, as they had been focused on ensuring the environment was safe for people. The registered manager agreed that some staff's practice needed to improve. The registered manager told us they felt 'removed' from what went on day to day due to the location of their office, which was away from staff and people. On the second day of the inspection the registered manager had moved their office downstairs, to the front of the service. They told us, "I feel I'll be able to keep an eye on things better here, it's something I have been meaning to do for ages."

Some records were not completed, were not accurate and up to date. Staff did not always complete incident forms when incidents occurred so they could not be analysed to look for trends or any ways to prevent further incidents. Although some care plans were detailed, others lacked the information staff needed to support people effectively. Some care plans had not been updated when people's needs had changed. For example, when people displayed new behaviours that staff had not seen before. On the second day of the inspection the registered manager introduced a new daily notes form. These prompted staff to fill out an incident form if necessary that required signing off by a team leader. The registered manager said they hoped this would encourage staff to complete all required records.

There was a culture of openness and honesty within the service. The staff team said they were committed to improving the lives of the people who accessed the service, and everyone we spoke to said they thought that staff were kind and caring. However, we observed some instances where people did not receive person-centred care. Staff sometimes made choices for people, instead of encouraging them to make choices for themselves. Staff did not always use people's communication books when needed. The registered manager had not picked this up as observations, and supervisions were not happening. Staff meetings were not held regularly to give staff a chance to talk about any issues and share ideas to improve the service.

The provider had failed to assess, monitor and improve the quality of the service. The provider had failed to keep an accurate, complete and contemporaneous record in respect of each service user. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Annual questionnaires were sent out to people, relatives, staff and other stakeholders so they could give their views about the service. Easy read surveys were also available so that everyone had the opportunity to

take part. The responses were collated and action when people and their relatives had ideas or made suggestions. For example, people were able to stay in the bedroom of their choice whenever possible. Positive comments had been received such as 'Always found the service accommodating, helpful and caring' and, 'I enjoy my stays at Meadowside and like going out to the pub.'

Relatives said there was good leadership at the service and that they found the management team approachable. One relative said, "I see the manager and they're very on the ball and very helpful." People said they liked the manager and knew they could go to them with any issues. One person said, "The manager is really great, and they are the best manager in the world." Staff said they felt well supported and that although there was a high number of staff on sick leave, morale at the service was high. One member of staff said, "The manager is lovely. They've got so much going on but are always very approachable. It's clean, it's run well and the service users love it here."

The registered manager understood relevant legislation and the importance of keeping their skills and knowledge up to date. They were experienced in working with people with learning disabilities. The registered manager participated in a variety of events and forums with other managers.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had submitted notifications to CQC in an appropriate and timely manner in line with CQC guidelines.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to enable people to make choices about their support. People were unable to make choices regarding what they ate. The provider had failed to enable people to make choices about their support. Communication support was not provided for people on a consistent basis. The provider had failed to ensure that people received care that met their needs and reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always assessed, managed and mitigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure constant supervision and any deprivation of liberty was lawful.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

The provider had failed to assess, monitor and improve the quality of the service. The provider had failed to keep an accurate, complete and contemporaneous record in respect of each service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not enough staff to meet people's needs. Staff did not have the appropriate supervision, support and training to enable them to carry out their roles effectively.