Runwood Homes Limited

Lower Meadow

Inspection report

Drayton Avenue
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Warwickshire
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Tel: 01789268522

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Lower Meadow provides accommodation and personal care for up to 69 people. It provides care to older people, some of whom are living with dementia. Care is provided in four separate units over two floors. Each unit has their own lounge and dining room. At the time of our visit 30 people lived at the home as there had been a placement stop for 12 months and nobody had been able to move into the home.

People's experience of using this service:
•Changes in managers meant there had been no consistent leadership at the home.
•The provider was working towards a service improvement plan (SIP) to address the issues that led to the placement stop being imposed. Improvements in practice had not been consistently maintained when managers changed.
•Due to the high level of vacant rooms and significant changes in the staff team, we were not able to determine whether staffing levels would remain effective when the home was fully occupied.
•Improvements needed to be embedded into the culture of the home under the new manager and with the new staff team to ensure they would be sustained, particularly when new people started to move to the home.
•Overall medicines were managed safely and people received their medicines as prescribed.
•Staff had received safeguarding training and knew how to keep people safe protecting them from harm or abuse.
•People's risks to safety and well-being were assessed, recorded and reviewed to reduce the risk of avoidable harm occurring.
•People made decisions about their care and were supported by staff who worked within the principles of the Mental Capacity Act 2005.
•Staff were suitably skilled to meet people's needs.
•People received enough food and drink to meet their dietary requirements.
•People had access to healthcare as and when required.
•Care plans focussed on people's individual needs so staff could provide a personalised response to those needs.

Rating at last inspection: At the last inspection the service was rated as good. (The last report was published on 22 August 2017).

Why we inspected: This was a planned inspection based on the rating at the last inspection. The service is now rated as 'Requires Improvement' overall.

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as per our inspection programme. If any concerning information is received we may inspect sooner.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our Safe findings below.

Requires Improvement

Is the service effective?

The service was effective.

Details are in our Effective findings below.

Good

Is the service caring?

The service was caring.

Details are in our Caring findings below.

Good

Is the service responsive?

The service was responsive.

Details are in our Responsive findings below.

Good

Is the service well-led?

The service was not always well-led.

Details are in our Well-Led findings below.

Requires Improvement

Lower Meadow

Detailed findings

Background to this inspection

The inspection: We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: The inspection team consisted of three inspectors.

Service and service type: Lower Meadow is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. Registered managers and providers are legally responsible for how the service is run and for the quality and safety of the care provided. A new manager had been appointed and started working at the service on 25 March 2019. The provider told us the new manager would be submitting their application to become registered with the CQC.

Notice of inspection: The inspection visit took place on 3 April 2019 and was unannounced.

What we did: We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as abuse and serious injuries. We assessed the information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

We sought feedback from the local authority and other professionals who work with the service. At the time of our inspection visit there had been a placement stop in place for 12 months due to concerns about the

consistency in quality of the care provided at Lower Meadow. The provider was working towards a 'service improvement plan' to address these issues.

During the inspection: We spoke with the interim manager, the deputy manager, the regional operations director, two care team managers, one member of care staff, two members of housekeeping staff and the chef. We spoke with nine people and three relatives to ask about their experience of the care provided. However, some people who used the service had complex needs and could not communicate verbally. We used our short observational framework tool (SOFI) to help us understand, by specific observation, the experience of people who could not talk with us.

We reviewed a range of records. This included three people's care records and a selection of medicine records. We also looked at records relating to the management of the home. These included systems for managing any complaints, checks undertaken on the health and safety of the home and training records.

Requires Improvement

Our findings

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

Requires improvement: Some aspects of the service were not always safe and there was limited assurance about safety. There was increased risk that people could be harmed. Regulations were met.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
•The provider had systems and processes to ensure people using the service were safeguarded. Staff had received training in safeguarding people and understood their responsibilities for keeping people safe. One staff member told us, "I would report it to my manager. If they didn't do anything, I would take it further. I am very comfortable to do that."
•However, in one person's daily records we found reference to two incidents in October 2018 when they had become agitated with other people. Incident forms had not been completed which meant we could not be sure managers at the time had been made aware of the incidents.
•When staff completed body maps for unexplained marks or bruises, it was not always clear what action had been taken to identify the cause.
•The interim manager had recognised this as an area that needed to be improved and had raised staff awareness through meetings, memos and 'lessons learned' alerts.

Staffing levels and recruitment
•During our visit we saw sufficient staff on duty to meet people's needs. Staff told us they were happy with staffing levels and could respond to people's requests for support.
•However, staff from one of the provider's other homes had been working at Lower Meadow while the other home was being refurbished. Some of those staff had already returned to the other home and the rest were due to return the week following our visit.
•Whilst new staff had recently been recruited to Lower Meadow, some had yet to start work and others were still undergoing a probation period and receiving the appropriate training to support them with their work. This meant shifts would not always be staffed with care workers who had extensive knowledge of people's individual needs, and the relevant experience to provide care without support of other staff.
•The regional operations manager assured us they would consider the skills, knowledge and experience of staff when assessing staffing levels and, if necessary, increase staff numbers to ensure people's safety.
•Due to the high level of vacant bedrooms, we were not able to determine at this inspection whether staffing levels would remain effective when the home was full.
•The provider had a recruitment process that ensured staff had the appropriate skills, knowledge and values

to provide personal care.

Using medicines safely
•Medicines were stored securely and at the correct temperature to ensure their effectiveness.
•Overall, the administration of medicines was recorded accurately and showed they were being given as prescribed.
•Where people were prescribed 'as required' (PRN) medicines for anxiety, agitation or pain for example, there were guidelines in place as to when these medicines should be given.
•Some people's topical medicines to prevent sore skin were applied by care staff. The charts to record when topical medicines had been applied were not clear because they only stated they were to be applied 'as prescribed'. It was difficult to establish whether these medicines were applied in accordance with the prescriber's instructions.
•Some people received their medicines via a trans-dermal patch applied directly to their skin. It is important patches are rotated around the body to avoid people experiencing unnecessary side effects. Rotation charts showed the site and removal of the patches. However, one patch medicine was regularly applied to the same site when it was recommended that application to the same site should be avoided within 14 days. The deputy manager immediately contacted the prescribing healthcare professional for advice and assured us action would be taken to address this.

Assessing risk, safety monitoring and management
•People's care plans included assessments of their individual risks and described the equipment needed and actions staff should take to minimise their risks. Care plans had been reviewed and updated when people's needs and abilities changed.
•Equipment was used to support some people to stay safe. For example, pressure relieving mattresses to prevent skin damage and hoists and walking frames to transfer and move people safely. Routine checks and maintenance was carried out to make sure equipment was safe and in good working order.
•Staff demonstrated a good understanding of risk management. A member of domestic staff told us, "We don't spray chemicals when people are in there. Some people have asthma and we don't use aerosols in their rooms."
•A relative advised risks associated with their family member's health condition had been managed well.
•People at risk of not drinking enough had their fluid intake recorded. Improvements were required in the completion of these records as they were not always completed in a timely way. Some charts were completed from staff's memory, so we could not be sure they always accurately reflected people's fluid intake.

Preventing and controlling infection
•The home was clean, tidy and well maintained. A member of housekeeping staff had received training so they understood their role and responsibilities in relation to infection control and hygiene. They told us, "Infection control is so important as we are all at risk. Viruses transport from room to room and if they do, we will have poorly residents and staff which is not good for anyone."
•The laundry was arranged to support best practice, in line with the Department of Health guidance.
•Staff were provided with and wore personal protective equipment (PPE) to help prevent the spread of infections. Staff followed safe food hygiene practice when preparing and serving meals.
•Checks were regularly carried out to ensure good infection control practice was maintained within the home.

Good

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

Good: People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
•Although nobody had moved to the home in the previous 12 months, there was a pre-assessment process so the provider could be assured they could meet the needs of people new to the service. People could have trial periods at Lower Meadow before any decisions were made.
•Care plans were reviewed monthly and records were amended to reflect any changes in people's needs.
•Staff read the care plans so they could understand how to care and support people in line with people's wishes and choices.

Staff support: induction, training, skills and experience
•People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities.
•New staff completed an induction and worked alongside an experienced member of staff before working on their own to ensure they knew how to support people. The induction included observations of competency that were required to be signed off by a senior member of care staff.
•The provider's induction included the Care Certificate standards. At the time of our visit the service did not have a mentor to oversee the completion of the Care Certificate. The interim manager had implemented a plan to ensure new staff completed this part of their induction.
•Records demonstrated a high level of compliance in staff training. Staff spoke positively of the training and how this made them feel competent in their role. One staff member told us the provider had supported them to attend a course to become the moving and handling lead trainer. This had a positive impact on the home as they could do on the spot training and equipment audits.
•Staff had regular supervision meetings with their manager to discuss any concerns or training and development needs. One staff member said, "We have supervisions quarterly. They are really useful as you can discuss important issues."

Supporting people to eat and drink enough to maintain a balanced diet
•People were encouraged to eat and drink and maintain a healthy balanced diet and staff ensured people received food that met their dietary and cultural needs. Menus were changed every three months and based

on people's preferences.
•The menus in the dining room included pictures to assist people to make a choice about their meal. Staff showed people sample meals on small plates which enabled them to see and smell the food before they made a choice.
•The chef and staff knew people's dietary needs. Each person had a 'dietary requirements sheet' which detailed specific health requirements, likes, dislikes, allergies and cultural needs. The chef told us any changes in people's needs were communicated by the care staff.
•The chef understood the importance of increasing calories for those people at risk of weight loss and told us, "We provide fortified milkshakes and cook with whole milk and butter."
•Meals were a social experience where people sat together at nicely laid tables with music playing in the background. On one unit, staff sat with people to eat lunch which gave them the opportunity to encourage people to eat more and enjoy their meal. However, on another unit staff carried out other tasks rather than spending time with people.
•The chef sought feedback about the quality of the food by visiting people after lunch. They assured us these comments were acted upon to improve the quality of food people received.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
•People had access to healthcare as and when required.
•Staff liaised with specialised healthcare professionals as needed to ensure people received consistent and effective support. For example, senior staff were confident in responding appropriately to people who had lost weight. They understood when to seek GP input so a referral could be made to a dietician.
•One staff member told us how they had recently received advice from an occupational therapist to ensure they were using the most effective methods to support a person to transfer. They told us, "Working with other professionals improves things for the residents and gives us confidence in what we are doing."

Ensuring consent to care and treatment in line with law and guidance
•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 to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
•We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
•The provider completed mental capacity assessments for people's understanding and memory, to check whether people could weigh information sufficiently to make their own decisions or whether decisions needed to be made in their best interests. Assessments were decision specific, but lacked detail about how decisions were reached and what was discussed. The interim manager was arranging further training in this aspect of the MCA.
•In their everyday practice staff followed the principles of the MCA. People who did not have capacity to make decisions were supported to have choice and control over their lives and staff involved people in decisions about their care. Staff obtained people's consent before proceeding with any care interventions. One staff member explained, "We try and enable people to make decisions. We always ask them questions and we try asking things at different times of day (when people may be more alert)."
•Applications had been made to the local authority to ensure that where people were being deprived of their liberty, this was done lawfully.

Adapting service, design, decoration to meet people's needs

•The environment was supportive of people's needs. It was well decorated, inviting and directional signs in words and pictures supported people to identify rooms and find their way around independently where possible.

•People could choose to sit in a variety of communal areas or the easily accessible gardens. There were areas along some corridors where people could sit quietly or watch people going by. Many communal areas had large windows overlooking the street or areas of interest which gave people an understanding of the changing seasons and provided topics of conversation.

•People's bedrooms were personalised to give them a sense of belonging in the home.

Good

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity:
•People experienced positive caring relationships with staff. One person told us, "It's lovely here. Staff are very caring." A relative told us, "Staff are caring and will act on any of my concerns." Another relative commented, "[Staff] care for [relative] as though they are family."
•Staff approached people in a warm and caring manner and staff understood the individual needs of each person. One person on seeing a member of staff walk in the room said, "Look here she is, I have been missing her. Me and you go back a long way don't we."
•One relative particularly commented that staff had time for people. They told us, "I do like very much how everyone always calls her by name and stops and talks to her in the corridors. They never just walk past. It is only a little thing but it makes you think she is being treated properly."
•People living at the home had developed warm and caring friendships with each other. Staff encouraged people to engage and join in social activities together.
•People and their relatives were invited to share information about people's previous lives, work, interests and important relationships. People's life histories were explained in their care plans which helped staff understand people's motivations and routines.
•Staff knew people well and responded to their needs in a person-centred way, including if people became distressed. For example, one person became upset during lunch. A staff member recognised this could be due to pain. They offered the person their pain relief medicine before sitting at the table with them and eating a meal, chatting about the afternoon's activities to try and distract them. The person responded positively to the interaction.
•Staff completed training in equality and diversity and were committed to ensuring people's equality and diversity needs were met. They had the information they needed to provide individualised care and support, for example respecting people's religious beliefs.
•People told us they had felt they were treated fairly and were free from discrimination. They were able to discuss any needs that were associated with their culture, religion and sexuality.

Supporting people to express their views and be involved in making decisions about their care.
•People were supported to make decisions about their daily care. One relative told us, "[Relative] prefers to

sit in quieter areas but still observe what is happening in the home so staff support [relative] to sit by the office where they can watch what is going on."
•People told us they could live their life as they wished to. One person told us, "I like my own space and to be in control of my own life. I like to go to bed when I want, get up when I want and to have a shower when I want to. Staff support me when I need it and encourage me to remain as independent as I can without interfering in my life."

Respecting and promoting people's privacy, dignity and independence:
•People's privacy and dignity was respected. Staff knocked and sought permission before entering people's bedrooms, and doors and curtains were closed during personal care interventions.
•Staff understood that ensuring people were tidy and well-presented was an important aspect of supporting people's dignity. A member of laundry staff told us, "I am very passionate about making sure the residents look nice. I iron all clothing."
•People were encouraged to maintain their independence. One person told us, "It's like a home from home here, I can do what I want, when I want. I'm not a fan of gatherings so [staff] come and spend time with me in my room." Another person told us. "Staff help me have a wash when I feel like it but don't just do it all for me, they pass me the cloth or my toothbrush and I do what I can first."

Good

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

Good: People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
•Care plans focussed on people's individual needs and provided staff with enough information so they could provide a personalised response to those needs. This included their physical, mental, emotional and social needs.
•People, and where appropriate their relatives, were involved in developing and reviewing their care plans.
•Experienced staff knew people well and were knowledgeable about people's preferences and routines. They shared that knowledge effectively with newer staff.
•Information was shared so staff could respond to any changes in people's needs. The interim manager had introduced a daily meeting where the heads of department came together to discuss items such as any changes in people's health or any risks that had occurred over the last 24 hours.
•The provider worked in accordance with the Accessible Information Standard (AIS). Care plans showed people's sensory and communication needs had been assessed and were being supported.
•Some information such as the service user guide, activities schedule and menu had been produced in a pictorial format that was accessible for people living at the home.
•There was an activities co-ordinator who arranged group activities at the home. They were absent on the day of our inspection so no formal activities had been planned.
•However, care staff on the units had time to sit with people and engage them in spontaneous activities. For example, on one unit a member of staff facilitated a reminiscence activity where people shared their first memories and their favourite subject at school. On another unit people joined in a gentle exercise activity with a ball. In the afternoon a group of people enjoyed watching a film together and other people had a game of bingo.
•Whilst some people were happy with the level of social engagement, others felt more could be done to keep people engaged and provide meaningful occupation. One relative told us, "My only concern is the lack of stimulation."
•The deputy manager told us improvements had already been made in this area and people were being offered a wider range of activities. However, they acknowledged there was still scope for further improvement. They said, "It has improved with the care staff, they are doing more activities with people and we have a new activities co-ordinator in post so it will improve."

Improving care quality in response to complaints or concerns
•There was a complaints policy and system in place to ensure complaints were responded to in a timely way. The policy was available in the entrance to the home and in the service user guide given to people when they started to use the service.
•One complaint had been received in the three months prior to our inspection visit. Action had been taken in response to the concerns raised and 'lessons learned' had been shared with staff for future learning and reflection.

End of life care and support
•At the time of our inspection there was no one in receipt of end of life care.
•People's end of life wishes and preferences were discussed with people and this was documented in their care plans.
•The deputy manager told us they liaised with the GP and district nurses to ensure all required medicines were in place so people were comfortable and pain free in their final days.

Requires Improvement

Our findings

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

Requires Improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Regulations were being met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements

•The service had last had a registered manager in October 2018 but they had only been registered for two months. Since that time there had been several changes in manager which meant there had been a lack of consistent leadership in the home.
•Managers and staff told us the reason there had been a placement stop for 12 months, was because improvements had not been sustained when managers changed. One staff member commented, "It has been a nightmare. We have had seven managers in the last year so it has been very difficult to get settled. When we have a new manager, they want everything done their way so it has been difficult to adjust to their different ways." Another said, "Lack of management and management changes has impacted on the home. Mainly the staff morale, we don't know if we are coming or going. We adjust but it has been hard."
•At the time of our inspection visit, an interim manager had been managing the home since February 2019. They told us they had concentrated on implementing and following the provider's own processes and procedures rather than maintaining individual management ideas that had been introduced in the previous 12 months.
•A new manager had been appointed who had previously managed another of the provider's homes. They were due to permanently take up their position on 15 April 2019. The interim manager was confident there would be an effective transfer of responsibility as the new manager was experienced and had a detailed knowledge of the provider's processes. Staff were looking forward to having the stability of a permanent manager. One staff member told us, "The new registered manager is lovely, I am looking forward to her starting."
•Some people and staff had moved temporarily to Lower Meadow during a period of refurbishment at one of the provider's other homes. Staff felt this had also impacted on their ability to provide consistent standards

of care. One staff member explained, "When I started it was amazing, everything ran perfectly, but then things started to change. We took on [name of other home] residents and staff and we have not been able to show continuity."
•Managers acknowledged this period had been a challenging time which had impacted on both staff and the people they cared for. The interim manager told us the final phase of transition back to the other home was due for completion and Lower Meadow would regain its own "identity" again.
•Staff and relatives spoke highly of the deputy manager and senior staff team who had provided consistency during this period of transition and managerial change. One staff member said, "The deputy manager here is great, she is so helpful. She will always jump in and support with medication if I am tied up with other things." Another said, "We have had consistency because of [deputy manager], we treat her as the manager to be honest." A relative told us, "[Deputy manager] has been a permanent feature, but there does seem to have been two or three managers. It all seems in limbo until the new manager arrives. The care team managers are quite consistent."
•Managers carried out regular quality audits to check staff were working in the right way to meet people's needs and keep them safe. Whilst these had been effective in identifying some areas for improvement, they had not identified some of the issues we found. For example, people on different units did not benefit from the same positive lunch time experience.
•Whilst staff told us communication within the home had improved, further improvements were still required. At lunch time one person was not given the pudding choice because they were diabetic. The cook later confirmed the pudding had been prepared so it was suitable for diabetics.
•The provider completed compliance assessment visits to ensure the service was meeting the essential standards of quality and safety. The last visit had taken place in January 2019 when the provider recognised further improvements were required to ensure positive outcomes for people were consistently achieved.

Continuous learning and improving care; Working in partnership with others
•The provider was working towards a local authority service improvement plan (SIP) to address the issues that led to the placement stop being imposed.
•One of the major issues in the SIP was that care plans and risk assessments were not consistently and effectively used to ensure people received safe, consistent and personalised care. A care team manager (CTM) told us the provider had recently arranged extra training and support in assessing risks and writing care plans. CTMs had also been given protected time to prepare care plans to ensure they accurately reflected people's needs. This staff member said, "It was so helpful as now we know what we are supposed to be doing as before everyone had different views." Another staff member confirmed, "Plans have got much better. The care plans weren't person centred when I first started here."
•Whilst managers and staff were confident improvements had been made at the service, those improvements had been implemented at a time when there were less people living in the home than usual. Experienced staff who were supportive of new and less experienced staff, were due to leave Lower Meadow and return to the provider's other home.
•The improvements needed to be embedded into the culture of the home under the new manager and with the new staff team to ensure they would be sustained, particularly when new people started to move to the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•The provider welcomed the views of others and offered people and their relatives opportunities to make suggestions about the service and nominate the 'dignity staff member of the month'. However, during the management changes, 'relatives and residents' meetings' had not taken place as planned. The interim manager assured us meetings would be reinstated once the new manager was in post so people had increased opportunities to share their views and feedback about the service.

•Staff told us they had staff meetings and these were used as an opportunity to share their thoughts and views whilst receiving feedback and updates about the service. However, records showed some meetings did not go ahead because of a lack of attendance by staff. Attendance needed to be improved so the provider could be assured information was communicated to all staff to ensure consistency in the standards of care provided.