Four Seasons (DFK) Limited

Meadowbrook Care Home

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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on the 4 and 15 December 2017 and was unannounced on the first day and announced on the second day.

Meadowbrook Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Meadowbrook Care Home accommodates up to 69 people across three separate units, each of which have separate adapted facilities. The Garrett Anderson Unit specialises in providing care to people living with dementia. The Agnes Hunt Unit specialises in providing care to people living with neurological conditions. The Mary Powell Unit specialises in providing care to people with general nursing needs. At the time of our inspection, there were 48 people living at the home, two of whom were staying there on a temporary basis.

There was a registered manager in post who was present during our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in April 2017, we found five breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. These breaches related to the provider's failure to provide dignified care; to deploy enough suitably trained staff; to ensure people's rights were protected; to ensure that people received safe care and treatment and to ensure effective governance to drive improvements in the service. We gave the service an overall rating of 'Inadequate' and placed them in special measures. This meant significant improvements were required or further enforcement action could be taken. We asked the provider to complete an action plan to tell us what they would do and by when to improve the service and meet the regulatory requirements.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

The provider had developed and implemented an action plan to address the shortfalls in the service within set timescales and had worked hard to achieve improvement. Whilst we acknowledged the efforts made by the registered manager and provider, we found that systems put in place to address the shortfalls were not consistently embedded across the home and there were still areas that required improvement.
Staff were not always effectively deployed to meet people's needs in a person-centred manner.

People and their relatives had raised concerns about the choice and quality of meals. The registered manager and provider were in continued talks with the catering staff to make the required improvements.

People were protected from abuse and discrimination by staff who knew how to identify and how to report signs of abuse and poor practice. Where concerns were raised, these were investigated and action taken to prevent reoccurrence.

Risks associated with people's needs were assessed and measures were put in place to minimise them. The provider ensured the environment and equipment were maintained to ensure safe and effective care.

People were supported to take their medicines by staff who were trained and assessed as competent to administer them. Medicines were stored safely and accurate records maintained.

People were supported to access healthcare services as and when necessary to promote good health.

People's needs were assessed and kept under regular review. Advice of healthcare professionals was incorporated into people's care plan to ensure consistent and effective care.

People and their relatives were confident that staff had the skills and confidence to meet their individual needs. Staff were happy with the variety and quality of training available to them and were encouraged to better themselves.

Staff sought people's consent before supporting them. Staff provided information to people in a way they could understand to enable them to make decisions about their own care. Where people were unable to make certain decisions for themselves these were made on their behalf by people who knew them well to protect their rights.

People were supported by staff who were kind and considerate. Staff treated people with dignity and respect. Staff had formed positive working relationships with people and their relatives.

People were supported by staff who knew their needs and preferences well. People were supported to do things they enjoyed doing and were provided with opportunities to try new activities. People were supported to express their plans and wishes for the future.

People and their relatives felt comfortable to raise concerns with staff and management as they arose and were confident they would be listened to and addressed.

People, their relatives and staff found the registered manager approachable and easy to talk with. The registered manager provided strong leadership and led by example.

The registered manager had a clear vision for the service which was shared with and worked towards by staff and management. There was an open an inclusive culture at the home where staff felt supported and valued in their role.

The provider and registered manager had a range of checks in place to monitor the quality of the service and drive the required improvements.

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.

There were not always enough staff effectively deployed to meet people's needs in a person centred manner.

People were protected from abuse and discrimination by staff who knew how to recognise and report concerns of abuse.

People received their medicines when they needed them to maintain good health.

Risks associated with people's needs were assessed and measures were taken to reduce them.

The provider completed recruitment checks to ensure potential new staff were suitable to work at the home.

The provider had systems in place to maintain the cleanliness of the home and to prevent the risk of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People and their relatives had raised concerns about the choice and quality of meals.

Staff were happy with the range and quality of training available to them.

People were supported to make decisions about their own care where able. Staff sought people's consent before supporting them.

People were able to access healthcare services as necessary. The provider worked with partner agencies to deliver effective care based on current practice.

The provider had undertaken refurbishment work at the home to ensure the environment was suited to people's needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People were treated with dignity and respect.

Staff had formed positive working relationships with people and their relatives.

People were given choice and felt listened to.

Although we found some improvements in this area we were unable to assess whether these have been effectively embedded at the service. We will check this at our next inspection.

Is the service responsive?

Good

The service was responsive.

People were supported by staff who knew them and their preferences well.

People and their relatives felt comfortable to raise concerns with staff or management and were confident these would be addressed.

People were supported to take part in things they enjoyed doing.

People were supported to express their hopes and wishes for the future.

People and their relatives felt able to approach staff or management if they had concerns or complaints

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People, their relatives and staff found the registered manager approachable and easy to talk with.

There was an open and inclusive culture at the home where staff felt well supported in their roles.

The provider had a range of checks in place to monitor the quality of the service and to drive required improvements, however, these were not fully embedded across the home.

Meadowbrook Care 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 4 and 15 December 2017 and was unannounced.

The inspection team consisted of three inspectors, a specialist advisor and an 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.

As part of the inspection we reviewed the information we held about the service, such as statutory notifications we had received from the provider. Statutory notifications are about important events which the provider is required to send us by law. We reviewed the Provider Information Record (PIR). The PIR is a form where we ask the provider to give some key information about the service, what the service does well and what improvements they plan to make. We asked the local authority and Healthwatch if they had information to share about the service provided. We had received information from the local authority regarding concerns raised with them which they had investigated. We used this information to plan the inspection.

During the inspection we spoke with 13 people who lived at the home and three relatives. We spoke with 20 staff which included two regional managers, the registered manager, six nurses, eight care staff, one domestic staff member, an activity worker and the cook. We viewed seven records which related to the assessment of needs and risk. We reviewed records which related to the management of the service such as medicine and maintenance records and the recruitment records for three staff.

We observed care and 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 were unable to talk with us.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found people did not always get the support they needed because there were not enough suitably trained 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. We asked the provider to make improvements and to send us an action plan detailing how they would achieve this.

At this inspection we found that improvements had been made but found that further improvements were needed. Staff were not always effectively deployed across all the units. People, relatives and staff told us and we saw there were enough staff deployed to meet people's needs on the Mary Powell and the Agnus Hunt units. However, on the first day our inspection we found there were not enough staff effectively deployed on the Garrett Anderson unit to provide the individual support people needed to eat their lunch. Two people were provided with one-to-one support to eat their meals while two other staff were left to support the remaining people on the unit. We saw that two people waited for over 15 minutes before staff could support them to eat, one of whom fell asleep at the table while waiting. We saw that one staff member was helping one person to feed themselves whilst encouraging another two people to eat their food. A further staff member was assisting a person to feed themselves but at the same time was physically supporting a person to sit upright in their chair. In the meantime one person proceeded to take food off another person's plate. Whilst people did not display any signs of distress and were provided with fresh meals they did not receive the individual support they needed.

We spoke with staff on the Garrett Anderson Unit about what we had observed. They told us they felt there were not always enough staff to support people at key times during the day, such as, at breakfast and lunch times. One staff member went on to say that this day was particularly difficult as people were having a "bad day" and they couldn't support them as they would have liked. The unit manager told us this was not a typical lunch time experience on the unit and did not feel that they were short staffed. They did however feel that the dependency tool used by the provider did not take into account the unpredictable behaviours of people who live with dementia. This meant that there were not always enough staff to support people at meal times or during times when people became distressed by events or situations on the unit. We spoke with the registered manager about what we had observed, they told us they had provided 'walkie talkies' so that staff could contact other units should they require additional assistance. They said the management team were also available to provide support as necessary. The registered manager said they would speak with the unit managers and staff to ensure they requested additional support as and when needed.

At other times during our inspection we saw that there were enough staff deployed to meet people's needs in a patient and timely manner. On the second day of our inspection we observed a more relaxed and positive lunchtime experience for people on the Garrett Anderson unit with comparable staffing levels as was seen on the first day of our inspection.

The registered manager confirmed that they used a dependency tool to establish safe staffing levels at the home. These were reviewed on a weekly basis. Based on the dependency tool calculations they told us they were currently overstaffed. They said they were anticipating higher occupancy levels in the future and

wanted to ensure staff were trained and competent in their roles. The registered manager told us they had a continual recruitment drive in place and that all the care assistant vacancies had been filled. The service continued to use agency nurses to cover vacant nurse posts but used agency staff who had worked at the home on a regular basis to promote consistent support. This was confirmed by the people and staff we spoke with. One person told us, "There are no agency staff. It's (staffing levels) stable now which is what was needed." A staff member said, "We had a lot of agency staff at one time but now we only have people who know our residents well, like [staff member's name]. They are always here.''

Staff we spoke with told us the provider had completed checks to make sure they were suitable to work with people living at the home. These included references from previous employers and Disclosure and Barring Service (DBS) checks. The DBS helps employees make safe recruitment choices. Records we looked at and conversations with the registered manager confirmed that the provider followed safe recruitment procedures.

At our last inspection we found risks to people's health and well-being had been assessed and guidance developed to advise staff on the equipment and support required to minimise risk. However, these were not always reviewed or followed by staff. The provider did not ensure that people's environment was kept clean and hazard free. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that significant improvements had been made. We saw that risks were routinely assessed, monitored and reviewed. These included risks assessments for mobility, nutrition and skin care. The risk assessments identified the presenting risks and provided guidance to staff on how they could minimise them. For example, when one person was identified as at risk of falls, staff arranged for the use of equipment, such as a hoist and a wheelchair, to enable the person to be moved around the home safely. We observed that staff followed the guidance provided. On another occasion we observed staff moving a person from their wheelchair to their armchair with the use of a stand aid. The care staff and nurse communicated effectively with the person and each other throughout the process. They made sure the person was comfortable before they left them. The staff member explained that they used the sling type that was identified in the person's care plan. Records we looked at confirmed this.

Where people were at risk of skin damage we saw that there were management plans in place to identify and treat any wounds. There were systems in place to ensure dressings were changed at required intervals and pictures were taken to analyse the effectiveness of the treatments provided. Where required, people were referred to the tissue viability nurse for further advice and guidance.

There were ongoing building works at the home and these were managed in a safe and effective manner. For example, the provider was refurbishing the physiotherapy room and therefore people received treatment in their bedrooms. The provider employed a maintenance worker and gardener to ensure the environment was safe and well maintained. The provider had systems in place to ensure equipment used to support people was regularly serviced and fit for purpose. This included fire safety and wheelchair checks.

People had personal emergency evacuation plans in place detailing the equipment and support they required to leave the home safely in the event of a fire or any other emergency.

People were protected from the risk of abuse, avoidable harm and discrimination by staff who were able to recognise and knew how to report signs of abuse. One staff member said, "I would interrupt and stop what I thought was happening. I would see that the person was okay and if appropriate remove the staff member. I would report it straight away to the nurse or the manager and record everything." Another staff member told

us, "I make sure they (people) have their rights respected, are treated equally and not discriminated against." They went on to tell us if they witnessed any discrimination they would speak to the staff member and report the incident to the management team. People felt able to raise any concerns with staff or management. One person told us, "If something is upsetting, I speak for me and those who cannot speak for themselves." We saw that there was information displayed around the home informing people, their visitors and staff how to report any incidents of abuse or poor practice. Staff also told us they had access to the relevant policies should they require any further information.

Where safeguarding referrals had been received by the provider these had been investigated and actions taken to prevent reoccurrence. The registered manager told us all safeguarding issues or complaints received about the service were shared through daily 'flash meetings' held with staff. They also discussed these matters at staff meetings. Records of staff meetings we looked at confirmed this.

People told us they were supported to take their medicines when they needed them. We saw that staff took time to ask people how they preferred to take their medicines, provided them with a drink to take them with and checked they had taken them before signing the medicine administration record. Some people were prescribed medicine to take as and when required (PRN). We saw that there were PRN protocols in place to direct staff when these were to be given.

Some people were given their medicine covertly. Covert is the term used when medicines are administered in a disguised format, for example in food or in a drink, without the knowledge or consent of the person receiving them. A nurse we spoke with explained that when they identified the need for covert administration of medicine they completed a mental capacity assessment for the person. They then conducted a best-interests decision involving the person, their relatives, the GP and dispensing pharmacist to protect the person's rights and ensure safe management of medicines. We checked people's care and support plans and found that these discussions and decisions were recorded in accordance with current guidance.

Only staff who had received training in the safe handling of medicines were able to support people to take their medicine. The provider employed Care Home Assistant Practitioners (CHAPs) who received additional training to enable them to support the nurses with nursing care tasks. The CHAPs we spoke with were clear about the limitations of their role and did not administer certain medicines, such as insulin or warfarin. Similarly they had been trained to dress wounds but only those that were graded as level two or below. The provider completed medicine competency assessments to ensure the ongoing safety of medicine management. We saw that the provider followed current guidance and ensured people's medicines were kept under review with the GP.

At our last inspection we found the environment was not always kept clean and hygienic. At this inspection we found that improvements had been made. The home was clean and there were infection control stations at various locations around the home. We spoke with one of the infection control leads who explained that there were cleaning schedules in place which were randomly audited by the head housekeeper. The staff member completed monthly checks where they looked for any repairs that could compromise the effective prevention of infections. For example, they had identified the flooring required replacing in one room and this was taken out of use until the necessary repairs had been completed. In another instance they had found a tear in a bed rail cushion and this had been removed and disposed of.

We spoke with the registered manager and staff about how they managed accident and incidents at the home and what action were taken to prevent reoccurrence. Where people had falls staff would ensure the person's safety and call for the nurse who would check the person for injury and contact emergency service

if required. The nurse completed a report which was sent to the manager for their oversight and analysis. Where required people were referred to the relevant healthcare professionals such as, GP or physiotherapist.

Some people required help to manage their behaviours. Staff told us they monitored people's behaviours and looked at ways to help people better manage them. For example, one person could be aggressive and often resisted assistance with personal care. Staff completed 'distress reaction forms' each time the person displayed aggression which helped them identify trends in their behaviour. Staff had identified that the person appeared to be in pain when getting up in the mornings and this triggered a pain management review. Staff had worked with the person, their relatives and GP to develop a behaviour management plan that took into account the person's routine and what worked well. This had resulted in the person becoming much more settled and a reduction in the use of medicine to manage their behaviours.

We spoke with staff to establish how they shared learning from information about people's behaviours and incidents that occurred. One staff member said, "We have a senior team meeting once a week. We go through things like the patient incident reports so see if anything needs to be done or could have been done differently. As a team we can then identify what the management plan will be regarding any reported incidents." We also saw that the provider had brought in shift evaluation checks which encouraged staff to look at what worked well on shift and where improvements could be made.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found the principles of the Mental Capacity Act 2005 had not always been applied and people were unlawfully deprived of their liberty. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to make improvements and send us a plan to tell us how they would do this.

At this inspection we found that the provider had made the required improvements and were no longer in breach of the regulations. The provider had followed the principles of the MCA and where necessary had applied for authorisation to deprive people of their liberty to ensure their rights were protected.

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. Staff had received training about the principles of the MCA and had a good understanding of what this meant for people and their practice. One staff member told us, "I don't assume people lack capacity. I ask questions differently to help them understand." They went on to explain that one person had communication needs and if they showed them options with their hands the person could indicate their choice. Another staff member explained, "We all support people in different ways. We need to know if someone can make a decision. It can be as simple as, 'Can I wipe your table?' It is something we ask and not just do without thinking." The registered manager recognised people's different communication needs and sourced additional training and equipment to meet people's sensory needs with the optician that supported the home. For example, they had ordered new menu boards to better display menu options.

Staff understood that where people lacked capacity to make certain decisions these needed to be made in their best interests. We saw that there were best interest decisions in place for each specific decision made on people's behalf, such as, the use of bed rails and consent to influenza vaccinations. The best interest decisions recorded the involvement of the person, their relatives and where appropriate healthcare professionals. Where relative or people's representatives had indicated that they had authority to make decisions on behalf of a person, we saw the provider had undertaken appropriate checks to ensure this authority was correct. For example, we saw checks had been made with the Office of the Public Guardian to establish if any lasting or enduring powers of attorney (PoA) had been registered with them. A power of attorney allows people to appoint one or more people to help them make decisions on their behalf if they lost the mental capacity to make certain decisions.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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, and whether any conditions on authorisations to deprive a person of their liberty were being met. Since our last inspection the registered manager had introduced a clear system for applying for and reviewing DoLS authorisations to ensure people's rights were protected. Staff were aware of who was

subject to a DoLS authorisation and why. The registered manager stated that the relevant person's representative's role was, in the main, performed by a relative except for one person who had an advocate. They confirmed the relevant person's representative maintained regular contact with the respective people.

People and their relatives we spoke with raised concerns about the quality and choice of meals provided. One person told us, "The food is really poor, it's not brilliant. There is a lack of really fresh fruit, vegetables and salads. It's all very processed poor quality and not healthy." Another person said, "The food has improved a bit, but it's got a long way to go." One relative told us, "Everything has improved here but the food hasn't. We bring food in for [family member]." During the inspection we observed that people were offered a choice of meals and drinks. However, on the first day of inspection on the Garrett Anderson Unit we observed that staff on the unit began by offering people a choice of different lunch options and then realised the kitchen had not sent enough of the one meal option and could not offer the remaining people a choice.

One relative we spoke with had raised concerns about the quality of food with the registered manager who had arranged a meeting between relatives and the catering staff to discuss the concerns raised. As a result the menu had been changed. We spoke with the cook who informed us they were keen to gain feedback so that they could make the necessary improvements. They said they regularly went out into the dining room to speak to people. They also encouraged staff to report problems as they occurred so that they could be rectified as soon as possible. The cook showed us they received information about people's dietary needs which were updated as changes occurred. They knew people's likes and dislikes, any food allergies and the required consistency of meals required. They showed us that they piped pureed meals to make them look like the standard meal version to make the meals more appetising. The dietician had recommended fortified meal and drinks for some people and approved recipes were sought and used to prepare these on a daily basis. The registered manager told us they were in continued talks with the catering staff and were committed to addressing the concerns raised by people and their relatives about the quality of the food provided.

We saw that people's nutritionals needs were assessed and kept under regular review. Where concerns were identified, staff took appropriate action to reduce the risks. For example, we saw concerns had been raised by staff when they identified one person's unplanned weight loss. Fortified foods were provided with positive effect as we saw records where the person's weight had subsequently increased. We saw that speech and language therapist (SaLT) assessments were requested and that advice provided by the SaLT was included in people's care plan and followed by staff. For example, we saw one persons' SaLT assessment indicated that they needed thickened fluids and support from staff to take their drinks through a straw with small sips. We observed staff members supporting this person in accordance with these recommendations.
People and staff were positive about the bistro area that had been developed in the Mary Powell Unit since the last inspection. One person told us they 'loved' it as they could make their own drinks. They went on to explain that drinks were available to them but they had their own supply of 'special hot chocolate' they stored in their room. One staff member told us, "The introduction of the bistro area has been great. People and their families have a point of focus where they can make their own drinks and socialise in a café style environment."

People's needs were assessed prior to them moving into the home to ensure their needs and expectations could be met. People and their relatives told us they were involved in the assessment and care planning process. We saw where advice from other healthcare professionals had been sought that this had been incorporated into people's care plans to promote consistent and effective care. Staff we spoke with were mindful of people's differences and ensured that people's preferences for care delivery were recorded in their care plans. Where appropriate, the provider utilised assistive technology and equipment to support

people's independence and safety. For example, one person was unable to use the standard call bell so an alternative communication system was provided to enable them to call for assistance when needed. Some people had pressure mats in place to alert staff when they were attempting to mobilise without staff support.

People and their relatives felt staff had the skills and knowledge to meet their individual needs. One person told us, "The care is very good. The staff are all good and I feel very safe and secure which is important to me as I am quite vulnerable." Another person said, "I am happy with my care here. They (staff) do look after me well. My family are happy. They are lovely these people. Things have certainly improved over these last few months.'' A relative we spoke with acknowledged the improvements that had been made in relation to staff approach and the management of the home. They said, "I've got trust and respect for the staff." Another relative said, "The registered and unit manager are absolutely brilliant; they have made such a difference. I don't worry now. It is so much better; even though my [family member] is deteriorating they (staff) cannot do enough for them."

Staff were pleased with the training opportunities available to them and the support they received to develop in their roles. One staff member told us, "I get encouragement from [registered manager's name] to be the best I can, and to do more training." This view was echoed by another staff member who said, "I have requested to complete a level four qualification in health and social care. I feel that my development is supported by the registered manager and the provider." Where staff took on new roles, plans were put in place to develop their skills and knowledge. For example, one staff member had been promoted to a senior care position and had not had previous experience of supervising staff. They had agreed a plan with their line manager to sit in and observe several supervision sessions until they became comfortable themselves to lead such a session.

Staff who had undertaken the dementia training found this really beneficial as it made them consider people's experience of living with dementia. They were encouraged to get to know people, explore their past and, as a result, were able to better understand why people reacted to certain situations. For example, one person was reluctant to take off their apron following their meals. Staff established that the person used to serve meals in their working life while wearing an apron. This helped them understand why the person acted as they did when they asked them to take their apron off. Another staff member told us they had recently undertaken training on how to complete continence assessments. They had found this useful as they learnt about different products that may be of benefit to people living at the home. The registered manager had systems in place to monitor staff training needs and know when refresher training was required.

Staff told us they received a structured induction into to the service where they spent two weeks completing training prior to working on the units. One new staff member told us, "I went through a Four Season's nurse induction programme when I first started. This contributed towards my nurse revalidation." Revalidation is the process that all nurses and midwives need to go through in order to renew their registration with the Nursing and Midwifery Council (NMC). Staff who were new to the caring role were supported to undertake the Care Certificate programme. The Care Certificate programme is a nationally- recognised training award that trains staff about the standards of care that is required of them. The provider had introduced the role of care coaches to support the development of new staff. Each new staff member was allocated a care coach who worked alongside them introducing them to people and explaining to them their routines and how they liked things done. What does this mean – relate to meeting the KLOE and conclude by saying staff were supported to….

Staff felt well supported in their roles and were able to approach their seniors or the managers for support at any time. One staff member told us, "There is always someone to go to. All the staff here are caring; no one

minds helping new staff out. The assistant practitioners are very good, and they have been here a long time so that means a lot.'' Staff told us they had regular one-to-one meetings with their line manager where they had the opportunity to talk about any support and development needs they may have. They also received feedback on their practice. One staff member told us, "Supervisions are supportive and we can discuss what we are doing and if any improvements can be made. We meet individually quite regularly but also there are monthly group meeting where we can get together and discuss anything which needs to be done or done differently."

Throughout our inspection we saw staff shared information about changes in people's needs or any concerns they had. For example, we heard one staff member telling a nurse that a person had indicated that they were not feeling well and had decided to remain in bed. The staff member was advised to check on the person throughout the day to see if they were alright and if they needed anything. We saw this staff member following the instructions given, but at the same time they were mindful not to disturb them when they were resting. In another instance staff reported a person was unwell and the nurse arranged an ambulance to be called who took the person to hospital. Staff told us they had 'flash meetings' every day which gave them a very quick and basic update on people and staff issues. The purpose of the meetings was to ensure staff members had current information about people to enable them to provide effective care. Where a person accessed an external service we saw that staff had a check list in place to ensure they took with them their packed lunch, medicine and a communication book to share information between the services.

People were supported to maintain good health and access healthcare professionals as and when necessary. One person told us, "I have a stent which has to be done every six months and they are on top of that now and make sure it is all sorted. If I need to see the doctor it is sorted and I am put on the list for the next visit. We don't have to wait or worry it will be forgotten now." Another person said, "They (staff) look after you so much more now." The person went on to explain that staff had arranged for them to have a scan completed at the home which they felt was much better for them. A further person told us, "I am having regular physio here which is great and really helping me." We saw that outcomes of healthcare professional visits were recorded in people's care records. One person had developed a moisture lesion. This had been discussed with the GP and the outcome was recorded in the person's medical notes. The persons' skin integrity was subsequently reviewed taking into account the recommendations made by the GP. When we spoke to staff about this person's treatment they were able to tell us about the recommendations made and how they supported this person.

The provider endeavoured to ensure the environment met the needs of people living at the home and were undertaking refurbishment works at the home. The Garrett Anderson Unit had recently been redecorated and took account of décor that helped people orientate themselves around the building. The registered manager explained that the walls in the corridor had been painted different colours to make the areas distinct from one another. One relative told us their family member's room had been decorated and they would often tell them that they 'loved' their room. Since the last inspection the provider had constructed an external smoking area. This had freed up the previous smoking room to be used as a small lounge for those who preferred a quieter environment.

Requires Improvement

Is the service caring?

Our findings

At our last inspection people were not always treated with respect and their dignity was compromised. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to send us an action plan to tell us how they were going to address the shortfalls in care.

At this inspection we found that provider had made improvements and was no longer in breach of the regulations. The registered manager and provider recognised that they were on a journey and told us further improvement was needed. They had put in place new staff structures and had employed a lot of new staff. It was too soon to measure the effectiveness of these structures as they had only recently been introduced. We will assess this at our next inspection to see whether these have been effectively embedded at the service.

People and their relatives were pleased with the improvements made. One person told us, "I am very happy here now. It is much better and everyone is now so kind to us and they listen to us." Another person said, "They really do care and they respect you for who you are and what you are. I have no worries now about coming back in as I know I will be safe cared for and comfortable. I am never made to feel awkward or embarrassed when things have to be done for me." A relative we spoke with told us, "They (staff) are far more respectful, but still use a bit of banter. They use enough humour to make [family member] feel like a person. They whisper when they ask [family member] if they want the toilet." Another relative said, "There has been a vast improvement in the care here and how it is given."

We spoke to staff about what had changed since our last visit. One nurse told us, "We have concentrated on getting the basics right. This is individuality, choice and engagement with people to enrich people's lives. This is something as simple as making sure people's care plans reflects what their needs are." Staff recognised the importance of maintaining people's dignity and demonstrated respect for them and their environment. One staff member told us, "The residents are all individuals and this is their home; I am a guest who comes in to care for them. It is important to be visible so that they can all get to know me and I get to know them. This is especially important as we have to do very personal things for people." Other staff told us they encouraged people to remain as independent as possible as this helped maintain their dignity. One staff member said, "We encourage them to do as much as they can for themselves, even it is just eating their own sandwiches."

People and their relatives described staff as kind and considerate and enjoyed positive working relationships with them. One person told us, "I've got a lovely working relationship with all of them (staff)." Another person said, "It is so nice here again now and time absolutely flies by. Things have improved so much. I am very happy again here. The staff give you so much kindness and care now and they have time for you and your needs. They give you so much attention and they are much more social with you which makes life so much better." Staff we spoke with talked about people with warmth and respect and expressed a wish to deliver good quality care. One staff member told us, "I love working here. I was upset by the last report because it is a nice home really and we are all now working so hard to make it better and better for our residents." Throughout our inspection we saw that staff took time to sit and chat with people, and that there

were lots of smiles and laughter.

Staff provided people with emotional support and comfort at times of distress or ill health. One person told us, "I have seizures and I am sometimes quite ill and how they look after me has improved. This last time they couldn't do enough for me and one carer stayed beyond their time to sit with me to ensure I was okay. That's good care for you." Staff we spoke with demonstrated they would take appropriate action if a person became upset or anxious. One staff member explained how they supported people when they became agitated. They told us, "We can distract. [Person's name] likes to hold a doll and we can talk to them about it. Others we can talk about their previous occupations and this works. Sometimes just a cup of tea and asking them to help will distract." Sometimes we don't know what is bothering them but can just support them calmly." Another staff member said, "You can see when they [people] are upset about something, so I just try and find some time to talk to them to see if we can do anything to help."

People and, where appropriate, their relatives were given choice and involved in decisions about their care. One person told us, "I think things are much better here now. The staff are very good. They care, keep us safe and secure and they have time for us and chat which is nice. Also, they ask us what we would like to do now." Another person told us, "They (staff) come and knock on my door and ask me if I want to get up." They went on to confirm they could get up and go to bed when they wanted. One relative told us they had formal and informal discussion with staff when they visited their family member and were informed of any changes as they arose. We saw and heard that staff took the opportunity to chat with relatives when they visited and provided updates on their family members. During the inspection, staff were seen to offer people choices about where they wanted to sit and what they wanted to do.

Good

Is the service responsive?

Our findings

At our last inspection we identified that people were not always provided with personalised care suited to their needs. Staff had limited time to spend with people other than when providing personal care and were task led. There was a lack of stimulation and many people sat doing nothing for most of the time. At this inspection we found that improvements had been made. We found staff knew people and their preferences well and they had time to support people to do things they enjoyed doing.

People received care and support that was individual to them. One person told us, "Over the time I've been here, they (staff) have got to know me and I know them. I've got continuity of care." Another person said, "[Staff member's name] sees to things for me." They went on to explain that the staff member asked them about their needs and how they wanted to be supported.

Staff used 'Me and My Care' documents to help people set out their preference for service delivery through discussion with them and where appropriate their relatives. This included discussion about their life history and their wishes for the future. This information was then used to develop people's care plans and to plan activities suited to people's interest and ability. The provider employed two activity workers who supported people to do things they enjoyed doing. One person told us, "I am enjoying everything here now. It's much better and the music is great." Another person told us, "I am really comfy here and I am enjoying this music. We asked for it and [staff member's name] has sorted it for us." A further person told us they chose not to join in planned activities but enjoyed spending time chatting and joking with staff.

We heard one staff member reminding a person about a chat they had with them the previous week about music from their youth. The staff member had taken time to download the songs the person had talked about. They asked the person and other people in the lounge if they would like to listen to them which they agreed to. This created a joyous occasion for people. We saw people in the area singing along to the song and moving to the music. The staff member left the music playing and this became a focal point of interaction between those in the area prompting conversation between themselves. We saw people partaking in various activities, such as a ball-throwing game and dancing to music.

The activities workers had recently been on a course organised through the dementia care framework. This had given them ideas on how to plan and provide suitable activities. They had visited other homes and met with other activity workers which they had found helpful. They told us and we saw that they arranged both individual and group activities based on people's interests. For example, one person had an interest in motorbikes and they had purchased a jigsaw of a motorbike for them. They arranged outings to local attractions and for entertainers to visit the home. On the first day of our inspection, we saw people from across the units gather to see one such entertainer. This created a real social atmosphere and during the performance snacks and alcoholic drinks were provided for those who wanted them. Other options of soft drinks and cakes were also available.

People and their relatives felt able to approach staff or management should they have any concerns. One person told us, "If I've got a complaint I ask to speak to [registered manager's name]; I go to the top of the

tree." This was echoed by other people and relatives we spoke with who told us they would ask to speak with the unit or registered manager. We saw that the provider had a clear complaints process in place which could be made available in other formats. The provider had appropriately responded to concerns that we had raised with them and taken action to prevent reoccurrence.

People's plans for the future were clearly recorded in their care plans. One person had expressed a wish to remain in Meadowbrook and not be admitted to hospital for end-of-life care. A nurse we spoke with told us they worked closely with the GP when people were approaching end-of-life care to ensure that they were comfortable and their dignity maintained. Some people had do not attempt cardiopulmonary resuscitation (DNACPR) orders in place and this information was readily available to staff to ensure their wishes were respected.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found that there was ineffective leadership at the home. The systems the provider had in place to assess and monitor the quality of care and support provided were not always effective in identifying or driving improvements in the service. As a result, the provider had not identified or taken action to address the shortfalls in the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that significant improvements had been made and the provider was no longer in breach of the regulations. The provider had developed and implemented an action plan to address the shortfalls in the service within set timescales and had worked hard to achieve improvement. Whilst we acknowledged the efforts made by the registered manager and provider, we found that systems put in place to address the shortfalls were not consistently embedded across the home. This included the ongoing concerns about the deployment of staff which resulted in people not always getting the support they needed when they needed it. Therefore, we did not have complete assurance that the changes made to improve the service would be sustained. Both the registered manager and provider recognised there was still room for improvement. They were working with the catering company to improve the choice and quality of food and were looking at how they better shared good practice across the units. They had introduced end of shift audits to reflect what worked well and where they could do things differently as well as checks to ensure records were completed correctly. However, we found these were not consistently completed across all the units. For example, we found that there were gaps in recording on some people's repositioning charts. The registered manager showed us they had purchased white boards ready to be installed in each nurse station to facilitate better communication between staff.

Everyone we spoke with, without exception, commented on the improvements that had been made since our last inspection. They attributed this to the strong leadership provided by the registered manager and the management team. One person told us, "I have noticed a huge improvement; everything has improved. The staff, their attitude to you and their whole approach to the job they do is much, much better. That is because they now have good leadership and good direction. The manager leads by example and our safety and security comes first." Another person said, "[registered manager's name] has done a fantastic job here with the staff. You see them all the time walking about; they don't miss anything. They help out if they (staff) are short or under pressure. They are always accessible and listen if you have a problem: great leadership." A relative we spoke with told us, "[Registered manager's name] is amazing. They have such a nice way with them (staff). They know what is going on with everyone. Another relative said, "[Unit manager's name] has made a huge difference to the care here and you know when they are on things run like clockwork. They really manage the carers so they are clear about their roles and responsibilities to the residents." They went on to explain they no longer encountered the problems we found at the last inspection. We saw that the registered manager knew people well and had warm and meaningful interactions with them as they walked around the home.

The registered manager told us their aim was to achieve outstanding care for everyone. They wanted people to be happy and safe and to remain as independent as possible. They wanted staff to understand the

importance of promoting people's dignity and respect. This was a vision shared and worked towards by staff and management alike who wanted the best care for people.

There was a clear management structure in place where the registered manager was supported by a deputy and three unit managers. They were also recruiting to a second registered manager post and were able to rely on the support from regional managers as necessary. Staff we spoke with found there was better support and direction from the management team since the last inspection. They recognised the importance of team work and effective communications to further improve the service. One staff member told us, "The units have been managed very separately and have not been cohesive. We realise this needs to change to improve effectiveness. This involves skill sharing across the units and we are already talking around how to do this."

The provider and registered manager had shared with staff the report from their previous inspection in order to make the necessary improvements. This was confirmed by a staff member who said, "We were all encouraged to read the report. I feel the manager has been open and transparent about where we were in terms of the care delivered. Now they want to move forward and improve things for everyone." They went on to say, "The new manager has made a huge difference. They are very accessible and we can go to them with anything. Before the culture was one of blame and, 'What did you do?' Now if something is wrong or needs changing we can talk about it openly and do what needs to be done without fear of reprisals." Their views were echoed by another staff member who said, "Now it is much more a team approach. There is no longer a blame culture here and people get as much time as they need. Staff morale is much better and we all pull together as a team." This team approach was evident in the recent inclement weather where staff had worked together to ensure all care shifts were covered. Some staff stayed overnight at the home and one staff member used their four wheel drive vehicle to transport staff to and from work.

Staff were very complimentary about the registered manager and their leadership. One staff member told us, "The difference [registered manager's name] has made is phenomenal. Without them we wouldn't be where we are now. They make sure we are involved. They wanted my opinion." Another staff member said, "I find [registered manager's name] to be fantastic. They are very approachable, open and honest. They never just say no but if they don't agree with you they will always provide an explanation." For example, the staff member had asked the registered manager about purchasing some innovative equipment they felt would be of benefit to people they supported. The registered manager was initially reluctant to purchase this as they had recently bought equipment that was fit for purpose. However, they then purchased one item as a trial and agreed if they found this successful they would put forward a business case to purchase further items.

Staff enjoyed a positive working culture and felt valued in their roles. One staff member told us, "The registered manager here is very motivated; that's why I felt it was a good place to work. They were a nurse and have not lost the ability to care about people.'' Another staff member said, "[Registered manager's name] always says, 'If I've got happy staff, I've got happy residents.'" They went on to tell us the registered manager was approachable and always came on to the units to see people and staff to check everything was okay. The provider had introduced staff awards where people, their relatives and colleagues nominated and voted for them in recognition of the positive difference they made. Staff who had been nominated were really pleased to have been chosen and it had boosted their moral.

People and their relatives told us they were given opportunities to express their views on the service through meetings held at the home and directly with staff or management. We were told and saw that meetings included discussions about the food and environmental issues. One person told us, "The new manager is certainly turning things round and I feel much happier and more secure, which is good as I have always liked

it here and I have a nice room. It was just a shame it went downhill. The impact on us as residents is that we are looked after, feel safe and we are involved in things much better." The registered manager told us it was important to establish what people expected from the service and therefore spent time getting to know people and their wishes.

The registered manager was keen to establish and maintain links with the local community. They invited students from the local schools to visit the home. They had advertised the Christmas fete and many people visited local amenities such as the garden centre. The provider also had a mini bus for people to access the wider community. The registered manager was looking to provide training to drive the mini bus to further staff to give more opportunities to take people out.

The registered manager and provider had in place a range of checks to ensure safe and effective care. As well as gaining 'quality of life' feedback from people who lived at the home they completed care plan and medicine audits. They kept abreast of best practice through local and national training resources and attendance at professional forum meetings. They monitored staff practice by working alongside staff and providing support visits at evenings and weekends. They had recently introduced and achieved accreditation for the Dementia Care Framework to improve the life experiences of people living with dementia.

The registered manager was aware of their regulatory responsibilities. They had ensured the ratings from the previous inspection were conspicuously displayed at the premises and on their website. They had also submitted statutory notifications as necessary.