Veecare Ltd

High Meadow Nursing 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?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 16 and 17 November 2017 and was unannounced.

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

High Meadow Nursing Home is registered to provide accommodation and personal care for a maximum of 34 people. The home provides care to older people, people who are frail and some people living with dementia as well as a range of health and support needs such as diabetes, epilepsy and catheter care. At the time of our inspection there were 25 people living in the service. At the last inspection on 1 and 2 March 2017 we asked the provider to take action to make improvements. Six breaches of regulation were found and the service was rated as Inadequate in the key questions of safety and leadership. It was rated as Requires Improvement for the remaining key questions of effective, caring and responsive. This was because the provider had failed to ensure actions designed to minimise risk were always adequate in practice. These related to diabetes and pressure wound management and the risks of people being isolated and unable to use call bells to summon staff. Staff were sometimes neglectful of people's need to use the toilet, asking them to wait for up to 30 minutes while other tasks were completed. There were not enough staff on duty to meet people's needs, and staff training needed improvement in some areas. Dietician advice was not always followed to ensure people received adequate nutrition and staff were not aware of target fluid intake for individuals. Records about food and fluids were filled out in retrospect and were sometimes inaccurate. Staff were not consistently caring; some had become desensitised to people's calls for assistance. There was not enough interaction or stimulation for people who stayed in bed every day. Quality assurance processes had not picked up and addressed these issues. Following the last inspection, the service was rated as Inadequate overall and placed into Special Measures. The provider sent us regular updates about improvements they were making.

When we completed our previous inspection March 2017 we also found concerns relating to people's hopes and wishes for their end of life care. At this time, this topic area was included under the key question of Caring. We reviewed and refined our assessment framework and published the new assessment framework in October 2017. Under the new framework this topic area is included under the key question of Responsive. Therefore, for this inspection, we have inspected this key question and also the previous key question of Caring to make sure all areas are inspected to validate the ratings.

At this inspection significant improvements had been made and the legal requirements of the previous breaches had been met. However, we identified some areas where further improvements could be made, these related to a formal review and resolution of an adhoc way in which some nursing needs were covered, for staff to always ensure that call bells were within people's reach, for choice to be offered and an understanding about how people preferred to receive their medication and an enhancement to the way in which the size of wounds were recorded. The registered manager met with people and carried out an in-

depth assessment of their needs and wishes before they came to live in the service; to ensure these could be appropriately met. Potential risks to people's health and welfare were assessed and there was detailed guidance for staff to follow to mitigate those risks; for example, in relation to diabetes, epilepsy, wound, pressure and catheter care.

People had been asked about their end of life wishes and these had been recorded to ensure people's these were respected. Staff had received training appropriate to their role, including end of life care. Staff received one to one supervision and appraisal to discuss their role and their training needs. There were sufficient staff on duty to meet people's needs, staff were recruited safely. People's medicines were managed safely and people received their medicines when they supposed to.

Staff worked with health and social care professionals to ensure people received the support they needed. Staff monitored people's health and people were referred to specialist healthcare professionals when required.

People were protected from abuse and discrimination. Staff knew how to recognise signs of abuse and knew that they should challenge colleagues if people were being discriminated against. Staff knew how to report concerns and felt confident they would be dealt with appropriately. Accidents and incidents had been recorded and analysed, action had been taken to reduce the risk of them happening again.

The building had been adapted to meet people's needs. People were protected from the risk of infection, staff wore protective clothing when required and kept the building and equipment clean.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. The service was meeting the requirements of the Deprivation of Liberty safeguards and Mental Capacity Act 2005.

People knew how to complain. Any complaints received were investigated and action taken to prevent incidents from happening again. People and their relatives were encouraged to provide feedback about the quality of the service and any suggestions they may have. These were acted upon by the registered manager and people and visitors told us any concerns had been acted on immediately.

People were treated with dignity and respect. Staff had developed caring relationships with people; they were aware of and sensitive to their needs. Staff encouraged people to be as independent as possible. People's confidentiality and privacy was promoted by staff. There was a wide range of activity available to people who enjoyed meaningful entertainment and individual sessions. The service had established links and were involved in the local community and church.

There was an open and transparent culture within the service. People, relatives and staff were positive about the leadership at the service and said there had been changes for the better. The registered manager attended local forums to keep up to date with best practice. Staff understood their roles and responsibilities.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service, so we could check that appropriate action had been taken. The manager was aware that they needed to inform CQC of important events in a timely manner.

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 service is rated Requires Improvement. This is the second time High Meadow Nursing Home has been rated as Requires Improvement.

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 always safe.

Areas were identified where improvements could be made to enhance the experience of people and staff. These included managing nursing staff allocation better, ensuring call bells were always in people's reach and providing choice about how people take medicines.

People were protected from the risk of infection.

There were sufficient staff, who had been recruited safely, to meet people's needs.

People's medicines were managed safely and people received them when they needed them.

People were protected from abuse, and discrimination.

Is the service effective?

Good

The service was effective.

Care plans were developed ensuring that people's preferences and choices were reflected.

Staff were given an induction when they started working at the service and were supported to access training required for their roles.

People were supported to maintain a balanced diet and were offered snacks and drinks throughout the day.

People's health care needs were supported by qualified nurses and diabetic, catheter and wound care were well-managed.

The building was accessible for people with mobility needs and reasonable adjustments had been made for people who needed them.

Is the service caring?

Good

The service was Caring.

Staff spoke to people kindly, routinely acknowledged people and responded to requests for assistance.

People told us they felt well cared for and relatives were complimentary about the care their family members had received.

People were supported to make choices about their care.

Is the service responsive?

Good

The service was responsive.

Care planning took account of individual needs, choices and personalities.

People's wishes for the end of their life had been recorded and respected.

Staff referred people to other healthcare services when they were concerned about their health and took advice from other healthcare professionals.

People felt able and supported to raise concerns if needed.

Is the service well-led?

Requires Improvement

The service was not always well led.

Checks and audits were completed and previous breaches addressed, however further areas were identified as requiring improvement to ensure best practice and continuous improvement.

There was an open and transparent culture within the service.

Staff and people told us the registered manager was approachable.

People, relatives and staff were asked to give feedback about the service.

Staff understood their roles and responsibilities.

High Meadow Nursing 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 16 and 17 November 2017 and was unannounced. The inspection was carried out by one inspector, an expert by experience with knowledge and understanding of caring for older people and people with dementia and a specialist nurse advisor with nursing experience of older people.

Before the inspection we looked at information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once a year to give some key information about the service, what the service does well and improvements they plan to make. The provider had also sent us regular action plans following the last inspection. We looked at previous inspection reports and notifications we had received. Notifications are information the provider is required to tell us about by law when significant events happen, like a serious injury. We also considered the information which had been shared with us by the local authority.

We met and spoke with 17 people who lived at High Meadow, we observed some people's care, the lunchtime meal, some medicine administration and some activities. We spoke with nine people's relatives. We inspected the environment, including the laundry, bathrooms and some people's bedrooms. We spoke with one senior carer, two care assistants, the kitchen and housekeeping staff as well as the deputy manager, registered manager and service administrator.

We 'pathway tracked' four of the people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home where possible and made observations of the support they were given. It is an important part of our inspection, as it allowed us

to capture information about a sample of people receiving care. We also looked at care records for five other people. To help us collect evidence about the experience of people who were not able to fully describe their experiences of the service for themselves because of cognitive or other problems, we used a Short Observational Framework for Inspection (SOFI) to observe people's responses to daily events, their interaction with each other and with staff.

During the inspection we reviewed other records. These included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

We displayed a poster in the communal area of the service inviting feedback from people and relatives. Following this inspection visit, we did not receive any additional feedback.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the service. Comments included, "Since my fall at home I have needed a lot more help and I feel I am really in the right place now. I live here because I do feel safe and I know that someone is always at the ready in an emergency or even just to give a helping hand". One relative told us, "Dad is diabetic and we thought we were going to lose him but since he's been here he has really perked up and they are keeping a sharp eye on his medication and doing a sterling job with his diet too".

At our last inspection, there were not enough staff to meet people's needs. Staff were not properly reactive to people's needs to go to the toilet, other people were calling out from their beds for assistance at times and one person's visiting relative became concerned about another person shouting for staff and went to comfort them. One person told us they were sometimes left waiting for pain relief because staff were busy doing other things. At this inspection staff were evident throughout the service and mindful of people who needed more frequent or specific support. Call bells were answered quickly, when people asked for support to use the toilet they told us staff responded promptly. Where people needed support to mobilise, the required number of staff, using the correct equipment, supported people safely. Staff asked people if they required pain relief and appropriately responded to their needs.

There were sufficient staff on duty. Discussion with the registered manager found they continuously reviewed staffing requirements against people's needs and were up to date with people's changing needs. There was one nurse and eight care staff on duty in the mornings and one nurse and five care staff in the afternoons. At nights there was one nurse and 2 care staff, with an additional member of care staff working until 10pm to help put people to bed and give out drinks. Other staff carried out cleaning, laundry and maintenance duties and the cook was supported by a kitchen assistant. Of the 25 people living in the service the registered manager told us nine people needed support or supervision to eat and 21 people needed two staff to assist them to mobilise and with personal care. People and their visitors felt previous concerns about staffing had been addressed and commented positively, however, one person told us, "The staff all know their jobs and know exactly what they're doing and they do not rush but perhaps have to just get the task in hand done with sometimes not much time for small talk". We discussed the allocation of nursing staff with the registered manager and the provider; nursing staff told us the mornings were busy but manageable, however, on occasion nursing staff were diverted from a task in hand to deal with other matters. When this happened, the registered manager, who was also a registered nurse, stepped in to support nursing staff. We were told some nursing staff arrived up to two hours before the start of their shift, particularly in the mornings, to support the nurse on duty, who may be engaged in administering medicines or changing dressings. Discussion with the provider found the nurses supporting each other in this way relied upon their good will and was not formally recognised in the staff rota. While the provider explained they gave the registered manager free hand to arrange staffing as they saw fit, this had not been formally addressed and is an area we have identified as requiring improvement.

At our last inspection, risks to people from the layout of the building had not been properly assessed and minimised. This was because some people were receiving end of life or palliative care and were unable to use call bells to summon staff for assistance. At this inspection, no people were receiving end of life care.

Call bell risk assessments had been completed and staff were aware whether people were able to use call bells. Records showed hourly or more frequent checks were completed where there was a risk that a person may not use the call bell. One person told us, "I do have a call bell by my bed and can use it when I'm worried or if I need something, it does make me rest easy knowing that someone is always there for me". However, another person commented, "If I can't reach my call bell, like now for instance, I just call out that bit louder and help will come". Call bells should always be placed within people's reach, this is an area we have identified as requiring improvement.

People's medicines were managed safely by nurses, who updated their practice regularly by attending training and reflective practice. Staff recorded the temperature of the room and fridge where medicines were stored, to make sure it was within safe limits. There were appropriate arrangements for ordering, administering and disposing of medicines, in line with best practice. Staff followed these and there were records to support this; for example medicines were ordered in advance and checked into the service to ensure that they were always available. Medicines Administration Records (MAR) had been completed and checked at the end of each shift to ensure people had received their medicines as prescribed. The MAR were completed accurately with no gaps giving a clear record that medication was administered to the right person, it was the right medication, the right dose, via the right route and at the right time. Medicine records were checked as part of the registered manager's audits so that any gaps or errors could be followed up.

Some people were prescribed medicines on an 'as and when' basis for example pain relief medicine and to manage behaviour. At the time of the inspection there was no one requiring medicines to manage their behaviour. There were guidelines in place for staff to follow about when to give the medicines and how much should be given. Some medicines required special storage and additional records to be maintained and these were accurately completed. Staff asked people if they wanted to self-administer when they moved in, however, people had requested staff to administer their medicines and this was recorded in their care plan. People's medicines were reviewed by their GP when required to check they were still needed and suitable. We observed people receiving their medicines with a drink and being supported to take the medicine in their own time. However, people were not given a choice of how they like to take their medication, via the spoon or have it in their hand or in medication cup. This is an area we have identified as requiring improvement.

At our last inspection the management of people's diabetes was not safe because staff lacked the knowledge to escalate concerns quickly. At this inspection clear protocols were in place about treating high or low blood sugar levels for people living with diabetes. These were individual to each person and provided a clear strategy for staff to follow and had been compiled with specialised input from the diabetic nurse. Diabetic care plans set out a person's blood sugar level range and measurements of this were made and recorded at the prescribed interval. Care plans set out how to identify if a person was experiencing Hypoglycaemia or Hyperglycaemia (low or high blood sugar levels), they were clear and easy to follow, no jargon was used and the support and treatment guidance identified expected outcomes and what to do if this was not achieved. Discussion with nursing and care staff found they were aware of physical signs and symptoms to look out which may indicate a person's blood sugar level was outside of an expected range and what to do in such circumstances. Staff were able to tell us which people were diabetic and understood that what they ate would have an effect on their condition. Low sugar, and non-sugar food options were available for people with diabetes and this information had been clearly communicated to kitchen staff. Regular eye screening and foot care ensured other conditions that can be associated with diabetes were actively monitored enabling any changes to be quickly acted upon.

At our last inspection protocols about managing epileptic seizures were not sufficiently detailed because they lacked information about first aid to be given to prevent injury during a seizure and possible choking

afterwards. At this inspection there was detailed information about meeting the needs of people diagnosed with epilepsy and seizures. Step by step guidance set out the support needed when people experienced a seizure, including support during and after a seizure, together with information about any medication to be administered. Discussion with staff found they were aware of what to do if person had a seizure. Records of people's seizures were maintained and up to date and were used to inform medication reviews and the effectiveness of treatments.

At our last inspection people were not protected from the risk of abuse. This was because staff did not understand that failing to respond appropriately to people's need to go to the toilet was neglectful. At this inspection people were protected from the risks of abuse and discrimination and were supported to go to the toilet in a timely and respectful way.

Staff knew what to do if they suspected incidents of abuse. Staff told us they were confident that any concerns would be dealt with by the registered manager quickly and appropriately. Staff had received safeguarding training and this was discussed with them at supervision. The registered manager understood their responsibility to report incidents to the local safeguarding team; they had reported incidents as required. People who used the service were aware of what keeping safe meant; they were encouraged to raise any concerns about safety with a staff member or the registered manager or with their relatives. Meetings were held for people and their relatives and the registered manager gave everyone their contact details, those of the local authority and Care Quality Commission so they contact them with any concerns or feedback. Staff told us how they promoted people's differences and how they supported them with their choices and preferences, for example, in relation to their religious beliefs. The activity coordinator spoke with people confidentially to make sure the service identified any of the protected characteristics of the people they support, for example, in relation to their sexuality. Staff understood their responsibilities to challenge people who discriminated against people and had received training in equality and diversity.

Staff working at the service had been recruited safely. The registered manager had completed all required pre-employment checks including a full employment history and any gaps had been investigated. Each person had a proof of identity with a photo. Disclosure and Barring Service (DBS) criminal records checks were completed before staff began working at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services. Each nurse's Personal Identification Number was checked to ensure they were registered to practice. Once employed, established supervisory and disciplinary processes were in place to address any areas of conduct or performance that did not meet expectation.

There was a system in place for staff to report any accidents or incidents and staff knew how to do this. None had occurred in the previous three months, with the exception of one fall that had occurred two days before the inspection. We saw the person had seen the GP on the day of the fall and their risk assessments and incident report were with the registered manager for review. Any learning from incidents and accidents was shared with the staff team at staff meetings and at handover meetings. The registered manager shared records of accidents and incidents with professionals involved in people's care for example, physio and occupational therapists as well as care managers to help review people's care.

The provider had a policy on preventing infection and any potential for it to be spread.. Staff followed this policy and could tell us about how they would reduce the spread of any infection including the use of 'barrier nursing' which reduces the risks of infection spreading. There were cleaning schedules that domestic and kitchen staff followed. The service was clean and hygienic and smelled fresh. There were sufficient domestic staff employed to maintain the standard of cleaning required. One person told us, "There is never a nasty smell, they are always on top of the cleaning and the laundry". Care staff wore protective clothing

such as gloves and aprons when required and disposed of soiled linen appropriately to minimise the risk of cross infection. We observed good practice such as staff supporting people to clean their hands with antibacterial wipes before eating. A water management plan was in place to test for any waterborne bacteria.

Fire safety equipment such as extinguishers, emergency lighting and the fire alarm system had been routinely checked and maintained. All staff had received fire safety training and those we spoke with could point out fire exits and assembly points. Checks protected people against the risk of hot water scalding by ensuring hot water outlets remained within a safe temperature range. Other equipment such as hoists, special baths and the passenger lift had regular safety tests to ensure they remained fit for purpose. A maintenance person was employed and kept records of repairs they were asked to make and when these had been completed. These showed that jobs had been carried out promptly to keep the premises in a safe and suitable condition.

There was a business continuity plan in place which contained details of how the service should respond in an emergency situation. Each person had a personal emergency evacuation plan (PEEP), these gave details of the persons physical and communication needs, to support them to be evacuated safely.

Good

Is the service effective?

Our findings

People and relatives gave us positive feedback about the food and choice; they told us they had confidence in the staff supporting them and felt staff contacted healthcare professionals when they needed to. One person told us "I don't enjoy my food much but the staff here really do try and come up with all sorts of ideas for me to try" and "I always have a drink on my tray and can always ask for more at any time of the day". A relative commented, "Mum is very comfortable here and well looked after. She enjoys the food, which is quite something as she didn't enjoy eating at home and she even decides what she'd like whereas before she showed absolutely no interest in food at all". Another relative told us, "They had the doctor out the other day for mum and they are very good like that, nothing is too much trouble". Relatives told us they thought communication within the service was good and staff and registered manager kept them updated of changes in the health of family members who used the service.

At our last inspection wound care was not well-managed; some pressure sores had deteriorated to a stage worse than records showed. While equipment, such as pressure-relieving air mattresses were in use, some pumps had been set at incorrect levels, they were not checked when they were supposed to be and therefore did not provide the desired therapeutic benefit. Where care plans recorded some people should be supported to reposition every two to three hours to help relieve pressure, charts showed on some occasions gaps of up to six hours between repositioning.

At this inspection wound care management was robust and met with good practice guidelines. Care plans identified the dressings to be applied to pressure sores and when they must be changed. Care plans tracked the progress of pressure ulcers and pictures were taken of the wound each week or when dressings were renewed. People had been appropriately identified and referred to the Tissue Viability Nurse (TVN) when needed, however, the TVN was not involved in direct wound care as these were dressed and cared for by the nursing team. There was evidence of good practice which had resulted in the reduced severity of pressure areas and evidence of good wound care where other conditions such as psoriasis, cellulitis and skin tears had healed or reduced in severity. Daily checks of air mattress pumps ensured they were correctly set and we saw these settings corresponded with people's current weights. Where needed, repositioning records showed people were supported to move when they should have been to help relieve pressure on their skin. Any new pressure areas, deterioration, or skin conditions were reported to the registered manager immediately and a comprehensive pressure ulcer audit ensured they remained aware of and were able to track each person's condition. People's pain was assessed regularly and PRN analgesic offered. Pain was assessed using the Abbey Pain Scale and pictures were used to assist people who were not able to verbalise where and how severe their pain may be. While the pressure ulcer audit included a measurement of the size of pressure areas, there was no scale shown in the photographs; which would have helped to give a more detailed picture.

At our last inspection none of the staff had received training in specialist subjects such as diabetes, end of life care, wound care or nutrition. That inspection found the lack of specific training in these areas affected the quality and safety of the care people received. At this inspection training in each of these areas together with all mandatory training in areas such as infection control, safeguarding and moving and handling

people had been delivered and was up to date. People received care from staff that knew them and had received training appropriate to their role. Staff completed an induction when they started working at the service. This included working with experienced staff to learn about people's choices and preferences. New staff were mentored and their competency in each area of their role was assessed and signed off by their mentor or the registered manager. We observed staff using equipment to move people safely and following guidelines set out in people's care plans. There were specific areas of training that nurses were required to complete such as syringe driver and catheterisation. Syringe drivers are used to provide people with continuous pain relief in certain circumstances such as end of life care. There was a nursing competency framework in place for nurses to complete. This included key areas such as wound, catheter and pressure area care. Nurses were assessed for their competence in medicine management. The registered manager recorded when each nurse had demonstrated they were competent in each area. All staff received regular supervision and an annual appraisal. They were able to give their feedback and reflect on their performance as well as receive comments from the registered manager. Supervision and appraisal forms were signed to confirm they were an accurate record of discussions. Staff told us that they felt supported by the registered manager and people told us they had confidence in the staff who cared for them.

At our last inspection some people were assessed as at risk from a poor nutritional intake. In these cases food charts were completed by staff to record what had been eaten. However, these were filled out retrospectively and observations showed the details recorded were not always correct. At this inspection food charts were completed when people had finished eating and gave a description and percentage of what they had eaten. People's weight was monitored and when people lost weight, advice was promptly sought from a dietician. Where some people required snacks outside of mealtimes to help them maintain a healthy weight or needed fortified food, these were made available by kitchen staff and recorded on food intake records. Some people also had charts in place to record how much they drank each day. These included target fluid amounts taken from care plans so that staff knew how much they should encourage people to drink. Charts had been totalled up and showed most people were drinking around their target amounts. There were plenty of drinks available for people. Jugs of water and squash were in bedrooms and a tea trolley was taken around several times a day.

People were supported to eat and drink enough to maintain a balanced diet. They were happy with the times they received their meals and they were able to ask for snacks at any time. People appeared to enjoy their meals; a choice was available at lunch and supper and picture cards were used to help people make a decision about what they would like to eat. Some people ate in their bedrooms and if needed staff supported people in their rooms to eat and drink. Most people ate in the dining area. Meals were served hot and the atmosphere was relaxed and a social occasion, people were given the time and support they needed. The cook was aware of people's different dietary needs; they were able to tell us about people's dislikes and their favourites. The cook understood about the different types of diets people may need, during the lunchtime meal, we observed that some people had pureed meals as recommended by health professionals. Where people had been assessed as needing thickened fluids, these were provided and staff knew which people had these and how they should be prepared.

People were able to see a doctor when needed and had access to chiropodists and dental appointments. People were referred by the nurses to specialist healthcare professionals such as the dietician, speech and language therapists, tissue viability nurses and mental health teams when required. Guidance from healthcare professionals was recorded and followed by staff to keep people as healthy as possible, for example, in relation to special diets, thickened drinks and supplement drinks. Where people showed behaviour that could challenge, records of incidents helped staff and external professionals understand and develop strategies to better support people. Staff monitored people's physical and mental health and took prompt action when they noticed any changes by reporting changes to the nurse on duty. People told us

staff reacted quickly if they were unwell and this view was shared by relatives we spoke with.

People's consent to some aspects of their care and treatment had been formally sought. Verbal consent was sought by staff for day-to-day matters like asking permission to go into people's bedrooms or when giving people medicines. Some people lacked mental capacity to make some decisions and in these cases, a detailed mental capacity assessment had been made. These are necessary to comply with the principles of the Mental Capacity Act 2005. 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 much as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their interests and as least restrictive as possible.

Staff understood their responsibilities under MCA. We observed staff asking people what they wanted to eat and drink and how they wanted to spend their time. Staff spoke confidently about how they promoted people's choice and how people should be treated as individuals. People's capacity had been assessed, some people had Lasting Power of Attorneys in place, and this was recorded in their care plan. Best interest decision discussions had been held involving people who knew the person well and recorded when people were unable to make their own decisions.

People can only be deprived of their liberty so that they can receive care and treatment when it is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards. We checked to make sure 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. At the time of the inspection, the two authorisations that had been granted were being met. In total, 16 further Deprivation of Liberty Safeguard applications had been made to the local authority. The registered manager kept themselves updated about the status of these applications and awaited notification of the decisions.

High Meadow Nursing Home is a large converted house with a garden. The building had been adapted to meet people's needs including the installation of a lift and specialist bathing equipment. There were areas where people could meet with their relatives privately and where activities could take place. People were able to access the garden and hand rails helped people to move around the building. The building was maintained and clean, large pictorial and written signs were used to identify the toilets and other rooms to help people find their way around.

Good

Is the service caring?

Our findings

Feedback about staff from people and relatives was positive. People told us, "The staff are really very kind and so very gentle and caring", The staff are really great, they always come when I need them and will go out of their way to help me" and "I am very slow at getting around and am rather afraid now so a member of staff will make sure I am happy and help me along my way gently so I don't feel trapped in my room or in the lounge". A relative told us "Dad frequently needs injections and they always make sure he has his privacy and put the screen around him or close his door if he's in his room. Dad has a short fuse and will often shout at the staff to get out, they never falter and will always respond with great respect and dignity, they have got the patience of saints they really have. I take my hat off to them they do a difficult job in a fantastic way". Another relative commented, "I have nothing but praise for the staff, they are very careful and kind with mum and can really communicate with her in a meaningful way". Our own observations showed that staff spoke with people in a gentle and kind manner and supported them appropriately.

At our last inspection people were not always treated with dignity and respect. Staff had become desensitised to some people's calls for assistance and walked past rooms where people had been shouting out for some time, without offering any words of comfort. At this inspection people were treated respectfully and with dignity. Staff were responsive to people's needs and requests for assistance. People and their relatives felt staff were sympathetic and cared genuinely about the people they supported. Staff spoke with people in an appropriate way, explaining what they were doing and reassuring people as they supported them. Staff were patient with people giving them time to respond to questions and express themselves; they listened to people to find out what they wanted and explained how they were going to meet this.

Staff knew people well and their backgrounds. Staff spoke with people about their lives and people who were important to them. People told us staff supported them in the way they preferred and enabled them to be as independent as possible. People were supported to move around the service as independently as possible. We observed staff supporting people to walk around with mobility aids such as walking frames. Staff were patient with people and allowed them to go at their own pace. They talked with people as they walked and reassured them and reminded them to use their equipment.

People were encouraged to decorate their rooms with personal items such as photos and ornaments that were important to them. Relatives told us they were able to visit whenever they wanted and were always made to feel welcome; they were greeted by name and offered refreshments. One visitor told us, "The staff were all extremely welcoming. When mum moved in they helped us to decorate the room and put pictures up to make it feel like home"

People and their relatives told us that they were involved in discussing their needs with staff so that their care was tailored to their personal preferences. We observed staff asking people how they felt. When one person said they were in pain, nursing staff offered painkillers and asked if they would like to see a doctor. Relatives told us that they were kept informed when their family member's health had deteriorated or if they had been involved in an incident.

People told us and we observed, staff knocking on people's doors and waiting to be invited in before entering. Staff told us and people confirmed that they maintained people's dignity by closing the curtains and covering them when providing personal care. If people needed urgent or unexpected support in a communal area, screens were put in place to ensure people's privacy. Staff were discreet when supporting people to use the bathroom and we observed staff respond to these needs in a timely manner.

People's religious beliefs were discussed and recorded to enable staff to support people. The local church visited and conducted services that people were able to attend if they wished. One person told us, "I used to go to church every Sunday but now it is not that often. My faith is still very important to me and we do have a little service here once a month or so which enables me to practise my faith".

Some people were unable to express their views about their care, so staff ensured that decisions were made involving people who were important to them including their family and friends. Some people had nominated a person to represent them, however, some people had not. When this was the case, staff knew how to refer people to advocacy services when they needed support. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf. Information was provided in a way that was meaningful for people living with dementia to help them make decisions and be involved. For example, some information was available in picture format.

Good

Is the service responsive?

Our findings

People felt they received the right care and told us they had been asked how they preferred their needs to be met, a visitor told us, "They all know what Mum likes and how she likes things done". Another visitor commented, "I know all the staff who care for Dad and they really do observe and take note of the way he likes things done". One person told us, "As long as I am looked after I don't want to see a care plan, I trust the staff to know what they are doing is for my safety and well-being".

At our last inspection we found that there was not enough social stimulation for people and where some people spent most of their time in their bedroom, their need for interaction was not appropriately met. At this inspection people were particularly complimentary about the activity coordinator, their compassion and the thought they put into planning the activities provided. One relative commented, "Mum likes to sit in the hub of things down in the lounge and always likes to help with the craft activities, there's always some sort of activity taking place". They also told us "Mum doesn't get out any more but she loves the garden in the summer and they had a party out there this summer which was great". Another visitor said, "The staff always try to get Dad involved in activities and sometimes he will happily join in, they never give up trying to include him".

The service employed a fulltime activity coordinator and people were given the opportunity to take part in activities. The activity coordinator knew each person and had spent time with them and often their family members to understand and record what activities people enjoyed and whether they preferred spending time by themselves or with other people. They encouraged people to make suggestions about what activities they would like and these were added to the activities on offer. These included bingo, skittles, movie afternoons, word search, quizzes, armchair exercise and arts and craft. External entertainers including musicians and singers visited regularly. People who spent time in their rooms had one to one sessions, chatting about the things they enjoyed and their life before coming to live at the service. Care plans were well-presented and had been written in a person-centred way. There was sensitively prepared information about people's former lives and achievements which helped staff to understand more about people's families and backgrounds and engage in meaningful conversations. Some people enjoyed and found reassurance and comfort in having their hand held or were given hand massages. People told us the activities coordinator regularly visited people in their bedrooms for one-to-one time and had chats.

At our last inspection care plans about end of life only held information about next of kin and funeral arrangements. There was no detail about actions to be taken to make people's last days comfortable and pain-free. At this inspection each person had been asked about their end of life wishes and these had been recorded. Some people had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) in place, which was kept at the front of their care plan so it would not be overlooked. Nursing staff had received training in using specialist equipment to ensure that people received end of life medicines, to keep them comfortable. The registered manager told us if needed, people could be referred to specialist palliative services for additional support.

At the time of our inspection no one was receiving end of life care, however, the service had adopted a

system of 'Just in Case' medicines to support anticipatory prescribing and access to palliative care medications for people who were approaching the end of their life. People often experience new or worsening symptoms outside of normal GP practice hours. The development of 'Just in Case' boxes seeks to avoid distress caused by poor access to medications in out of hours periods, by anticipating symptom control needs and enabling availability of key medications in the service. Staff monitored people, records showed they recognised when people were becoming frail and liaised with the GP to ensure that people received the care and support they needed. The GP reviewed people's medicines to ensure that they remained appropriate. Some people had completed an advanced care plan that detailed the care and support they required and whether they wanted to be admitted to hospital or not. Staff, the person's GP and family were aware of the advanced care plans, helping to ensure that people's wishes were respected. Staff reviewed the care plans regularly to ensure that this still reflected people's wishes. Staff were aware and the care plan had information on people's cultural and spiritual needs regarding their end of life care. Some people had said that they didn't want to discuss end of life care at that time. Staff were sensitive when they spoke with people about the subject and, if people didn't want to talk about it, they would ask them another time. The registered manager told us if relatives wanted to stay with their loved ones this would be arranged.

Staff told us how they supported people. They spoke knowledgeably about people's likes and preferences. We observed staff supporting people in a person centred way, in that they tailored their support to each individual. Staff altered how they supported people, they understood how people communicated, especially those who used non-verbal communication or were hard of hearing. Staff adjusted their posture so people could hear them better. They used pictures and showed people objects so they were able to choose. Staff explained about one person's behaviour and how they could shout out and become frustrated, they reassured the person by speaking directly to them, maintaining eye contact and touching their arm. Some people were able to use call bells to alert staff if they needed something. Staff checked people who were not able to use the call bell to ensure they were safe, comfortable and had all they needed. These checks were recorded.

The registered manager confirmed there had not been any complaints since the last inspection. We saw an established complaint recording system was in place, so that the registered manager could log any future complaints and document when acknowledgments and final responses were sent. The provider's complaints policy was displayed in the front entrance foyer, giving guidance about how to make a complaint if necessary. All of the people and relatives we spoke with said that they knew how to complain and would approach the registered manager in the first instance. One relative told us, "I haven't had any worries about Mum here and if there were any problems Mum would certainly let me know about it in no uncertain terms".

Requires Improvement

Is the service well-led?

Our findings

People and visitors told us they felt the service was well led. Comments included, "She (the registered manager) is approachable, kind and caring and I can tell she genuinely cares about the residents here and their well-being. I think she may even put this place before her own life" and "I come to the meetings and really do feel involved and that we are listened to when we raise anything even if it is trivial such as the soap being used or asking for more gravy to be served". Staff told us they felt fully supported by the manager and were proud of the work they did and the care and support they provided.

At our last inspection in March 2017, the provider's quality assurance processes were not sufficiently robust to effectively identify and resolve shortfalls in the quality and safety of the service. None of the issues we raised at the inspection before that one in April 2016 had been fully resolved. Although protocols had been produced about diabetes management, they did not contain enough information to guide staff properly and keep people safe. There had continued to be inadequate levels of staff and people's need for social interaction remained unmet in many cases. We also highlighted risks which had not been monitored or properly mitigated in relation to people being unable to use call bells, staff training needs were not recognised, record-keeping was inaccurate creating risks to people's well-being, professional advice was not always followed when people lost weight and pressure wounds had not been managed in line with best practice guidelines. Had the provider's quality assurance processes been effective, all of these areas should have been addressed, the risks identified and minimised.

At this inspection significant improvement was made. Developed auditing and checking procedures were in place. The registered manager compiled an action plan to focus on each area raised at the last inspection and placed great emphasis in driving through the improvement needed. The registered manager and key staff undertook regular checks of the service to make sure it was safe and responsive to the support people needed. These included areas such as infection control and building maintenance, wound care, nutrition, mobility and care plan quality. Audits ensured time frames were set against identified concerns and staff were appointed to make sure requirements were completed. Other auditing processes ensured standards in areas not currently of concern were maintained and improved. Auditing processes were transparent and results communicated to people and their relatives. As well as completing their own checks, the provider commissioned an independent audit as an extra tier of quality assurance and to objectively test the measures in place.

While the quality assurance framework was much improved and the legal requirements of the previous breaches were met, we identified a number of areas where improvement was needed to again drive forward the quality of the service provided and the experience of those who received it as well as for the staff working at the service. These included the formal review and resolution of the adhoc way in which additional nursing needs were covered, staff to ensure that call bells were always within people's reach where they have been assessed as able to use them, choice offered and an understanding about how people preferred to receive their medication and a visible scale of wound measurement rather than a verbal description.

People were asked for their views on the service. The provider had carried out surveys about people's

experience of the service to understand how they felt and ensure that their preferences were being respected. People had responded positively to the questions and comments received were complimentary. People and their relatives were invited to attend meetings every one to two months. People were given updates on the service and any changes happening and were also able to raise any concerns, ask questions and comment on their experience of the service. A process was in place for action plans to be developed following meetings to keep track of what had been raised in the event that suggestions or requests were put forward. Minutes of the meetings we saw were complimentary about the staff and the cleanliness of the service. People had put forward ideas to nominate staff for awards such as employee of the year and staff and relatives planned to take part in a Christmas pantomime for people at the service.

Staff attended meetings every two to four months. Staff were reminded about key issues and given updates on topics such as PRN creams, infection control, diabetes management, weight loss and nutrition. Staff were able to give their views and opinions on the service. Staff attended daily handovers where the registered manager and nurses ensured staff were aware of any changes or informed of any incidents they needed to be aware of. The registered manager addressed any concerns they had involving staff immediately and reminded other staff their responsibilities.

The area manager told us about working groups they had attended with other homes that the provider owned. These were designed to develop policies and procedures and promote best practice, for example, in relation to the revised key lines of enquiry. The registered manager attended local forums such as forums held by Clinical Nurse Specialists to keep up to date with best practice.

The service had a registered manager in post. A registered manager is a person who is registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care act 2008 and associated Regulations, about how the service is run.

There was an open and transparent culture within the service. We saw the registered manager had an open door policy. They worked some shifts with staff so that they had an understanding of the role of staff and the challenges they faced. Staff told us that they felt very supported by the registered manager and were comfortable to speak to them about any concerns they may have. The registered manager worked with other agencies such as the local safeguarding authority and commissioning groups to ensure that people were protected and received the care and support they need. The registered manager ensured that information was shared with relevant agencies under the information sharing guidelines, in an open and transparent way.

The registered manager told us their vision for the service was that everybody felt part of a loving family and this was promoted by the staff team. The registered manager discussed the vision for the service at staff meetings and spent time with people and staff to ensure that the values of the service were promoted. In discussion with staff, it was evident that they shared this ethos.

The registered manager had organised for children from the local school to sing carols as part of the Christmas celebrations. A local church attended regularly to give people Holy Communion if they wished. The service had forged a number of links with the local community; for the purpose of improving the quality of people's lives.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. This enabled CQC to check that appropriate action had been taken. The registered manager was aware that they needed to inform CQC of important events in a timely manner and had done

this.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating on a notice board and on their website.