Northgate Healthcare Limited

Meadowfields Care Home

Inspection report

Pasturefields
Great Haywood
Stafford
Staffordshire
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Date of inspection visit:
03 May 2017

Date of publication:
21 June 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 3 May 2017 and was unannounced. At our last inspection in October 2015 we rated the service as Good overall but some improvements were required in how the service was managed. At this inspection some improvements had been made in relation to the management of the service however further improvements were required.

Meadowfields Care Home provides support and care for up to 65 people, some of whom may be living with dementia. At the time of this inspection 61 people used the service.

The service had a registered manager. 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.

Risks to people's health and wellbeing were not managed to keep them safe from harm. Some situations which could be harmful to people were risk assessed but staff did not always follow the plans put in place to reduce risks. People's medicines were not always managed safely.

There were sufficient numbers of suitably trained staff to provide people with the support they required. However, there were occasions when people experienced delays in receiving the support they required because of the lack of organisation of staff.

People were supported by staff that had been recruited using safe recruitment procedures to ensure they were of good character and fit to work with people who used the service. People were supported by staff who knew how to recognise and report potential abuse to safeguard them from harm and abuse.

People's rights were protected as the provider followed the principles of the Mental Capacity Act 2005 (MCA). People were offered and supported to make choices about their care and support.

Staff had been recruited using safe recruitment procedures to ensure they were of good character and fit to work with people who used the service.

People were not always provided with the appropriate support to eat their meals. People told us the quality of the food was good however they were not always given their preferred choice of food.

People's privacy and dignity was upheld but there were occasions when staff did not support people consistently in a caring or sympathetic way.

People received regular health care support and were referred to other health care agencies for support and advice if they became unwell or their needs changed.

People were provided with a varied recreational and leisure activity programme.

People and their representatives (where appropriate) were involved in the planning and review of their care. The provider had a complaints procedure and people knew how and to complain when they had concerns.

The provider had made improvements to the systems in place to assess, monitor and improve the quality of care. However, some further improvements were needed to ensure all areas of care were assessed and monitored to mitigate potential risks to people and to improve the quality and consistency of the service.

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. Risks to people's health and wellbeing were identified and reviewed but not always managed in a safe or consistent way. People's medication was not always managed safely or administered as prescribed.

People were not always supported promptly as staff were not always appropriately deployed. Staff were recruited using safe recruitment procedures and processes.

Is the service effective?

Requires Improvement

The service was not consistently effective. People were not always given a choice of food at mealtimes and some people did not receive the support they required.

The principles of the MCA and DoLS were followed to ensure that people's rights were respected. People were supported by staff who were appropriately trained and supported in their roles. Healthcare needs were met and people saw other professionals when required.

Is the service caring?

Requires Improvement

The service was not consistently caring. People were treated with dignity and their privacy was respected. However people did not always experience or receive a caring approach from some staff.

Is the service responsive?

Requires Improvement

The service was not always responsive. People did not always received personalised care that met their individual needs and preferences. People were not always offered opportunities to engage in their preferred hobbies and activities.

The provider had a complaints procedure and people felt able to complain.

Is the service well-led?

Requires Improvement

The service was not consistently well led. Further improvements were needed to ensure the quality and consistency of the service was being appropriately monitored.

People and staff felt that the providers and the registered manager were approachable and feedback on the service was being used to make improvements.	

Meadowfields 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 3 May 2017 and was unannounced.

The inspection team consisted of two inspectors 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.

Prior to the inspection we looked at the information we held about the service. The provider completed a Provider Information Return (PIR). This is a form that asked the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the notifications that we had received from the provider about events that had happened at the service. A notification is information about important events which the provider is required to send us by law. We reviewed the information we received from other agencies that had an interest in the service, such as the local authority and commissioners. We used this information to help us to plan the inspection.

We used a range of different methods to help us understand people's experiences. We spoke with eight people who used the service about their care and support and with two relatives and visitors to gain their views. We spoke with other people but due to their communication needs they were unable to provide us with detailed information about their care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed staff interactions and how they provided care and support to people.

We spoke with two providers of the service, the registered manager, three care staff a member of the ancillary team and a visiting GP. We looked at care records for seven people to see if their records were accurate and up to date. We also looked at records relating to the management of the service including quality checks.

Requires Improvement

Is the service safe?

Our findings

People's risks had been assessed, but we found that they were not consistently managed to protect people from the risk of harm. One person used a wheelchair to support them with moving to different areas of the service. Their risk assessment had been reviewed when the person fell out of the wheelchair, they did not sustain any injury from this incident. The updated risk assessment recorded that for their personal safety a lap strap should be used whenever the person was in the wheelchair. We saw the person was in their wheelchair without the safety of the lap strap. Care staff knew that a lap strap should be used, however they unaware of where to find a lap strap when we asked them about it. This meant the safety of this person was being compromised because staff did not follow the instructions in the risk assessment. The provider and registered manager told us they would ensure lap straps to ensure people's safety were available and staff would be instructed on their use.

Another person was at risk of choking and had been prescribed a thickener to be added to fluids so the risk was reduced. The care plan and risk assessment had been completed with details of the risk for this person and for use of the thickener. Some staff we spoke with were unsure of the ratio of thickener to fluid to ensure the required texture was achieved. One person was offered an unthickened drink, contrary to the risk assessment and their personal needs. We saw that a senior staff member quickly spotted this error and provided the person with another drink of the required consistently. The provider and registered manager told us further information would be provided to staff so that the prescribing instructions would be consistently followed.

We found that improvements were needed to the way medicines were monitored and managed. We saw that where people needed 'as required' medicines, protocols were not always in place. For example, one person who often became distressed and agitated was prescribed medicine to reduce their anxieties. However, there were no protocols in place to guide staff on how to recognise the level of anxiety the person exhibited. This meant the person was at risk of receiving their as required medicines in an inconsistent way.

We looked at the records for people who were using medicinal skin patches. Staff did not make a record to show where the patches were applied to the body. Skin patches can sometimes cause skin irritation and can put people at risk of experiencing pain. This meant the risk of patches not being applied in line with the manufacturer's guidance, which could result in unnecessary side effects for some people. We brought this to the attention of a team leader who amended the medication record with this additional information and guidance.

Some people were prescribed cream and lotions to support them with maintaining good skin. We saw one person had been prescribed a topical medicine; staff told us this was currently out of stock and they were waiting for a delivery from the pharmacy. The person's topical medication administration record had been signed to indicate the person had received their medicine when they had not. This meant this person was at risk of inconsistent and reliable care because the medicines were out of stock and staff incorrectly completed the monitoring records.

On one unit we saw the medicine trolley was in an unlocked office, the keys were in the lock of the trolley. There were no staff present in the office. Although the office door was closed, but not locked, we saw people were able to access the area. There was a high risk that medicines could be removed from the trolley without the knowledge of staff. The registered manager took immediate action and spoke with the staff member concerned.

These issues constitute a continuing breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people told us they felt safe, secure and comfortable at the service. One person told us: "Yes I do feel safe, the staff are good and they look after me well". One person was not quite sure how they felt in regard to their personal safety: "Sometimes I feel safe and at other times not quite so". A relative told us: "Yes I do feel my relation is safe here, everyone is so friendly and the staff know people very well".

Staff explained how they would recognise and report abuse. One staff member: "We have had training in safeguarding people and how to keep people safe. I would report any concerns immediately to the manager or the senior staff, they would deal with it". Procedures were in place that ensured concerns about people's safety were appropriately reported to the registered manager and the local safeguarding team. The registered manager spoke with us about the safeguarding issues they had been involved with which had been referred to the local safeguarding teams.

The service was undergoing refurbishment to all areas around the home. Arrangements had been made to ensure the safety of people during the on-going works with certain areas being taken out of use. The environment and the equipment used were checked at regular intervals to ensure the service and equipment were safe.

People offered mixed views regarding the staffing levels. One person who used the service told us: "Oh yes there seems to be plenty of staff but it sometimes depends on who's on what shift'. Another person said: "Can't fault the staff at all they're very helpful but it would help if they had a bit more time but I would say the staffing levels are barely adequate really". A member of care staff said there was plenty of staff but sometimes agency carers were needed at weekends to cover the shortfalls. They told us they felt the agency workers were 'okay'. We saw that generally (with the exception of the lunch time period) there were enough staff were available to support people when they required assistance.

People were supported by staff that had been safely recruited.The provider showed us that they followed safe recruitment procedures to ensure that prospective new staff were fit and of good character to work with people who used the service. Pre- employment checks included disclosure and barring service (DBS) checks for staff. DBS checks are made against the police national computer to see if there are any convictions, cautions, warnings or reprimands listed for the applicant. The registered manager told us an existing member of staff was an Induction champion with their role being to support newly employed carers. New staff were closely monitored to ensure that they were competent to fulfil the role. On occasions new staff had their induction extended to give the induction champion more time to assess their competence. This showed the provider was ensuring that new staff were competent and fit to fulfil the role they had applied for.

Requires Improvement

Is the service effective?

Our findings

We observed the lunch time period in both of the dining areas and saw some people were delayed in receiving their meals. Some people did not receive the meal they had chosen and some staff were unsure of people's preferences. A person was provided with meat when they had requested vegetables only. The person said: "I don't want meat, I asked for all vegetables. I don't eat meat". Some people were offered support and encouragement however other people were not. One person who was visually impaired was not supported, we saw they tried to scoop food from the plate without success and put empty forkfuls in their mouth. Staff were busy serving food to other people, no one offered the person support and help. On occasions people were left unsupervised in the dining areas, staff were not available in the vicinity. People then became restless and agitated with each other and some people left the dining room unseen.

We spoke with the providers and the registered manager they told us some of the delays were caused because one of the heated food trolleys was broken and was in need of repair. During the afternoon we saw the repairs had been made. The providers confirmed that the on-going improvement works were having an impact on the daily routines within the service but would ensure improvements were made to the dining experiences for people.

People told us the food provided was of a good quality and standard. One person who used the service said: "The food is very good actually. I've got no complaints about that. They always tell you what's for tea, breakfast and dinner, I always have toast, and I like it". Another person described the food as 'excellent'. We saw that people were offered a range of food and hot and cold drinks throughout the day.

Staff told us they received the training they needed for them to provide the care and support to people. One member of staff told us that the recent training in dementia awareness was very useful and informative. Staff confirmed they had regular supervision sessions with their line manager this gave them the opportunity to discuss any work related or development issues.

The registered manager followed the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). 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 made their own decisions and were helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We saw that some assessments had been completed when people did not have capacity to make some decisions for themselves. Where people were unable to agree to their care and treatment, support from their representatives was gained to make an agreement in the person's best interest. For example, people's end of life care preferences and wishes. This showed that people were being supported to consent to their care and support in their best interests.

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). The registered manager recognised that some people were being restricted of their liberty and freedom. We saw that some people had restrictions to their liberty such as rails on their bed or systems in place to prevent them from leaving the building unsupervised. The registered manager had made referrals to the local authority for authorisation to restrict peoples' freedom of movement when they did not have the capacity to consent to this. The registered provided told us they were waiting for confirmation of the authorisations for the restrictions from the supervisory body. This showed that people's rights were protected as the provider was applying the principles of the MCA.

Staff supported people to access health care services should they become unwell or require specialist interventions. People had access to regular consultations with their doctor if this was requested and required. The doctor told us the service was responsive and quick to respond when any concerns with people's changing healthcare needs were identified. The doctor made regular visits to the service and commented since the new manager had been at the service 'things are better'. We saw referrals for specialist healthcare advice and support were made when this was needed. One person who used the service told us they had recently seen the chiropodist. People's care and support plans were updated when guidance and information was received from the specialists. This showed us that additional support was requested in a timely way which ensured people's healthcare needs were met.

Requires Improvement

Is the service caring?

Our findings

Most people told us they were satisfied with the care provided. A relative told us: "Oh yes, they care, if anybody isn't very well they tell you. They [the staff] told me today that [the person's relative] was not very well". Another relative told us they were happy with relation's care and said: "Yes, definitely. The whole feeling of the place is friendly and it's not too big". People who used the service had mixed views. One person said: "Sometimes I'd say yes I am happy and sometimes I'd say no. I think they [the staff] do their best, some more than others".

A member of staff was supporting people who were living with dementia; they were patient and understanding and explained what was happening in a calm way. They told us: "All people are very different so we have to be very patient and spend time with them". However we did see some interactions that were not as caring or thoughtful as they could be. For example we saw and heard staff telling people to 'Sit down and eat your dinner please', and, 'We don't want any arguments with each other please!' The staff supporting these people had not considered why they did not wish to eat or why the arguments had occurred this did not demonstrate that they cared about people's overall wellbeing. This did not demonstrate a caring and respectful manner towards people who used the service.

Most people were offered choices and their choices were respected. Some people chose to spend time in their room, whilst others spent time in the communal areas. We saw that people were free to independently move around the units but the access to other areas and the gardens were restricted. One person continually walked around one unit and kept banging on a locked door. The person was unable to fully communicate their needs due to cognitive difficulties and we saw staff directed the person to other areas of the same unit where they continued to walk around. One member of staff said the person 'always walked around' but was unsure why the unit door was locked but thought it maybe for the safety of people. However, we saw the same person had specific nutritional needs and was supported with their meals in an individualised and person centred way. There was a lack of consistency in the caring approaches by staff.

People's privacy and dignity was upheld and they told us they were treated with respect. One person said: "Oh yes, you get some respect. They always knock before they come in anyway". We observed staff supported people with their personal care needs in private and people were supported back to their bedrooms for consultations with the doctor. Relatives told us they felt welcome when they visited the service.

Requires Improvement

Is the service responsive?

Our findings

People were provided with a range of social and recreational activities which they could participate in if they so wished. One person told us how much they liked to dance as it was something they had always enjoyed. Staff supported this person with this and arranged for some dance music to be played. Other people seemed to enjoy watching. A group of people participated in playing bingo during the morning. One person declined to take part and said: "No interest for me to play Bingo or what have you. No, I'm not that type of person". Another person had one to one support with a member of staff and counted some money. They told us dealing with money and finances were part of their job when they were at work. The person was fully engaged and enjoyed this activity.

One person told us they would like to be outside more and told us: "I have no interest in anything indoors". The providers told us the rear garden area was secure and people had access to this area when they wished to do so. We saw one person continually asked to go outside, although staff offered a reasonable explanation regarding their safety and going into the front garden, the person was not offered the opportunity to access the secure garden at the rear of the premises. The registered manager was unsure why on this occasion people did not have free access to the secure garden area. This meant that the facilities offered by the provider were not always readily accessible for people to use.

People told us they had choices regarding their daily living, one person told us they could choose what time they went to bed. Where people were unable to be fully involved with discussing their care needs the person's representative had been contacted. One relative confirmed: 'Yes, they do actually, I talk with staff about my relation's care needs and I do think they are progressing, I don't think they'd say everything's all right if it isn't, which is a good thing".

Staff told us, and we saw, they regularly reviewed the care and support needs of people and updated the relevant documents. A relative told us they regularly spoke with staff about their relation's care and support needs. They had recently spoken with staff about a personal care issue that their relation 'keeps forgetting about'. Staff told us the actions they took to remind the person about this. We saw that at the beginning of each shift change staff had a formal handover to ensure they were aware of any significant changes to the care and support needs of people. However, we saw that not all staff were aware of people's assessed needs, for example one person not being given the correct amount of thickener in their fluids or that safety equipment was needed for when people used wheelchairs. This meant people who used the service were at risk of receiving care that did not meet their individual assessed care and support needs.

The environment was being extensively upgraded and adapted to meet people's social and emotional needs in relation to living with dementia. People were able to orientate and find their way around the service. Attention had been made to the décor and signage was used so that areas people needed to use regularly were recognisable. Bedroom doors were provided with information regarding the person who was accommodated in the room so that people could easily identify their own room.

The provider had a complaints procedure. People and their relatives told us they would speak with the

registered manager, the deputy manager or any of the staff if they had any concerns. One person who used the service told they had no complaints and said: "No, never thought about, no". The provider told us they dealt with any complaints but currently none have been received.

Requires Improvement

Is the service well-led?

Our findings

Quality monitoring systems were in place, with audits completed each month. Any issues or themes, trends or patterns that affected the safety of people or the service were identified quickly. For example checks were made on the incidents which occurred monthly; these included information regarding slips, trips and falls. We saw where people were referred to the doctor and the falls services when they experienced a high level of falls. However, the recent audits did not identify that lap straps had not been fixed to wheelchairs, that some medication was out of stock, that not all 'as required' prescribed medicines had related protocols or that risk assessments were not followed consistently. The audits and lack of management oversight had failed to identify and improve the quality and safety of the care provided. This put people at risk of receiving care that did not meet their individual needs in a safe and consistent way. The registered manager told us they were aware that improvements were needed in some areas and spoke of 'going back to basics' to ensure people received high and safe standards of care.

Some people knew the registered manager by name others were not quite sure. One relative said: "Yes I know the manager and if she is not available I can speak with the deputy". One person who used the service said: "I think you can talk to her [the registered manager]". The registered manager told us when she is unavailable there was always a member of the senior care team around. Staff told us they felt well supported by the providers, the registered manager and the senior care staff and they worked well as a team. The service had a registered manager who was supported by a team of senior staff, carers and ancillary staff.

People and their relatives were asked their views, opinions or experiences on the service they received. Relatives had completed a recent survey and suggested more community outings would be beneficial. The provider told us of their plan to have their own minibus so that people could access the local community easily. A relative commented: "I think it would be a really good idea to have relative's meetings. I don't know if there are any arranged but I've never been invited to one".

Staff meetings were arranged at regular intervals which offered staff the opportunity to meet and discuss any work related issues and make suggestions for improvements. At a recent staff meeting there was discussion regarding the numbers of staff required at night. The registered manager explained this was work in progress with determining staffing levels in regard to people's dependency needs and requirements at night.

The registered manager reported significant events to us, such as safety incidents, accidents and deaths that had occurred at the service, in accordance with the requirements of their registration. The rating of the service was displayed on a notice board within the units so that people could clearly see information on the quality and safety of care provided.

The providers and registered manager told us of the plans to improve the service. They told us and we saw that parts of the environment had benefitted from redecoration and refurbishment to provide a more dementia friendly and comfortable place for people to live, work and visit. Further improvements to other

areas of the service were on-going.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service was failing to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.