AJ & Co.(Devon) Ltd

Meadowside and St. Francis

Inspection report

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30 June 2017
04 July 2017
05 July 2017
14 July 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The overall rating for this service is 'Inadequate' and the service is therefore in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The inspection took place on 29 June 2017, 30 June 2017, 04 July 2017, 05 July 2017 and 14 July 2017 and was unannounced. Meadowside and St Francis is divided into two units; St Francis provides complex nursing care for up to 44 people. Meadowside provides personal care for up to 25 people. The home is registered to provide care for up to 69 older people. On the day of the inspection, 58 people lived in the home. The provider also operates another nursing home in the same locality.

There was a management structure in place. The service had a registered manager. 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 also a separate manager for each unit; with a clinical lead and a matron in post, to oversee the nursing care being provided. A new manager had recently been recruited to share the responsibility of the day to day management of the home. They were in the process of registering with CQC. Following the inspection, the registered manager told us they would be recruiting a new manager to replace them, so they could focus on their role as a director of the two nursing homes owned by the provider.

Prior to our inspection we had received concerns from the local authority safeguarding team. These included concerns about poor standards of care, lack of dignity, respect and compassion shown to people,

unsafe recruitment practices, lack of training for staff and staff not meeting people's complex care, skin care or end of life care needs safely. They also included concerns regarding incomplete monitoring and recording of people's healthcare needs, staff not following recommendations made by external professionals, unsafe medicine's management and ineffective monitoring or equipment and stock.

At our last inspection on 14, 15, 19 April and 03 May 2016, we found breaches of regulation. We found care and treatment was not always appropriate to meet people's needs or reflective of their preferences. Care and treatment was not always provided in a safe way. People's risks were not always assessed and guidance regarding people's care was not always followed. Medicines were not always managed in a safe way. The legislative framework of the Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards (DoLS) were not always being followed. Records of people's care were not always accurate, complete and contemporaneous. At this inspection we found that action had not been taken to make improvements to the service and to the care people received.

St Francis (Nursing Care)
People did not receive safe care and treatment. Nursing practice was not always safe and put people at risk of potential harm. We witnessed nursing staff provide unsafe care and treatment and they did not always have a comprehensive understanding of people's health needs or how to meet them. The registered manager had not ensured requirements set by the Nursing and Midwifery Council in relation to staff had been complied with. This meant nursing staff were not receiving the correct support to help ensure they provided safe care and remained competent in their role. We have referred our concerns to the nursing and midwifery council. The nursing and midwifery council is the regulator for nursing and midwifery professions in the UK

People's healthcare needs were not always dealt with promptly and recommendations from external healthcare professionals had not always been followed. This meant people were at risk of their health deteriorating. Where people required staff to monitor their health this had not always been done effectively or acted upon which meant any further action required, to maintain the person's health was not taken.

People's care plans and risk assessments did not reflect their up to date, complex care or health needs. People's dietary needs were not always known or met by staff. People who needed a soft, pureed, diabetic or high calorie diet did not always receive appropriate food to keep them safe and healthy. Staff were often unaware of people's needs, how to meet them and how to recognise they were unwell; and we found examples of staff providing incorrect care to people.

Staff had not all received up to date training or training to meet people's individual needs such as diabetes or epilepsy. Nursing staff had not all completed or updated the training required to help ensure they provided safe, effective care. Records showed they had not received assessments of their competency to carry out procedures related to people's complex needs such as tracheostomy care.

Where people lacked the capacity to make decisions, their rights had not always been protected. There was no evidence to show how decisions about people's mental capacity had been made or who had been consulted. Staff showed a lack of understanding about people's mental capacity.

Staff did not always have access to information about how people could, or preferred to, express their views. People's care plans for care at the end of their life did not always contain information about their preferences or details about how to meet people's needs.

Medicines were not always managed safely and infection control practices were not always being followed

to reduce the risk of cross infection.

The provider did not seek and act on feedback from external professionals in order to improve the service.

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Staff members had not always been recruited safely to help ensure they were suitable to work with vulnerable people. Some new staff members had started working at the service before a satisfactory Disclosure and Barring Service (DBS) check had been returned. Other staff members had begun to work at the service, even though their career history or references did not give a clear picture of their skills and previous experience. Nursing staff had been employed without references being sought regarding their nursing expertise and with no information about where they had worked previously.

The provider had not developed a culture of continuous improvement. They had not used the outcomes of previous inspections, complaints, incidents or safeguarding investigations to ensure the quality of the service improved. They had not acted to make improvements when external professionals had raised concerns with them. During the inspection we found similar concerns to those that had been found at previous inspections or raised during recent safeguarding investigations.

The provider and registered manager had not maintained a clear overview of the quality of the service and had failed to act when gaps in quality had been brought to their attention. Audits that had been completed to assess the quality of the service were not always fit for purpose and where improvements had been identified through audits; these had not always been acted upon. Feedback had not been sought on a regular basis from people or their family members in order to improve the service.
People and staff had not always felt confident raising concerns with the registered manager. Staff members told us they did not have the opportunity to share their ideas and when they had questioned practice, this had not been received positively by senior staff. The provider had a whistle blowing policy but no-one working at the service had whistle blown about the quality or safety of the care being provided. Some people and relatives told us they knew how to raise a complaint but did not always feel comfortable doing so.

The provider had not ensured staff understood their responsibilities for reporting incidents accurately. There was no formal system in place to monitor any themes or trends arising from accidents or incidents occurring in the home.

Staff did not always act to keep people safe from risks relating to the environment. Doors to several rooms or cupboards containing potentially hazardous material or equipment were left unlocked. Medicines were not always stored securely. When people had accidents, incidents or near misses these had not been monitored to look for developing trends. This meant learning to reduce the risks of these happening again had not been identified.

Some staff members had not attended training on how to move people safely but were still supporting people to move. This meant they might have put people at risk of harm or injury.

People were not always treated with dignity and their confidentiality was not always protected.

Activities were planned that people could be involved in and the activities co-ordinators spent some time with people who preferred one to one time rather than group activities. The activities co-ordinators were in the process of finding out what activities and hobbies people enjoyed. They told us they intended to tailor planned group and individual activities so they could help ensure people's preferences were catered for.

Some people told us they felt safe and that they were happy with the care they received. Staff showed concern for people's wellbeing in a caring way, talking calmly to people and giving them hugs. People and their relatives spoke positively about staff.

Meadowside (Residential Care)
People received care and support from staff who had got to know them well. Staff respected people's privacy. People had care plans and risk assessments that clearly explained how they would like to receive their care, treatment and support, and staff understood how to meet people's needs. Staff were knowledgeable about the Mental Capacity Act 2005 (MCA) and their responsibilities under it.

People's health care needs were monitored and staff sought advice from external professionals when required. Medicines were managed and given to people as prescribed and disposed of safely. Staff supported people with their medicines and related health needs in a personalised way.

Training had been planned to support staffs' continued learning and was updated when required.

People and relatives told us they felt Meadowside was well led.

We have made a recommendation about staffing levels.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People did not always receive their care and treatment in a safe way.

People's risk assessments did not always reflect all the risks relating to their care or guide staff how to mitigate them.

Staff were not always recruited safely.

Medicines were not always managed safely.

Is the service effective?

Inadequate

The service was not effective.

People did not always receive support from staff who knew them well and had the knowledge and skills to meet their needs.

Staff had not always received training relating to people's specific needs. Nursing staff had not received up to date assessments of their competency to carry out complex clinical care.

People's human rights were not protected because staff did not fully understand their responsibilities under the Mental Capacity Act 2005 (MCA).

Is the service caring?

Inadequate

The service was not caring.

People's confidentiality, dignity and privacy were not always respected by staff.

People were not always consulted regarding decisions about their care and treatment.

People's end of life care was not planned in a personalised way.

Is the service responsive?

Inadequate

The service was not responsive.

People's care plans did not always reflect their up to date needs

People did not always receive personalised care and support. Staff were not always aware of people's needs.

People were not always involved in reviewing the care they received.

People knew how to make a complaint and raise any concerns but did not always feel confident to do so.

Is the service well-led?

Inadequate

The service was not well led.

The management team did not provide strong leadership.

People did not benefit from the provider having a clear aim to improve the service.

People's views and feedback about the service had not been sought to ensure the service was meeting their needs.

Quality assurance systems had not been implemented in a way that raised standards of people's care by learning from mistakes.

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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.

The inspection took place on 29 June 2017, 30 June 2017, 04 July 2017, 05 July 2017 and 14 July 2017 and was unannounced. The inspection was prompted in part by safeguarding alerts we received via the local authority safeguarding team.

The inspection was carried out by two adult social care inspectors, a member of the medicines team, a specialist nurse 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 similar services.

Prior to the inspection we reviewed the records held on the service. This included the Provider Information Return (PIR) which is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed previous inspection reports and notifications. Notifications are specific events registered people have to tell us about by law.

During the inspection we spoke with 17 people and seven relatives.

We reviewed nine people's care records in detail. We also spoke with 19 members of staff and reviewed 13 personnel records and the training records for all staff. Other records we reviewed included the records held within the service to show how the registered manager reviewed the quality of the service. These included audits, minutes of meetings and policies and procedures.

We spoke with two visiting nurses. Following the inspection we also spoke with a respiratory nurse specialist who knew the service.

After our inspection, because of identified concerns, we raised a safeguarding alert with the local authority. We also attended an urgent strategy meeting with the local authority and clinical commissioning group

safeguarding teams to discuss the concerns.

Inadequate

Is the service safe?

Our findings

The service was not safe.

At our last inspection on 14, 15, 19 April and 03 May 2016, we found records of people's care were not always accurate, complete and contemporaneous; people's risks were not always assessed and guidance regarding people's care was not always followed. We also found people's medicines were not always managed in a safe way. Following the inspection, the provider sent us an action plan of how they would make improvements. However, at this inspection, we found improvements had not been made.

St Francis (Nursing Care)

Staff did not always act to keep people safe. During the inspection, we became aware of a staff member who had put one person at risk of harm. The person had recently required their catheter changing regularly. Staff had identified the person was unable to pass urine and that there was not sufficient catheter equipment to meet their needs. There was no record to show that any action had been taken about this. As no catheters were available for the person, a senior nurse on duty used a catheter designed for a female even though the person was male. The senior nurse had not consulted any other healthcare professionals before making this decision nor had they considered requesting the correct catheter from the person's local GP, pharmacist or the provider's sister home. This action could have caused the person severe internal trauma, pain, haemorrhage as well as longer term health effects. We were told by the senior nurse they had requested an external company deliver the correct catheter urgently and used this for the person as soon as it arrived. Following the inspection, the local authority safeguarding team investigated and found that the person still had the incorrect catheter fitted seven hours after we had originally raised this with the provider. They also found that following identification that the person was not passing urine, and the incorrect catheter being fitted, the person had not received medical attention for 48 hours. We have informed the nursing and midwifery council about the nurse's practice. The nursing and midwifery council is the regulator for nursing and midwifery professions in the UK.

Following our inspection we were informed by the local authority safeguarding team they had substantiated abuse against a person whose family had raised concerns about them being strapped to a chair, not having enough to drink and that their health was deteriorating rather than improving. The person told the safeguarding team they were only given a cup of tea with their breakfast. Staff told the local authority safeguarding investigation team that they left the person strapped in a wheelchair all day so they did not hurt themselves. The safeguarding team found that the person was also left with their bedroom door closed. Staff reported they had not got time to support the person to maintain their mobility and as a consequence of this, their family stated the person was losing the ability to be independent. Despite the staff not being able to meet the person's needs no further support had been requested from external professionals. This meant the person had been treated in a way that significantly disregarded their needs.

The provider had not ensured people were protected from abuse and improper treatment. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks relating to people's health and care needs were not managed safely. Risk assessments did not always reflect people's up to date needs and staff did not always know all risks relating to individuals or what action to take to reduce the risks. For example, people receiving complex care such as tracheostomy care or their food via a PEG (through their stomach wall), did not have risk assessments in place to guide staff how to reduce the risks involved in these procedures. There was also no guidance regarding what to do if something went wrong with the equipment or if the person became unwell. A healthcare professional confirmed it was very important to have this information in place to guide staff if anything went wrong with the person's equipment. One person's care plan stated that their 'swallowing was compromised' but they had no risk assessment in place to guide staff how to minimise the risk of choking to the person. Staff were not aware that the person was at risk of choking and told us they had not had training about what action to take if someone choked.

Where risks to people had been identified records did not include actions staff should take to mitigate the risks and keep people safe. For example, several people's records had highlighted a risk of their skin being damaged. However, there were no records to show what staff should do to help reduce the risk. Some people had special mattresses in place to help alleviate pressure on their skin, however their records did not always show what settings the mattress needed to be at, to maintain their skin health. Prior to the inspection, a safeguarding alert had been raised because someone had sustained significant skin damage. The skin damage had not been identified or reported by staff and staff had not then followed recommendations made by the nurse; this had included the person's mattress not being kept at the correct setting. Following overview of the skin damage by an external healthcare professional, the skin damage had improved. A relative told us they had previously found their loved ones mattress deflated. This put their skin at risk of damage.

The provider's policy stated that when someone experienced skin damage, staff would complete a wound assessment chart to record its appearance each time it was dressed. This would help staff monitor whether the skin was healing or not. However, this had not been carried out for people with skin damage. People had been referred to the relevant external professional; but records held at the service meant it was not possible to identify whether the wound had improved or deteriorated and to take appropriate action.

The skills of staff who were working with people with complex needs had not been taken into consideration in order to keep people safe. For example, one person who had diabetes and vulnerable skin health was being supported by staff members who had not received training in these areas. One staff member confirmed they would not recognise if the person's diabetes had caused them to become unwell. This meant staff may not have acted to keep the person safe if they were unwell.

Medicines were not always managed safely. Staff did not keep accurate records of the quantities of medicines received into the home. Also, medicines administration records (MARs) were not always accurate. This meant it would be difficult to ensure people had received their medicines or know how many of each medicine should be left in stock. For example, one person had been prescribed antibiotics. Staff had signed to show that the antibiotics had been given as prescribed, however the remaining number of doses for the person did not reflect this. Staff could not explain why the quantities did not tally. This meant the person may not have received the medicines in a way that would have effectively treated their infection. Another person had been prescribed a tablet to be taken once a week. Due to handwritten changes on the MAR, it was unclear that the person would receive their medicine for the next two weeks. One dose had been signed as given three weeks in the future. Staff could not explain why this had happened.

People's medicines did not always reflect recommendation made by health professionals; and changes to medicines were not always recorded. For example, a seizure plan, written by an external epilepsy specialist

nurse in March 2017, was in place for one person with epilepsy. Not all the medicines on this plan were currently being prescribed and there was no up to date information in the person's care plan to show when or why the medicines had been changed. People's care plans did not contain information regarding people's medicines, why they were taking them or people's preference about how to take their medicines. One person had been discharged from hospital the previous day. Several of their medicines had been changed from tablets to liquids to make them easier to swallow. The medicines trolley contained both their original tablets and the new liquid medicines. Two MARs reflecting both types of medicine were being used. This meant there was a potential risk that both liquid and tablets could be given at the same time. Staff had not identified this as a risk, but said they would remove the tablets from use.

There was a lot of external ice on the icebox in the medicines refrigerator. This refrigerator contained a lot of insulin for diabetic patients, some of which was resting against the ice. Insulin may not be effective if frozen. Staff were not measuring the minimum temperature of the medicines refrigerator and had not identified this as a potential risk.

The provider had not ensured staff acted in a way that protected people's safety, that risk assessments were in place to guide staff how to reduce risks to people or that medicines were managed and administered safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Infection control practices were not always being followed. Bathrooms did not appear unclean but cleaning rotas in three bathrooms showed no record of cleaning on three days before the inspection. This meant it was unclear how often the bathrooms had been cleaned. People's rooms and clinical equipment were not maintained in a way that would prevent cross infection. For example, an external professional had recorded in one person's care notes that the stand, pump and wall had liquid (used to feed the person through their stomach wall), splashed on them; and a relative confirmed they had had to ask staff to clean their loved one's wall and equipment. During the inspection, there were splashes of the liquid on another person's wall and on their equipment; and the syringe used to provide their medicines was not clean. The syringe should only be used for one day but it was not clear how long it had been used for, as it had no date on it. The cup used for sterile water was also stained. This meant the staff were not protecting the person from the risk of infection. An infection control audit had been completed seven weeks before the inspection and had identified areas for improvement. However these had not been actioned. For example, the audit identified checks on food stored in communal fridges were not recorded. During the inspection we found these checks were still not recorded. We also saw food stored in a way that increased the risk of it contaminating other foods. The food was not dated either, making it unclear when it was no longer safe to eat.

The provider had not ensured people were protected from infection by ensuring they followed safe infection control procedures and best practice. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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The provider's recruitment policy stated that references for new staff members should be complete and appropriate and, that staff should not be offered a position if their references or DBS were not satisfactory. It also stated the provider should complete an assessment for any potential staff member who did not have these, considering the possible implications of employing them and exposing vulnerable people to them. However, the provider had not followed their own policy. Staff recruitment records, (including nursing staff), lacked information about staffs' career histories and some did not specify which companies they had previously worked for. It was not always clear who references for new staff members were from, who the

referee worked for, how long they had known the staff member or in what capacity. Nursing staff references did not always provide assurance that the nurse was competent in their role. For example, some references did not relate to nursing roles, or only provided dates of previous employment. This meant the provider could not be certain these staff members were suitable to work with vulnerable adults. Staff files also showed some new staff members had started working at the service before a satisfactory Disclosure and Barring Service (DBS) check had been received. There were no documents to show what actions would be taken to ensure the staff member posed no risk to the vulnerable adults living in the home whilst this check was in process.

The provider had not carried out sufficient checks or assessed for any risks to assure themselves staff were safe to work with vulnerable adults, before they commenced employment at the service. This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When people had accidents, incidents or near misses these had not been monitored to look for developing trends. For example one incident form stated someone had been found with their "legs stuck in their bed rails." There were no records to show that any learning had taken place about how to avoid this happening for other people. Most people we saw did not have bumpers on their bed rails in order to protect them from sustaining injuries from them. One person's care plan stated they required bumpers on their bed rails but none were present.

Some staff members had not attended training on how to move people safely but were still supporting people to move. One staff member told us they always worked with a member of staff who was trained to move people, however this can put the person at risk of skin damage or other injury by using incorrect techniques. We observed one staff member push someone in a shower chair without using the foot plates. This put the person at risk of injury as their feet could become trapped and they may fall out.

Staff did not always act to keep people safe from risks relating to the environment. Doors to several rooms or cupboards containing potentially hazardous material or equipment were left unlocked for example, rooms containing a hot water tank, electricity meters and cleaning products all had signs highlighting the importance of keeping them locked.

Medicines and medicines records were not always stored securely. When not in use, medicines were stored in locked cupboards and trollies however, during the inspection, we saw a container with multiple bottles of eye drops and an inhaler left unattended on top of medicines trolleys and a bottle of out of date eye drops left in someone's room. This meant there was a risk these could be used by the wrong person or tampered with.

Some people were prescribed medicines to be taken when required. Staff managed 'when required' medicines for people in different ways. Some people were asked if they needed their 'when required' medicine and some were not. Staff told us some people were not offered 'when required' medicines because "they are creatures of habit". However, there were no records in place to explain what this meant for each individual. This meant staff members may not have been acting consistently regarding when to offer these medicines. People's records also did not provide guidance for staff about when these medicines might be needed and how long they should be taken for. This meant people may not have been receiving their medicines when they needed them. Staff did not record the outcome of giving 'when required' medicines, so could not always be sure that they were effective.

Medicines requiring cold storage were monitored to check temperatures were suitable for storing medicines, however only the current refrigerator temperature was recorded. This meant that staff could not

be certain whether the maximum and minimum temperatures the refrigerator reached had maintained medicines within the required range.

Regular checks were carried out of fire alarms and firefighting equipment to protect people from the risk of fire. However, at the start of the inspection, wheelchairs and mobility aids were found to be stored in corridors and below flights of stairs which may cause a hazard in the event of a fire. By the end of the inspection, the registered manager had taken action to ensure these items were stored in more suitable locations.

The provider had not acted to keep people safe from risks. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The registered manager had not calculated how many staffing hours each person required, according to their individual needs. This meant it would be difficult to establish whether there were sufficient staff on duty to meet people's need safely. A relative raised concerns that as people's needs increased, there was no evidence that staffing levels had increased. They also told us at night time, it was difficult to find a staff member. A professional told us they felt the number of staff members on duty needed reviewing due to the complexity of people's needs in the home. People and staff told us they felt there were enough staff on duty to meet their needs and keep them safe. A staff member commented, "There are enough staff, call bells don't ring frequently, there is always a member of staff on each floor." People had call bells in their rooms and these were seen to be answered in a reasonable time frame. One person told us, "I've always got my call bell on hand if I need anything."

We recommend the provider assures themselves staffing levels meet the needs of individual service users, using a recognised process.

People told us they felt safe. People were protected by staff who had an awareness and understanding of signs of possible abuse. Some staff knew who to contact externally if they felt their concerns had not been dealt with appropriately. For example, the local authority or the police. However, not all staff had received up to date safeguarding training.

Meadowside (Residential Care)

Medicines were managed and given to people as prescribed and disposed of safely. Staff were appropriately trained and confirmed they understood the importance of safe administration and the management of medicines. Staff, were knowledgeable with regards to people's individual needs relating to medicines.

People had medicine administration records (MARs) in place to record what medicines they had been prescribed .However, although handwritten changes to MARs were checked for accuracy by a second member of staff, we saw some handwritten MARs were inaccurate. For example, one person had the wrong strength of their pain killer recorded. This meant, although this person had not taken any of this medicine, there was a potential risk the wrong dose could be administered. We highlighted this to staff who arranged for the medicine to be stopped as it was no longer needed.

Staff supported people with their medicines and related health needs in a personalised way. For example, one person administered some of their own medicines. There was a risk assessment in place that helped to ensure this was safe for the person and that they could use the medicines in a way that meant they would be effective. Staff had also created a 'Hypo Box' to store information and glucose sweets and drinks for people with diabetes to use when they had low blood sugar levels. Staff explained how they helped people to

monitor their blood sugar levels and how to identify signs that a person may have low blood sugar.

Where people had risks relating to their health or social care needs, risk assessments were in place which highlighted these risks. For example, one person was at risk of falling and another person had risks relating to diabetes. Records guided staff how to mitigate the risks to these people and staff were knowledgeable about how to do this.

Inadequate

Is the service effective?

Our findings

The service did not effectively meet people's needs.

At our last inspection on 14, 15, 19 April and 03 May 2016, we found the legislative framework of the Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards (DoLS) were not always being followed. Following the inspection, the provider sent us an action plan of how they would make improvements. However, at this inspection, we found improvements had not been made.

St Francis (Nursing Care)

People's health care needs were not always monitored effectively or changes in their health reported promptly to health care professionals. Following the decline of one person's health during the night, a nurse had taken medical observations. The observations showed their health was unstable but the nurse had not recorded that they had taken any further action to monitor the person's health or make contact with external healthcare professionals. At 7am the next morning, a different nurse who was starting their shift, called the emergency services and the person was admitted to hospital. Another person's catheter had become blocked regularly during the previous seven weeks. The nursing staff stated the GP was updated on their weekly visit. However, there was no evidence of this in the person's notes and there had recently been an entry stating that the GP had visited but no new concerns had been identified or shared. This meant people had not received timely interventions to maintain their health.

The provider had not ensured staff acted promptly to help protect people from the risk of their health deteriorating. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans did not always provide staff with information about people's health needs. One person had recently moved into the service and information from social service stated there were a significant number of health needs that might affect them. However, their care plan did not mention any of them. This meant staff members would not be aware of signs they were unwell. Other people's care plans did not reflect changes to their health needs. For example, one person's care plan stated, due to their health needs, the person could have three spoons of thickened custard, however their review stated no oral input. The care plan had not been updated with this change and staff did not have a clear understanding of what the person was able to eat. This meant there was a risk the person may receive food or drink that was unsafe for them. One person had sustained 10 different injuries over 11 weeks; however there were no records to show whether any action had been taken regarding six of the injuries. An external professional visiting the service confirmed they found it was difficult to find information about people's care or to establish what level of care had been carried out.

The provider had not ensured staff maintained contemporaneous records of people's needs of the care provided to them. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's PIR stated, "Staff are skilled and competent to fulfil their role and responsibilities." Some people and their relative confirmed this to be the case. However, training records showed many staff members had not received up to date training in the provider's mandatory subjects, such as safeguarding and moving people, or training to meet people's specific needs. For example, one person had diabetes and also was at risk of skin damage. Staff caring for the person had not received diabetes training and told us they would not know what symptoms to look for or what action to take if the person became unwell. They also told us they did not know why they were checking the person's skin.

Nursing staff had not all completed or updated the training required to help ensure they provided safe, effective care. There were few records to show that competency assessments had been carried out to help ensure nursing staffs' skills remained up to date, when delivering complex care procedures such as medicines management and tracheostomy care. The provider's medicines management policy stated competency assessments should be completed quarterly and recorded. However, this had not been complied with. A relative told us they had not seen staff being observed when providing complex care to their loved one and on one occasion they had had to show nursing staff how to use the equipment. During the inspection we observed nursing staff members providing unsafe care to people; for example not administering insulin to someone as soon as they required it and fitting the incorrect catheter for someone. Both these incidents put the people at risk and demonstrated that the nurses were not competently providing safe care and treatment.

The provider had not ensured staff received the necessary training to enable them to carry out their duties effectively. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When people had specific dietary needs, these were not always met by staff. Changes to people's nutritional needs were communicated by care staff to the kitchen staff to help ensure they provided the correct meals for people's needs. However, communication was not always effective. For example, we spoke with one person who was diabetic. They told us they had been given a non-diabetic pudding, even though a diabetic pudding was available.

Where staff had concerns about people, they had been referred to the dietician or speech and language therapists. However, recommendations made were not always known to staff and clear guidance was not recorded in people's care plans or risk assessments. For example, one person was at risk of weight loss so the dietician had recommended the person have a high calorie diet, eat prescribed desserts, try to drink 1.5 litres of liquid per day and that the staff should weigh the person twice per month. Care staff, nursing staff and kitchen staff were not aware of all of these recommendations and none of them had been followed accurately. As a result of this, the person had continued to lose weight but this had not been identified or reported. The registered manager told us they thought the person's weight had increased.

Another person required staff to record how much they were eating and drinking to help ensure they remained healthy. However, we noted one person's record had been completed even though staff could not have known how much the person had eaten, as they had only just started eating their meal. This meant it would not give a clear picture of how much they had eaten because records would be inaccurate. Some relatives reported concerns that because there loved one was not supported to eat they had sometimes found their meal left uneaten which was then taken away.

We looked at the records of two people who required a soft diet or thickened fluid to help them eat and drink safely. Staff we spoke to gave different information about how these people's need should be met and this information was not consistent with what was recorded in people's records. One person who required

their food to be mashed had recently been given chicken pie to eat and a senior nurse told us "They ate egg and chips last night and I have seen them eat a roast before. I don't know where this information has come from." This was not consistent with the person's care plan which stated the person required a soft diet.

The provider had not ensured staff understood and acted to meet people's dietary needs. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's comments about the meals were variable. Some people commented, "Lunch was very good", "I like all the food I get" and "The food is amazing." However, other people told us their meals were not always hot. Comments included, "I have my meal in my room, it could be warmer at times." The chef was passionate about people receiving good food, telling us, "I will not accept substandard food." They explained, that they had not been informed that sometimes meals were cold before people received them. Most people ate in their rooms. Some people ate in the dining room or in the conservatory; however the atmosphere during the meal appeared subdued between these people and the staff member present. This might mean for some people, mealtimes were not an enjoyable experience.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). The 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 members had a limited understanding of the MCA and did not understand their responsibilities under the act. Some people living at the service were described by staff members as lacking capacity; however there were no mental capacity assessments in place to explain how this conclusion had been reached. One person's care plan stated, "Husband makes all the decisions regarding care." This was because the person was deemed to lack capacity but there was no reference to how decisions were made in their best interests. This may mean the person's rights were not respected.

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). Staff had applied for DoLS on behalf of some people but staff's overall understanding of when DoLS needed to be applied for was limited. For example, one person had a restraint to their hand to stop them removing their tracheostomy equipment. A staff member told us the person lacked the capacity to make decisions about the restraint but no mental capacity or deprivation of liberty assessment had been completed. This, meant decisions to restrict people's freedom had been made without the correct authorisations. The registered manager did not have an overview of which people DoLS applications had been made on behalf of. This meant they could not be sure all applications had been made, where required or that all applications were appropriate.

Staff told us they asked for people's consent before commencing any care tasks. However, we observed a staff member administer medicines to one person without talking to them or asking their consent.

Decisions were made for people without clear evidence that they could not make the decision for themselves. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meadowside and St Francis

New members of staff completed an induction programme. Staff members told us this included shadowing

experienced members of the team. However, one new staff member, who had not previously worked in a similar role, had not received a supervision or support meeting to discuss their development. The service had introduced the Care Certificate. The Care Certificate has been introduced to train all staff new to care to nationally agreed level.

Staff did not receive support through formal supervisions but one member of staff told us they felt well supported and could go to anyone for support. Following feedback from the inspection, the registered manager told us, "I need to do more one to one meetings with staff."

People told us they liked the food. One person told us that since a new chef had been in post, the food had improved. The chef told us, "They can have whatever they want" and gave examples of cooking duck, lobster and dressed crab for people, as this is what they liked. They also told us, "One person has provided the kitchen with some baking recipe ideas that they used to make at home. These were being made by the kitchen staff."

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. One person stated that staff are helpful and cannot do enough to help. An external professional explained that this was their first visit to the service and that the staff had been very helpful and open.

Meadowside (Residential Care)

Training had been planned to support staffs' continued learning and was updated when required. This included core training required by the service as well as specific training to meet people's individual needs. For example one staff member told us they would be attending training about how to support people living with dementia next month. Staff told us they had the training and skills they needed to meet people's needs.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. For example action had been taken to seek external advice regarding one person's skin care. Records monitoring when they needed to be moved and how much they had eaten and drunk had been put in place so staff could help ensure their needs were being met.

Inadequate

Is the service caring?

Our findings

The service was not caring.
At our last inspection on 14, 15, 19 April and 03 May 2016, we found end of life care was not always planned well for people; and people's end of life wishes were not always, well known and recorded. Following the inspection, the provider sent us an action plan of how they would make improvements. However, at this inspection, we found improvements had not been made.

St Francis (Nursing Care)

People did not always receive care and support from staff who had got to know them well. Staff were not always aware of people's needs or how to meet them. We asked one staff member how they knew people's needs and preferences; they responded that they didn't know them. We saw no records that people had been consulted about decisions regarding their care or how they preferred their needs to be met.

The provider's PIR stated, "Staff who have completed 'end of life' training share their knowledge with colleagues and hold meetings with residents and their families to discuss how they wish to be cared for. Staff care and support families and friends of residents that matter to them when someone is dying and after death." However, we found people's care plans for care at the end of their life contained no information about their preferences or details about how to meet people's needs. One person's health needs were not recorded in their care plan. The registered manager told us these were not being treated as the person was being provided with end of life care. However, there had been no recorded discussion with the person or other professionals regarding the decision to not treat these health needs. No records were in place that assessed the risk to the person of not meeting these needs and there was no guidance for staff about how to safely and comfortably manage these needs for the individual at the end of their life. The person's care plan gave staff no detail about their preferences at this time. The registered manager told us, that for one person, this was because they had no family members. No consideration had been made of discussing this with the person themselves to identify their wishes.

People's records did not always guide staff about how people could, or preferred to, express their views. For example, one person's care plan stated they were unable to communicate. There was no further guidance for staff about how and when the person could be involved in making decisions about their care.

People were not always encouraged to maintain their independence. There was little information in people's records to guide staff how to meet people's needs regarding maintaining their skills. For example, one person's care plan stated that the person was 'bed bound' and no further information was provided about their needs, what they could do for themselves and what staff could do to help their maintain or develop their independence.

The provider had not ensured people's care and treatment was provided in a person centred way. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meadowside and St Francis

People's privacy was not always respected. The majority of people's bedroom doors were seen to be open throughout the day. There were no records to suggest their preferences about this had been sought and people had not been offered a key to their room so they could maintain their privacy. People told us they were treated with respect by members of staff. They gave examples of staff closing doors and curtains, for privacy when receiving personal care in their rooms. Comments included, "The staff show my relative so much respect, it's wonderful."

People were not always treated with dignity. Some people had had blue plastic aprons put on them whilst eating and we observed one person wearing a hospital gown one week after being admitted to the home. Most people told us they regularly received the wrong clothing after being laundered. One person showed us five items of clothing that were not theirs, but that had been delivered to their room. This showed a lack of respect for people and their belongings. Records containing details about people's personal care were left next to them throughout the day even when they were in the lounge or dining room. This was undignified for the people concerned.

The provider had not ensured people's dignity was always respected. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's confidentiality was not protected. The provider's policy stated they would ensure personally identifiable information was always held securely. It also stated it was the registered manager's responsibility to ensure all written personal records were kept securely in a locked cabinet. However, we found care records, medication records and medical observation charts were stored, unlocked in corridors. Offices containing people's confidential information were not locked and clipboards containing information pertaining to people's care needs were left next to them in communal areas of the home. This meant anyone in or visiting the home could look at peoples' confidential information.

The provider had not acted to ensure people's confidential information was protected. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were happy with the care they received. Comments included, "Staff pop in all the time to see how I am", "The care from the staff is absolutely wonderful" and "They're lovely." A relative told us they were happy with the care home and that they were looked after by staff when they visited. A professional confirmed people told them they found the staff friendly. Compliments received by the service included, "The staff were all caring and friendly all the time" and "I was as comfortable as a bug in a rug!"

Staff showed concern for people's wellbeing in a caring way, talking calmly to people and giving them hugs. A relative also showed us a signed football staff had obtained from Plymouth Argyle football club for their loved one's birthday. People's rooms were personalised with their own furniture or belongings and some people had brought their pet birds to live with them at the home.

Meadowside (Residential Care)

People received care and support from staff who had got to know them well. Whilst talking to staff and people, we observed a fun, but quiet and calm atmosphere. Staff and the manager of Meadowside knew people well and staff respected people's privacy; for example by knocking on people's doors before entering. We observed positive interactions between people and staff; and feedback received from district nurses was that they thought highly of the staff and nothing ever seemed too much for them.

Inadequate

Is the service responsive?

Our findings

The service was not responsive to people's needs.

At our last inspection on 14, 15, 19 April and 03 May 2016, we found care plans were not always reflective of people's needs or followed by staff. At this inspection, we found improvements had not been made.

St Francis (Nursing Care)
When people moved into the home, staff told us nursing staff gave them information about the person's needs. However, despite this system, we found staff were not always knowledgeable about how people's individual needs should be met. For example one staff member confirmed they did not know one person they were supporting required a high calorie diet or how this should be provided. The person had been losing weight as staff had not known their needs.
Staff told us changes to people's needs were discussed at handover at the start of each shift. However, one member of staff told us that care staff often had to sit on the edge of the room and this meant they could not always hear what was being said. Some people told us staff were responsive to their needs. Comments included, "The staff are always on hand to help." However a relative told us, "The nurses seem to be laden down by problems of the day and are not pro-active."

People were able to make some choices about how they spent their day. Comments included, "I can get up and go to bed whenever I want" and "I always have a bath once a week, that's enough for me." However, one person, who preferred to get up at 09.30am for a shower had not been able to have their shower until 12pm as the correct equipment had not been available at that time. The provider told us they had ordered more equipment to enable staff to better meet people's needs.

The provider had not ensured people's individual needs were known by staff, which meant staff were not always able to support people appropriately or in line with their wishes and preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's PIR stated, "Residents care and support is planned with them." However, there were no records to show how or when people were involved. People and relatives told us they had had to ask staff if they wanted to see what was in the care plan.

Staff told us care plans were not sufficiently detailed to provide responsive care to people. There was no information contained in people's care plans detailing what their preferred routines were or how they liked to receive their care and when. One staff member told us, "If I'm honest the care plans don't always tell you what you need to know about a person." A healthcare professional confirmed they had spoken to a staff member who was unable to tell them where records of people's care could be found. During the inspection, we found examples of staff providing incorrect care to people, for example providing food that was not safe for people to eat due to their health needs as this information had not been clear in people's care plans.

Care plans were reviewed regularly, however when significant changes to people's needs had been

identified these had not triggered the person's care plan to be updated. This meant, in order to understand someone's current health or care needs, staff had to read the care plan and all the subsequent reviews. This did not always happen and people did not all receive personalised care. A staff member confirmed, "Care plans are not updated enough. I've been quite shocked." A relative explained that if something needed changing in their loved one's care plan, because of a change in need, they had to ask the staff to make sure the care plan was updated.

The provider had not ensured people's records were up to date and reflective of their individual needs. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meadowside and St Francis

Activities were planned that people could be involved in and the activities co-ordinators spent some time with people who preferred one to one time rather than group activities. The provider's PIR stated, "Activity co coordinators are employed five days a week to build links with the community and events outside of the care home." People had recently had the opportunity to celebrate Ascot with strawberries and cream. One person told us, "There's not much to do, but I don't mind"; and another person told us they had been taken on a shopping trip to a shop they disliked but they had not been asked before going.

The activities co-ordinators were in the process of finding out what activities and hobbies people enjoyed. They told us they intended to tailor planned group and individual activities so they could help ensure people's preferences were catered for. They gave examples of people who had expressed a preference for certain books or music and were trying to source these for the people. One member of staff told us it was nice to have seen photos of one person's 103rd birthday in the recent residents' newsletter; and a relative told us they felt they had seen an improvement in the type of activities available.

The service had a policy and procedure in place for dealing with any concerns or complaints and people's concerns and complaints had been investigated and responded to. The provider's PIR stated that in the future, "The handling of concerns and complaints will be addressed in a more timely manner. New policies are being implemented. Learning from mistakes with a more open approach". However, some people and relatives told us they knew how to raise a complaint but did not always feel comfortable doing so.

Meadowside (Residential Care)
People had care plans that clearly explained how they would like to receive their care, treatment and support, and staff understood how to meet people's needs. When people's needs changed, staff told us this was discussed at handover. Notes were available to view following the handover for staff who were not present at the time. This helped ensure staff remained up to date with any changes. A member of staff told us handovers were "thorough".

Inadequate

Is the service well-led?

Our findings

The service was not well led.

At our last inspection on 14, 15, 19 April and 03 May 2016, we found that systems and processes in place were not sufficiently robust to ensure competency checks had been undertaken when due, and care planning was person centred and reflected people's needs. We also found some policies required updating. We found at this inspection, improvements had not been made.

St Francis (Nursing Care)

The provider's PIR stated, "The service adheres to conditions of registration provided by CQC, and all external organisations including NMC (nursing and midwifery council) registration compliance." However, the registered manager had not ensured requirements set by the NMC had been complied with. For example, they had not monitored nursing staff according to conditions put in place by the NMC to help ensure staff were working in a safe way. They had however, provided positive feedback to the NMC about one staff member who they had not monitored effectively. During the inspection the nursing staff member, provided unsafe care to one person, putting them at unnecessary risk.

The provider did not seek and act on feedback from external professionals in order to improve the service. The provider's PIR stated, "Staff have strong links with health and social services which they use to support and implement best practice to improve care delivery." However, social care professionals who had involvement with the home confirmed to us they often struggled to find recorded evidence of what care had actually been provided to people; and that the care provided often did not reflect recommendations provided by professionals. A professional who attended a strategy meeting about the service confirmed they had met with the registered manager to raise these concerns but did not feel action had been taken.

Staff roles and responsibilities were not clearly defined. For example, staff could not tell us the difference between the roles of senior nursing staff and gave us inconsistent responses about who was responsible for different tasks within the home. A relative told us, "At times the care staff are left to manage themselves."

The provider's PIR stated, "Staff regularly attend the dignity in care home forums. Health and Wellbeing Champion represent the care home." However, there was no evidence how learning from this forum had been implemented in order to improve the quality of the service for people.

People were not protected by the provider's policies and procedures. For example, the tracheostomy policy provided was only relevant to hospital discharges, not to care being provided in a nursing home. This meant there was no clear guidance for staff about the required standards of tracheostomy care within the service.

The provider had not ensured information from other agencies had been used to improve the quality of the service people received. The provider had not effectively assessed or monitored the service in order to mitigate risks to people or improve the quality of the service. This is a breach of Regulation 17 of the Health

and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As a result of our inspection, the provider told us they would voluntarily stop any new admissions to the St Francis, nursing unit, to give them time to make the necessary improvements. They also sent us an action plan telling us what action they would take to reduce the risks to people living in the service.

Meadowside and St Francis

People were not protected by the provider's systems and processes to monitor the quality of the service. As a consequence of this, the provider had failed to recognise the service had been deteriorating since our last inspection in 2016. For example, they had failed to identify nursing staff were failing to provide safe care and treatment, people's care records were not accurate, people were not protected from risks associated with their care, medicines were not managed safely and people's human rights were not being protected. This, meant changes had not been made so that quality of care was not compromised.

The registered manager and provider had failed to maintain an effective overview of the home and had failed to act when gaps in quality had been brought to their attention. For example, we highlighted that a notice had been displayed on each corridor of the nursing unit stating that "staff should not change people's continence pads if they were damp. This would be undignified for people and could result in people sustaining skin damage." The registered manager told us they were unaware these notices had been displayed.

The registered manager had been aware that staff training was not up to date but they had not taken action to ensure improvements were made. At a staff meeting five months before the inspection, they had reminded staff to keep their training up to date. At the inspection, there were still gaps in the training of staff working in the nursing area of the home. Following the inspection, they assured us that all nursing staff competencies had been carried out six months earlier. When we spoke to the healthcare professional involved, they explained they had provided training but not assessments of competency and that not all staff members had attended.

Audits that had been completed were not always fit for purpose. For example, tracheostomy audits were carried out by senior health care assistants on a monthly basis but a visiting professional had had to order a new pump for one person as it was found that the person's pump was out of date, however this had not been identified by the audit. A relative confirmed they also regularly witnessed problems with the availability of stock to meet people's health needs. Where improvements had been identified through audits, these had not always been acted upon. For example, an infection control audit completed seven weeks before the inspection had highlighted several areas for improvement but these had not been rectified at the time of the inspection.

The provider had not used previous inspection outcomes, safeguarding investigations or complaints to improve the quality of the service people received. When we asked the registered manager whether they had an action plan in place to identify where improvements needed to be made, they told us they had not. They explained, "I had confidence work from the last inspection was being carried out." During the inspection we found similar concerns to those that had been found at previous inspections or raised during recent safeguarding investigations. This meant learning had not taken place.

The provider had not ensured staff understood their responsibilities for reporting incidents accurately. A form for reporting medicines errors and near misses was in place and despite us identifying medicines errors, none had been reported. Staff could not tell us how to report errors or what action needed to be

taken to reduce the likelihood of it happening again. There was no formal system in place to monitor any themes or trends arising from accidents or incidents occurring in the home. A completed incident form stated one person had been found with their legs between their bed rails. However, the majority of people living in the home still did not have bumpers on their bed rails to protect them from a similar incident. This meant no learning was taking place from incidents that had happened in the home.

The provider had not developed a culture of continuous improvement. Staff told us they were not encouraged to question practice. A professional explained they had spoken to a staff member who reported they had been made to feel "stupid and like a trouble maker" when they had highlighted an error about someone's care. This meant unsafe care may not be reported or action taken to make the person safe. During the inspection, we identified incidents of unsafe care that the registered manager confirmed had not been reported to them.

The registered manager told us they aimed to be approachable in order for people and staff members to raise concerns, however had recently become aware that some staff did not feel confident raising concerns with them. They told us they planned to hold a staff meeting following the inspection to explain to staff how they could raise concerns. People we spoke with told us they did not know who the registered manager was and a relative added, "People are scared to speak up." The provider had not routinely consulted people and their loved ones about their experiences of living at the service. People told us meetings were not held to enable them to share their views.

Staff told us they did not feel empowered to have a voice and share any opinions or ideas they had. Staff meetings had been held, but not on a regular basis. One staff member told us, "I think team meetings should be once a month, we should be heard. Communication is lacking." A professional told us they had spoken to a staff member who felt they were not listened to.

The provider had not ensured systems and processes to monitor the quality of the service had been followed or results acted upon. The provider had not acted to improve the service by seeking feedback from people or their relatives. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a policy regarding the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.

The service had an up to date whistle-blowers policy which supported staff to question practice. It clearly defined how staff that raised concerns would be protected. However, no-one working at the service had used the policy to report any concerns about the safety or quality of care being provided.

Meadowside (Residential Care)

People and relatives told us they felt Meadowside was well led. Comments included, "This place is so good, so well run." Staff described the manager as approachable.