Archangel Healthcare Ltd

Tendring Meadows

Inspection report

The Heath
Tendring
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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

About the service
Tendring Meadows is a residential care home providing personal care and accommodation to up to 53 people. The service provides support to people who may be living with dementia or have physical disabilities. At the time of our inspection there were 38 people using the service.

The accommodation at Tendring Meadows is situated across two floors, with four distinct units. During this inspection, one unit was being used for people who were isolating due to COVID-19.

People's experience of using this service and what we found
Potential risks to people were not being safely managed. We identified serious concerns about the risk of choking. Risk assessments and care plans were not always detailed, consistent or in place. Records were not being accurately kept in areas such as medication and catheter care. There were insufficient numbers of trained staff available to meet people's care and support needs in a safe and person-centred way. Staff were not always aware of their safeguarding responsibilities. Infection prevention and control (IPC) measures were poor. Improvements in a number of areas had not been made and sustained since our last inspection.

Staff did not always have access to information on how to support people following best practice guidance or their assessed needs. Training and supervision were provided to staff but were not always effective or embedded. Agency staff were not robustly inducted into the service. There was a poor dining experience for people and menus were not accessible. The environment was in poor repair and extensive renovation work was required. A previous recommendation for maintenance plans had not been met. The manager was working with other health and social care professionals.

Systems were not in place for staff to provide support in a consistently caring way. We observed multiple examples of people's privacy and dignity not being upheld. People and their relatives told us their clothing, electronic goods and aids such as glasses had gone missing. People's belongings were not respected and kept safe, and people were wearing other people's clothes. This was a continued concern from the last inspection. The poor environment did not show people they were respected and valued.

It was not demonstrated people's care and changing needs had been planned for in a personalised way. There were no meaningful activities for all people living at Tendring Meadows on a day-to-day basis, although the service had supported some people with specific interests. People's relatives told us they were satisfied with the visiting arrangements. Complaints handling was poor, and the opportunity to improve the service from feedback was not taken. The manager was introducing new documentation to meet the Accessible Information Standard (AIS). There was no one being supported with end of life care.

The service was not well-led, and governance and oversight systems were poor. The provider had not met the objectives and requirements following the last CQC inspection and were not compliant with the Warning Notice issued. The manager told us they were committed to improving the service and had taken steps to do

so. The provider had not supplied sufficient resources and support for them to carry out their role effectively. The manager was working to try to improve the culture of the service, support staff and encourage openness.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 25 May 2021).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

This service has been rated requires improvement or inadequate for the last three consecutive inspections.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection in the key questions of safe, caring and well-led. It was also prompted in part due to concerns received about the risk of choking. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

We inspected and found there were concerns in multiple further areas of the service, so we widened the scope of the inspection to become a comprehensive inspection which included the key questions of safe, effective, caring, responsive and well-led.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

We raised urgent concerns about the safe management of people at risk of choking and infection prevention and control. The provider acted to provide assurances these risks would be mitigated and engaged with the support of external health and social care professionals.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to person-centred care, dignity and respect, safe care and treatment, safeguarding people from abuse, nutrition and hydration, premises and equipment, complaints handling,

good governance and staffing.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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 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.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Tendring Meadows

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors and one 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.

Service and service type
Tendring Meadows is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Tendring Meadows is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service should have a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of inspection, the manager had been employed since July 2021 but had not yet become registered.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 8 February 2022 and ended on 18 February 2022. We visited the care home on

8 February and 15 February 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with seven people to gain their views about the service. We also spoke with eight people's relatives or advocates about their experience of the care provided for people. We spoke with 16 members of staff including care workers, senior care workers, the administrator, the deputy manager, a chef, a kitchen assistant, the laundry assistant, a domestic cleaner, the maintenance person, the manager, the company director and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We observed people's care and support in communal areas of the service. We reviewed a range of documents.

After the inspection
We raised urgent concerns with the provider. We raised four individual safeguarding concerns with the local authority for investigation. We reported our concerns to the local authority environmental health department and to the fire service. We met with the provider alongside other stakeholders to understand what would be done to ensure improvements were made.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection systems were either not in place or robust enough to demonstrate safety was effectively managed, including for medicines, COVID-19 and ensuring accurate and up-to-date care records his was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

Assessing risk, safety monitoring and management

- People were not protected from the risk of harm due to a failure to assess and manage risks.
- There was a lack of oversight for people at risk of choking. Staff members, including the manager, were either not aware of who was at risk of choking or told us there was nobody at risk of choking, which was not correct. Five people had inadequate choking risk assessments which placed them at risk of harm.
- Prescribed thickener powder was found in a dining room that was unlocked and accessible. Thickener is recommended for people who can no longer swallow normal fluids safely. However, thickeners can cause choking if swallowed dry, and should be stored securely.
- Inspectors observed a new agency staff member spoon feeding someone at risk of choking, who was lying down with their eyes closed. Despite concerns about the staff member's competency, they were not being supervised, and were shortly seen supporting another person at risk of choking to eat.
- Records relating to people's care had not been consistently completed. One person with a catheter did not have a catheter care plan and no records were being kept of fluid intake and catheter output. This placed the person at risk of harm.
- Risks associated with the environment were not managed safely. Laundry room vents had a heavy build-up of lint which is combustible and poses a fire hazard. The fire door to this room was wedged open, preventing it from closing in the event of a fire. The provider told us they had taken action to repair this after our visit.

Preventing and controlling infection

- Multiple areas of the home were unclean. Toilets and bathrooms were unhygienic; the underside of a shower stool was rusty and stained with urine; toilet brushes were soiled and posed a risk of infection. Flooring was coming away from skirting boards allowing in water and harbouring bacteria. Other rooms had cracked tiles, mould and peeling paint impeding effective cleaning.
- Staff practice in the kitchen area posed a risk to people's health. Used personal protective equipment (PPE) face masks had been disposed of inappropriately next to a fridge. Aprons were either not worn appropriately or were visibly dirty. The kitchen and food storage areas were unhygienic, with dirty floors,

spillages left uncleaned and dead insects in webs.
● We raised our concerns with the local authority environmental health team who carried out an inspection as a result, giving a food hygiene rating score of zero, requiring urgent improvement. The provider told us they would shut the kitchen for remedial works and seek alternative meal provision.
● Staff did not follow best practice through use of PPE and handwashing and were not competent in adequate infection control practices, for example with appropriate PPE storage or donning and doffing practices. 'Donning and doffing' is used to refer to the practice of putting on (donning) and taking off (doffing) PPE.
● People told us they were unhappy with the standards of hygiene at Tendring Meadows. One person said, "The cutlery and crockery are often dirty, and staff don't always wash their hands." We saw this to be the case in practice.

Visiting in care homes
Whilst people were supported to receive visits from their relatives and advocates, visitors were provided with PPE contrary to government guidance, impeding good hand hygiene. IPC measures in the service were poor, placing people and their visitors at risk. Not all staff understood the need to check the COVID-19 test result and vaccination status of visitors before admitting them into the home.

Care homes (Vaccinations as Condition of Deployment)

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.

Whilst the manager carried out thorough checks on the COVID-19 vaccination status of inspectors on the first day of inspection, not all staff understood their responsibility in this area. On the second site visit, inspectors were admitted into the service by a different member of staff with no checks on their COVID-19 vaccination or test status.

We identified a breach of Regulation 12(3), but the Government has announced its intention to change the legal requirement for vaccination in care homes.

Using medicines safely
● People did not always receive their medicines safely, and systems and oversight measures for medicines were not effective. This placed people at the risk of harm of not receiving their medicines as prescribed.
● Processes for the receipt of medicines into the service did not follow best practice NICE guidelines and errors in people's medicines were not promptly identified.
● At the last two inspections, people had not always been given their transdermal patches as prescribed. A transdermal patch is a medicated adhesive patch which is placed on the skin to deliver a specific dose of medication. At this inspection, we found continued concerns, including one person who had not received their dementia medication for six consecutive days.
● Codes in MAR charts were inconsistent and confusing and medicines records were regularly missing key information such as dates.
● One person told us one member of staff was not confident in administering medicines and frequently gave them the wrong dose, "Either too much or too little." We raised concerns about medication errors with the local authority safeguarding team for further investigation.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This

included management of the risk of choking, medicines, infection prevention and control and COVID-19. This placed people at risk of harm. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We urgently raised our concerns about poor IPC practice, fire hazards and the risk of choking with the provider. We saw some improvement to cleanliness had been made on the second day of inspection. The provider told us they had taken action to reduce the risk of fire.

Staffing and recruitment

At our last inspection the provider had failed to ensure sufficient numbers of suitably qualified, competent and skilled staff were deployed to ensure safe, good quality care. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18.

● Despite concerns raised at the last inspection, there were still not enough staff to provide safe, good quality, person-centred care. There were insufficient cleaning staff to keep the service clean, and not enough management resource to carry out all the necessary improvement works required.
● There were insufficient staff to support people expressing distress, confusion or agitation and keep people safe, particularly at night. One person said, "I don't feel unsafe because there are nurses on duty here, but a couple of people are very unruly. I did have trouble with a man a couple of nights ago – he came in and sat on my bed and wouldn't move."
● One staff member said, "It can be challenging to do cleaning and meet people's needs. People's care needs come before cleaning, so we leave the cleaning."
● We received mixed feedback from people's relatives about staffing levels. One person's relative told us, "Yes, there are enough staff on the whole, sometimes they're run ragged though. Weekends are the worst times."

Sufficient numbers of suitably qualified, competent and skilled staff were not deployed to ensure safe, good quality care. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager carried out checks on staff as part of the recruitment process. However, one staff member had a reference stating they were 'poor' in most areas and would not be re-employed. There was no evidence to show this had been followed up to check they were suitable for the role.
● We raised our concerns with the provider who told us they would recruit more staff, including seeking sponsor licences for workers from overseas.

Systems and processes to safeguard people from the risk of abuse
● Systems for identifying and reporting safeguarding concerns were not effective. Inspectors raised four individual safeguards with the local authority during the inspection process. The provider's failure to identify and act upon safeguarding incidents exposed people to the risk of harm.
● Despite concerns from a previous inspection, there was still no meaningful analysis of safeguarding themes and trends. The provider had failed to reduce the risk to people and learn lessons from incidents.

Systems and processes had not been established or operated effectively to protect people using the service

from the risk of abuse or neglect. This placed people at risk of harm. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● Lessons had not been learned from previous inspections or enforcement action and concerns previously identified had been allowed to persist. The provider had failed to meet many of its own action plan objectives.

● During the inspection we identified people were at risk of serious injury from choking. On the second day of inspection, we saw that limited action had been taken to reduce this risk.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

At the last inspection where we rated this key question, we recommended the provider develop a planned maintenance schedule of works for the service to improve the environment. The provider had not made improvements.

- The environment was not safe, well maintained or adapted to people's needs, and extensive renovation works were required throughout. The approach to Tendring Meadows was not welcoming, with broken furniture piled up outside, overgrown gardens and items of used PPE discarded in the car park.
- Some areas of the service were not secure. Doors were unlocked to a steep stairwell with building works taking place. This posed a risk of harm if people accessed the area unnoticed.
- Wardrobes had not been secured to the wall in multiple people's bedrooms. Items were stored on top posing a risk of falling and injuring people. We found broken furniture with sharp edges, posing risk of harm. We asked the provider to take action to resolve this straight away, and this was completed after our visit.
- Equipment was not always clean and fit for use. Sharp edges were seen on a rusty and damaged toilet frame, posing a risk of injury. Multiple metal radiator guards had rust, peeling paint and sharp metal fixtures, including one with drips of blood on which had not been cleaned.
- The environment was not adapted to people's needs. Decoration was largely bland and sterile, with few landmarks for people living with dementia to support their orientation around the building.

The provider had failed to maintain the standard of premises and equipment to ensure safety, cleanliness and suitability for use by people using the service. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider told us they had sought quotes for maintenance works but had experienced difficulty in securing contractors to carry out the works due to the COVID-19 pandemic.

Supporting people to eat and drink enough to maintain a balanced diet

- People were not always supported to eat and drink enough to maintain a balanced diet. People did not have the information they needed to choose their meals. Menus were not accurate, with three different dining rooms displaying three different menus on the same day.
- Feedback from people showed they enjoyed the meals provided but did not always feel full. Three people told us they were hungry during the inspection. There were limited drinks freely available to people in

communal areas and little fresh food such as fruit and vegetables.
● We observed poor dining experience for people. One person was upset and stressed following another person expressing their distress and agitation in the dining room. The person told us, "I'm going to have a heart attack. I can't eat after that."
● Food was not prepared and served in an appetising way. Microwaves in dining rooms were unclean with food debris inside and food was transported uncovered on tea trolleys, posing risk of contamination. Some people's meals were pre-plated, microwaved and then the separate foodstuffs mixed before serving.

Systems and processes were not effective to ensure the nutritional and hydration needs of people were met to sustain good health. This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff support: induction, training, skills and experience
● Care plans and risk assessments were lacking detail, not person-centred or not always in place. This meant staff did not have access to information on how to support people following best practice guidance or in line with their assessed needs.
● People did not always receive safe and effective care as staff did not have adequate training or supervision. We identified continued poor practice in areas such as infection prevention and control, medicines management and dignity and respect.
● At our last inspection we found staff were not trained in catheter care. No recent training had been carried out despite there being people at Tendring Meadows with a catheter. This meant there was a risk staff could not identify early signs of complications such as blockages and infections.
● A high number of agency staff were deployed. The provider could not demonstrate they received sufficient training and induction into the service.

Sufficient numbers of suitably qualified, competent and skilled staff were not deployed to ensure safe, good quality care. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The service was not working within the principles of the MCA, to support people to make decisions and choices in the least restrictive way. Care records did not fully set out how a person might express themselves or indicate agreement, preference or choice. For example, one person's consent care plan only

stated, "[Person] does not have a legal representative."
● We received mixed feedback from people and their relatives about whether their choices and decisions were respected. Records were contradictory about whether people had capacity to make decisions or not and did not always show involvement of family members in decision-making processes.
● The manager had informed the CQC when DoLs applications had been granted for people.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The manager raised issues such as problematic hospital discharges or challenges with primary care to try to improve care pathways and outcomes for people.
● The service worked with other health and social care professionals, such as the local authority quality team, social workers and district nurses to try to drive improvement and meet people's needs.

Inadequate

Is the service caring?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

At our last inspection the provider had failed to support people in a way that ensured their privacy, dignity, autonomy and independence. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 10.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- Although some staff were seen to treat people kindly and with compassion, the provider had failed to ensure staff consistently treated people with dignity and respect. This included insufficient staffing numbers and ensuring effective staff competency and training.
- At our last inspection we raised concerns people were not able to communicate with their relatives. Although the manager told us new cordless telephones had been purchased, staff were not always supporting this in practice.
- One person asked the inspectors to help them call their family. The person told us, "I can't find a nurse, not a soul. I've been walking up and down for hours, asking and asking and asking but they've never got the time." We asked a staff member to support the person, but they did not respond to them in an understanding way. We raised a safeguard with the local authority about the person's emotional wellbeing.
- At the last inspection we found people's clothes, possessions and aids such as glasses were missing or belonged to someone else. We found this was a continued concern which had not been resolved.
- Five people or their relatives told us items were lost, damaged or that people were not wearing their own clothes. One person's relative said, "[My person] hasn't got their own clothes on, they're wearing old stuff, another person's slippers, no socks. Since being there, [person] has had no glasses on because they're lost."
- Despite the missing items, the provider and manager had not identified anyone who might require a key to their bedroom to protect their personal space. One person told us, "I'm not able to lock my door. I have walked into my room and found people in it."

Respecting and promoting people's privacy, dignity and independence

- The environment did not show people they were valued and respected. Bedding was grey and stained and people did not always have duvets, curtains or soft furnishings to bring warmth and comfort to their rooms, which were sparsely decorated. Some people had broken blinds or missing lampshades.
- People did not always feel their dignity and independence was being upheld. One person told us, "I've

never been in prison, never done anything to deserve to be in prison, but I imagine it's a bit like this. It's very disappointing to me to have come this far in life for this."

● Another person was seen to be upset and putting on their coat to leave the building but told us they felt resigned to there being nowhere for them to go. The person said, "Where can I go at night, I'm just an old [person]." There was nothing in place to support people experiencing low moods.

● There was a communal store of underwear in the laundry closets which did not reflect personalised, dignified care. We raised this with the manager who told us they were trying to change staff practice.

● People did not always have privacy when using the toilet, and staff did not always knock on people's doors before entering their private space.

People were not supported in a way that ensured their privacy, dignity, autonomy and independence. This was a continued breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- The provider failed to ensure plans were in place to provide personalised care which made people feel welcomed and safe. The provider failed to identify or plan for the distress it may cause to have one person living in an adjoining bedroom of a person who expressed agitation with shouting and swearing. We raised this with the manager who said they would move the person's room.
- Another person had returned to Tendring Meadows from hospital and required additional support, as they were unsteady and disorientated. The manager had failed to plan or accommodate these needs. We asked staff to provide the person with additional care and raised our concerns with the local authority safeguarding team.
- People's relatives told us they did not always feel fully involved in care planning and reviews. One person's relative told us, "They used to do regular reviews at [my person's] previous home but we haven't had any since [they have] been here. They send any paperwork through for me to comment on, that's all."
- Failure to ensure care plans and risk assessments were implemented in a timely manner placed people at risk of harm. One staff member told us, "Sometimes care plans are not uploaded straight away when people are admitted, we have to figure it out."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not supported with social and leisure activities. There were no meaningful or stimulating activities available on either day of inspection. The activity co-ordinator was not at work, but nothing had been put in place in their absence.
- People did not feel their social needs and interests were being met. One person told us, "They [the activities] are mind-bending and childish. I've never felt such loneliness." Another person said, "I get lonely at times because the staff are very, very busy and they don't have time to sit down to chat very much."
- Lack of engagement with interests and activities was seen to be commonplace and accepted. We saw two people sitting facing a television which had scrambled picture and sound. This had not been identified by staff and fixed. There was nothing else on offer to do.

People were not supported in a way that was personalised and specifically tailored to meet their needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager told us some people were supported with specific interests such as gardening, use of the tool shed or trips out to see their family.

● Whilst some staff were seen to spend time with people in their rooms talking with them in a kind and engaged way, there were insufficient staff for this to happen without an impact on other areas of the service.

Improving care quality in response to complaints or concerns

● The provider did not act to improve the service in response to complaints. Despite the numerous concerns people raised, there had been no recently recorded complaints. The manager told us this was because they either escalated to safeguards or were dealt with informally.

● Issues identified at previous inspections had not been effectively dealt with and continued to persist, such as concerns with missing items of clothing. Improvements had not been made in response to feedback.

● People did not always have the information they needed to complain. Only one person's relative we spoke with was directly aware of the complaints procedure for the service and had a copy. Another person's relative said, "I'm happy overall, [but] I'm not sure of the complaints procedure if I needed it."

● The complaints procedure did not inform people of their ability to refer their complaint to the Local Government and Social Care Ombudsman for independent review if they were not satisfied with the provider's response. This meant there was a lack of external oversight about complaints.

● There was no analysis of themes and trends of complaints to reduce the risk of reoccurrence and to share learning with staff. There was no evidence people or their relatives had received a written apology when things went wrong.

Effective systems had not been established for identifying, receiving, recording, handling and responding to complaints. This was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● The manager had begun creating a range of 'easy read' documents for people with information about the service. 'Easy read' is the presentation of text in an accessible and easy to understand format.

● An Accessible Information Standard policy and procedure was in place. However, the impact on people's ability to communicate or access information had not been considered and rectified where aids such as glasses had been lost.

End of life care and support

● At the time of inspection, the manager told us there were no people living at Tendring Meadows requiring end of life care. However, records showed staff were not provided with training in this area.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to ensure there were effective systems in place to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider could not demonstrate oversight of the quality and safety of the care being provided. We had to seek urgent assurances from the provider and refer concerns to multiple external stakeholders to support the service as a result. The provider had not acted independently of our inspection to identify and mitigate risk.
- Despite the CQC taking enforcement action to serve a Warning Notice at the last inspection, insufficient improvement had been made and the provider was still not compliant with their legal and regulatory responsibilities.
- Audits carried out at the service were lacking detail and not effective in identifying and remedying issues of concern, such as infection prevention and control and medicines.
- There was no effective plan in place to ensure the service met its own vision and values, including the philosophy of care set out in the provider's service user guide. This included a commitment to, "Recognise the individual uniqueness of service users, staff and visitors, and treat them with dignity and respect at all times." This was not seen in practice.
- The provider had not registered with the local authority as a food business as required, which meant they had not received the oversight and guidance of Environmental Health. The kitchen was not well managed, cleaned or maintained and this had not been identified for some time.
- Following our last inspection, the registered manager at that time had resigned. The new manager had been in post at Tendring Meadows since July 2021 but had not yet registered with the CQC.
- The manager told us they were committed to making changes and improvements at Tendring Meadows. However, we identified the provider had not given them enough resources and support to complete the significant volume of improvement work required. This included a full refurbishment of the environment.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal

responsibility to be open and honest with people when something goes wrong
● Feedback from people, their relatives and our own observations did not reflect a consistently engaging and empowering culture; concerns about privacy, dignity and the quality and safety of the care provided had not been acted upon.
● We identified multiple indicators of a closed culture at Tendring Meadows. The manager told us they had been working with the staff team to try to change the culture, improve retention and morale, and allow them to feel able to openly raise any suggestions or concerns. However, this had not been embedded in practice.
● The provider had employed insufficient number of staff to ensure people had access to person-centred, individualised care and support.
● The management team had failed to identify serious incidents and safeguard concerns. As a result, they had not been investigated to identify any wrongdoing. This meant they were unable to be open and honest with people and apologise if necessary.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● We received mixed feedback from people's relatives about communication from the service. One person's relative told us, "They [Tendring Meadows] don't hesitate to call and let me know what's going on." Another person's relative said, "Every time I go, [my person] has got bruises and marks on them and the staff say, '[Person] might have had a fall.' They're supposed to notify us, but they don't."
● Information was not always being shared or notified as required to external stakeholders, which led to a lack of oversight about potential risks or improvements required at the service.

The provider had failed to ensure there were effective systems in place to assess, monitor and improve the quality and safety of the service. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite concerns about overarching oversight, governance and resources from the provider, staff told us they felt supported by the manager on a day-to-day basis. One staff member said, "[Manager] is very supportive and very 'hands on'."
● The manager was working with the local authority to try and make improvements to systems and processes.