Appollo Homes Limited

Meadow Dean

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 19, 20 and 26 June 2018.

Meadow Dean is a 'residential care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service is registered to provide accommodation and personal care to 26 older people who may be living with dementia, in one adapted building. At the time of this inspection there were 13 people living at the service.

We last inspected Meadow Dean in October 2017 when we found continued shortfalls and non-compliance of the regulations. The overall rating was requires improvement however well led remained inadequate, therefore the service also remained in special measures. The provider sent us an action plan to demonstrate what they would do to meet legal requirements in relation to the breaches. We undertook this inspection to check that they had followed their plan and to confirm that they now met legal requirements. The provider had failed to implement the action plan and make the necessary improvements to the service.

The service did not have a registered manager in post. Although the provider had made some efforts to recruit a new manager this had been unsuccessful. The registered provider had decided to apply to CQC to be considered for the registered manager position. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

The provider had recognised that additional support for the management team was required and had sought advice from a consultant who had visited the service two weeks ago so it was too early to see what impact this had on the service to drive improvement.

The audits and systems in place to check the quality of the service being provided were not regularly carried out or fully effective as they had not identified the ongoing shortfalls identified in this report.

The management of the service remained unstable and the deputy manager left the service the day after the inspection leaving the provider with no other management support.

The provider, deputy manager and the team leader were not aware of the current methodology of how we inspect using the key lines of enquiries.

The provider had not sought advice from the local safeguarding team or raised a safeguarding alert in line with guidance when an incident occurred where special lotions was left on people's hair for too long which resulted in sores to their scalp. The provider had not informed CQC of this safeguarding incident in line with current legislation.

Accident and incident forms had been completed but had not been analysed to look for patterns and trends to reduce the risk of them happening again.

At the last two inspections risks assessments to support people with their behaviour and mobility did not always contain sufficient information to guide staff on how to mitigate risks and keep people safe. At this inspection some risk assessments had been completed to support people with their behaviour however there remained no guidance for staff of how to support people with their mobility.

People did not always receive the support they needed with their healthcare. Although referrals were made to health care professionals, such as dieticians and dentist, these were not always followed through to ensure that people were receiving the care they needed.

People's care plans were not always personalised to reflect the care being provided. Care plans had been regularly reviewed but not always updated to reflect people's changing needs.

People's dignity was not always maintained as staff did not respond promptly when people needed to go to the bathroom. People's independence was promoted.

Staffing levels were sufficient at the time of the inspection, however there were times when people who needed help and support from two staff had to wait to go to the bathroom. A review of the deployment of staff was therefore needed to ensure that two members of staff were available to respond to this person in a timely manner.

Staff had not been recruited with all the necessary checks in place as the provider had failed to ensure potential staff full employment history was recorded.

Although staff were receiving training to give them the right knowledge and skills to support people, records were not up to date or accurate to confirm this. The provider had a programme of supervision and appraisal in place to support staff.

At times, during the inspection, the provider was unable to produce the records we needed to complete the inspection. At the last inspection records were not always accurate or up to date and these shortfalls remained the same.

People were supported to be involved in their care. Although at times some people felt they were not being listened to as staff did not come promptly when they called.

People were asked for their consent when staff were supporting them and staff had an understanding of people's mental capacity.

The management of medicines had improved since the last inspection and people were now receiving their medicines as prescribed and at the correct times. However, risk assessments were not in place to reduce the risks when using paraffin based inflammable creams. Medicine records were also an area for further improvement.

The provider had made some improvement to the premises, peoples bedrooms had new flooring, the conservatory had been refurbished and people and relatives could now meet in private. The communal lounge and dining room had been re-arranged and this had improved the space for people to sit and relax. However, the provider told us that they did not have enough resources at the time of the inspection to

complete the maintenance programme.

People told us they enjoyed the activities and were able to join in with quizzes, playing board games, and singing. There was also outside entertainment such as singers. At the last inspection the provider told us that they intended to employ an activities co-ordinator but at this inspection they said this was no longer the case.

People and relatives knew how to complain and were encouraged by the provider to discuss any concerns or issues.

People told us they enjoyed the food and said there were able to choose to have a cooked breakfast if they wished. Drinks and snacks were available during the day to make sure they had enough to eat and drink. People's needs had been assessed when they moved into the service and people told us that they had been asked about their health and social care needs.

Infection control systems were in place together with deep clearing schedules to ensure the home was clean. Checks to the premises had been made, such as fire safety checks, health and safety and environmental risk assessments.

The provider had introduced a programme of supervision and appraisal to support staff. T hey had attended workshops to improve their practice and had links with the skills network to keep up with current ways of working. Staff told us that the provider was supportive and worked with the staff to provide person centred care.

The provider was trying to forge links with the community and had held an 'open' day to encourage local people to visit the service.

We found four continued breaches and three additional new breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.You can see what action we told the provider to take at the back of the full version of the report.

Although some improvements had been made, the progress was slow and there were still many areas which need to be addressed to ensure people's health, safety and well-being is protected. We identified a number of continued breaches of regulations and additional breaches at this inspection and there remained no registered manager in post. The service will therefore remain in special measures. We will continue to monitor Meadow Dean to check that improvements continue and are sustained.

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 and 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 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.

The provider had not followed safeguarding protocols to ensure that people were safe. Accidents and incidents were recorded.

Risks assessments lacked guidance for staff to ensure risks were fully mitigated.

New staff had not been recruited safely.

There was sufficient staff on duty, however they were not deployed efficiently to ensure people's needs were met.

People's medicines were managed safely.

Checks were made on the premises to ensure it was safe.

Infection control procedures were in place to reduce the risk of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not always receive the support they needed with their healthcare needs as referrals such as to the dietician and dentist had not been followed up.

Training records were not up to date to confirm what training had been completed or arranged for staff.

The provider had implemented a supervision and appraisal programme since the last inspection.

People had enough to eat and drink.

Peoples needs were assessed before they came to live at the service.

Staff supported people to make choices and the service had applied for authorisation to deprive people of their liberty if they

were unable to consent to staying at the service.

Adaptations to the environment had been made to support people with their individual needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Some people did not always think their dignity was maintained and staff did not always listen to them.

People's independence was promoted.

People were involved in decisions about their care.

People's rooms were personalised with their own possessions and to their tastes.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some plans lacked detail to ensure people received personalised care in line with their preferences and choices.

People were able to take part in a range of activities throughout the inspection.

Although the complaints log was not up to date, some complaints were recorded and responded to in line with the provider's policy.

Is the service well-led?

Inadequate

A registered manager was not in post; therefore the provider had failed to comply with a condition on their registration.

There were continued breaches of the regulations as the provider had not identified the shortfalls found at this inspection.

The management staff lacked an understanding of the current methodology used to inspect care services.

Audits and checks had been completed but these were not effective to continuously improve the service.

Accidents and incidents were not analysed to identify patterns or

trends to reduce risk of further events.

Records were not always accurate or completed properly.

People and their relatives were asked for their views about the service.

Staff told us that the manager was supportive they worked as a team to provide personalised care.

Meadow Dean

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18, 19 and 26 June 2018 and was unannounced. The inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the last day of the inspection an Inspection Manager visited the service to discuss the shortfalls found at this inspection.

The provider completed a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We looked at the previous inspection reports and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with twelve people using the service, the provider, the deputy manager, team leader and four staff. We observed staff carrying out their duties, communicating and interacting with people.

We also contacted two health care professionals about this service and included their comments in this report.

We looked at six people's care plans and the associated risk assessments and guidance. We looked at a range of other records including four staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance surveys and audits.

We last inspected Meadow Dean in October 2017 when four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. At this inspection some improvements had been made, but there remained continued breaches and two further breaches in of the regulations.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at the service. They said, "the good thing is that I am safe now, I would rather be in my own home, but this is the next best thing". "Yes, I feel most safe and it's quite nice here really". "I am safe yes, the staff pop in and out of this quiet lounge during the day to make sure I'm OK".

Relatives commented, "The service is so much better now, my relative is being looked after and is kept safe out of harm's way". "I can't tell you what a relief it is to know that my relative is now safe and looked after day and night. "I haven't been able to have a holiday in years because of the worry with my relative falling or coming to harm and next week I am going on my first holiday in years because I can finally relax knowing they are being well cared for and most of all safe".

Although there were positive comments from people and relatives the service was not always safe. At our previous inspection in October 2017, the provider did not have sufficient guidelines in place to safely support people with their mobility, and staffing levels were not sufficient to meet people's needs.

At this inspection some mobility risk assessments had been reviewed with clear detail of how to move people safely but others had did not contain how staff managed people's medical conditions to move them safely. This was clearly detailed in the previous report but the assessments had not been rewritten or reviewed six months later. We discussed this with the deputy manager who then reviewed and updated the care plan during the inspection.

Risks relating to people's care and support had not always been assessed or fully mitigated. Bathing risk assessments were not detailed with step by step guidance to ensure people were bathed safely. Bath risk assessments for two people stated, 'one carer to assist and bath hoist, needs one carer to assist". Other areas such as 'transfer from chair to wheelchair', stated one care staff and self, did not have any other details to say how this was done safely. There were no further details of what 'assist' meant to each individual person so that staff were aware how to support them to move safely.

Some people were prescribed creams containing paraffin to help keep their skin healthy. Paraffin is highly flammable, and using these creams increased the risk of a fire starting. There was no risk assessment in place regarding the use of these creams. We discussed the potential risks regarding paraffin based creams with staff, and asked what steps had been taken to reduce the fire risk, such as changing people's bedding or clothes more regularly to prevent the build-up. Staff were unaware that there was any risk relating to paraffin based creams, and merely said, "I have learnt something for the future."

Some people had chosen to have bedrails fitted to their bed. One person was documented as having chosen not to have any safety bumpers or covers fitted to the rails. Although their choice was documented, and their care plan stated there was a 'risk assessment in place' the risks relating to this, such as getting stuck or trapped in the rails had not been identified, and no action had been taken to reduce the risk of this happening.

When staff identified that people needed specialised health care, they made referrals to the dietician and dentist. However, in some cases these referrals were not followed up and people had not seen the required health care professionals for over six weeks. There was a risk that people's health would deteriorate if they did not have consistent support from health care professionals. We discussed this with the deputy manager who took steps to make the necessary appointments to address the issues.

The last safeguarding alert raised by the service was handled well and the service worked with the local team to resolve the issues. A health care professional said that the service had responded well to a safeguarding alert and after the incident risk assessments had been reviewed and updated and that further training of how to support people with their behaviour was being arranged.

However, on another occasion the staff had not recognised and reported potential safeguarding incidents to the local authority. Staff told us about an incident that had occurred in March when special lotion had been applied to several people's hair for too long. Following this incident, it was documented in one person's daily notes that they had 'open sores on back and top of head.' We discussed this incident with the provider and senior members of staff. They told us that they did not believe this was a safeguarding incident as, 'no one had been hurt.' Staff had not sought medical advice for the sores and as such there was no way of knowing if the two incidents were related. During the inspection we asked the provider to discuss the incident with the local safeguarding team, however, this was not done. We therefore raised a safeguarding alert after the inspection.

Accident and incident forms had been completed and action taken to make people safe. When a person needed additional support with their behaviour after a specific incident, behavioural risk assessments had been implemented. However, the management team had not analysed the information to identify any patterns and trends to prevent future events.

The provider had not ensured that risks had been mitigated fully. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At our last two inspections staff had not been recruited safely. Staff files did not always have the correct documentation in place to show the provider had carried out the necessary checks on staff before they started work. The provider had failed to ensure potential staff had a full employment history recorded. All staff had a Disclosure and Barring Service (DBS) criminal records check in place. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Other checks such as references, proof of identity were on file together with declarations that staff were fit to carry out their role.

The provider had failed to carry out the relevant recruitment checks to ensure that staff were suitable to work at the service. This was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

There were mixed comments with regard to the staffing levels. Some peoples said there should be more staff on duty, they said, "I do feel safe but there are not always enough staff and I do often have to wait quite a long time to go to the bathroom which is most distressing." "They answer the bell only to tell me that I have to wait until they can fit me in whilst they attend to someone else". In discussion with staff it became apparent that they did not respond to a person in a timely way to go to the bathroom as they were involved in other tasks. This was not acceptable and the provider agreed to review the deployment of staff to ensure people received the support they needed.

Some people also said that they felt rushed when staff supported them however others said, "They never rush or try to get out of the room without having a chat or making her comfortable". However, another person commented, "I don't get rushed here I have all the time in the world".
Each day there were three staff on duty, one senior and two members of staff, in addition there was one domestic and the provider. Staff confirmed that they always had three members of staff on duty and in busy periods the provider would also work alongside them to ensure people's needs were met.

The recruitment of staff had not been very successful as there had been a high turnover of staff in the last year. Senior staff had left including the deputy manager. We discussed this with the provider who told us that they did not know why staff did not stay and they were actively recruiting to ensure there was enough staff to cover the service. There had been no analysis by the provider as to the reasons why staff had not stayed at the service. This was an area for improvement.

Staff were aware of the whistleblowing policy and told us they would not hesitate to report any incidents to the provider. They were confident action would be taken to address any issues.

People told us they received their medicines safely, they said, "I get my medicines, I get my oxygen checked and monitored and I am looked after, that all goes to make me feel very safe and well looked after".

On the whole medicines were managed safely. There were appropriate systems in place for the safe storage, administration and disposal of medicines. The temperature of the medicine storage room was regularly checked, to ensure that medicines were stored at a safe temperature to remain effective. Medicine administration records (MARS) were fully completed, showing people received their medicines as and when they needed them. We observed the lunch time medicines round, and when people required medicines at a specific time these were given correctly. Staff had not consistently double signed hand written directives to show they had been checked as accurate. We discussed this with staff, and they agreed this was an area for improvement. Staff dated liquid bottles of medicines and creams when they were opened, so they knew they remained effective.

Checks had been carried out to ensure the fire system was working and a fire risk assessment had been completed. Staff had received fire training and each person had an individual personal emergency evacuation plans in place to inform staff how to support them to leave the premises. Fire drills had been carried out to ensure that staff knew what to do in case of an emergency.

Records of the safety checks made on the premises were not easily found at the time of the inspection. However, these were eventually provided and the required safety checks had been carried out including as the maintenance checks on the gas and electric supplies. Electrical equipment has also been tested including the hoists and lifts. Checks were also in place to make sure the water temperatures were within the safe range and to reduce the risk of scalding.

There had been redecoration work carried out and the dining area, lounge and conservatory were bright and clean. The flooring was in the process of being replaced throughout. A couple of the ground floor rooms had signs of water damage on the ceilings but in one of the rooms a relative was aware of this and had been asked if they would like it redecorated which they declined to avoid any disturbance.

The toilet off the dining room was out of order again at this inspection. People told us it was always breaking down and staff confirmed this. We spoke with the provider who said that each time it was repaired but it was an old building and really needed to be replaced, however they did not have the resources to do this at this time.

The provider told us that there was access for people to use three other toilets on the ground floor and after the inspection they confirmed that the toilet had been repaired the following day and was now in working order.

The service was clean and tidy and infection control procedures protected people from the risk of infection. At the last inspection the provider told us a new building would be erected to improve the laundry process, however this had not happened. Cleaning materials were locked away in line with the current guidance.

Requires Improvement

Is the service effective?

Our findings

People told us they received the care they needed. They said, "I think all the staff are fantastic really and it amazes me that they all know what to do and get trained well".

However, the provider had not taken action to ensure that people's health care needs were fully met and people were receiving the effective care they needed.

When people first came to live at the service a complete care needs assessment was carried out to ensure that the service was able to meet their needs. The provider was not able to describe how this process was linked to current guidance but did say the staff had support with person centred planning from the specialist nurse for older people. A health care professional commented that the provider was ensuring the service could meet people's needs before they came to live at the service.

Staff had not always taken timely action to ensure people received the support they needed to manage their healthcare needs. Some people required specialist equipment, such as stockings to help manage their healthcare condition. Although they had been assessed as requiring them, four weeks after they were documented as having been ordered, the stockings had still not arrived. Staff had documented they should 'chase' these stockings if they had not arrived after a week, however, it took them 19 days to do so. During the inspection the community nursing team contacted staff and asked if the stockings had arrived. When staff told us and they had not been received, we asked them to contact the local pharmacy and they were told there could be a two week wait for the stockings. The person told us that they had been waiting for these stockings to help their swollen legs, but nothing had happened.

There was no system in place to highlight referrals had not been followed though even though all staff were aware that this person had not received the support they needed to maintain their identified health care needs. After discussion with the deputy manager action was taken to ensure the stockings were received.

People at risk of poor nutrition did have assessments in place to monitor their weight but in one care plan there was contradictory information. On 27/3/2018 one person's weight monitoring chart showed they weighed 70.1 kg, on 23/4/2018 they weighed 65.4 kg a loss of 4.7 kg since the previous monthly weigh in. On 24/04/2018, in the mutli-disciplinary notes it stated that person had been referred to the dietician but no action had been taken since that date. We asked the senior staff about this and was told that they were not aware of this referral. The provider told us that the person was not at risk of weight loss as their nutritional assessments showed they were within their required level on the body mass, (BMI) weight chart. This information was not in the care plan. The provider told us that they were in the process of reviewing this plan and produced this record from your office.

This information did indicate that this person was within the guidelines of the chart and no referral was needed. There was no explanation of the variance recorded in this person's weight on the weight chart and what if any action needed to be taken. There was no explanation on the weight chart to question the variance of losing 4.7 kg one month and gaining 5.5 kg the following month and if the scales were working

correctly. Records were not consistent or clear and the deputy manager and team leader did not have any further information of the referral. There was therefore a lack of communication and oversight of people's health care needs which could put them at risk of not receiving the care they needed.

The provider had failed to ensure that people's health care needs were being fully met. This was a breach of Regulation 9 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

People told us that the staff called the doctor promptly if they felt unwell, they said, "The doctor or nurse is called whenever needed and an optician comes around too". Records also showed that people were being supported by the community nurse and podiatrist. A health care professional stated that staff seek advice when they visit and follow instructions to support people with their skin integrity. They said the service was proactive in making referrals when they needed to.

At the last inspection the provider had not ensured that the training matrix was up to date and this was noted as an area of improvement. At this inspection the training matrix remained the same.

Although staff were receiving training to give them the right knowledge and skills to support people, records were not up to date or accurate to confirm this. The provider told us that they had three different training matrixes which had not been updated therefore we were unable to tell what training had been delivered or when training should be updated. At the time of the inspection staff were signing up for new training in line with current guidance but there was still no oversight by the provider of the training programme to ensure staff were up to date with their training.

At the last inspection an induction programme for a new manager was not available. At this inspection the provider had still not developed an induction programme for managers to give them the skills to complete their role. Records were also not available to confirm that new care staff had received an induction in line with the Care Certificate, which had been introduced nationally to help new care staff develop their skills, knowledge values and behaviours.

The provider had failed to provide management staff with an induction programme that prepares staff for their role. This was a breach of Regulation 18 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

People thought the staff were well trained, they said, "The staff do know what is what and know what they are doing". "I do think that the staff are well trained and always know what they're doing with pills and equipment and with helping us old people here".

Staff were able to demonstrate that they had an understanding of the relevant training for their roles, including mental capacity, safeguarding and medicines. The team leader had observed staff giving people their medicines and did not sign people off as competent unless they had received the relevant training and had demonstrated their skills and competencies.

Staff told us that they felt supported by the provider and they were now receiving regular supervision and an appraisal. At the last inspection supervision and appraisal records were not available. At this inspection some supervision had been given to staff. Records showed that the programme of supervision was in place to support staff.

Overall people were satisfied with the food they received and felt they got a good choice and enjoyed their meals. People said, "The food in alright and I find the vegetables hard, but the new thing is "al dente" isn't it

and they say that's more nutritious". "I would like my vegetables cooked a bit longer". As a result of these comments the provider had purchased additional frozen vegetables to ensure that people received their meals as they would like them to be cooked.

Other people said, "I like the food here and get more than enough choice". "I like to choose my meal and I like to look at the menu too". "The food is not bad, but the pudding is the best bit".

At lunch time the dining area had a jovial and social atmosphere and people were not rushed to finish their meals. One person who preferred to sit on their own to eat in the small lounge was checked regularly by staff to ensure they were alright and had everything they needed. There were a varied four weekly menus for people to choose from which was on display in the dining room.

People were observed enjoying their cooked breakfast when we arrived on the first day of the inspection.

At the last inspection assessing and recording of people's mental capacity was an area for improvement. Although some improvements had been made records were not always updated to reflect this. When a person's capacity had deteriorated this was not updated in their care plan. This remained an area for improvement.

Staff told us they encouraged people to make choices, and during the inspection we observed them asking people if they would like different drinks and what they would like to eat. Relatives commented, "The staff always ask my relative first before attempting to assist them because they know without being able to hear them they sometimes get very confused and agitated".

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The provider had applied for DoLS for people when they were unable to consent to remain at the service and some of these had been authorised. People's capacity had been assessed and was decisions specific, such as consent to care and treatment and finances. When decisions had been made on people's behalf such as the administration of medicines covertly (meaning without the person's consent) the correct process had been followed and a best interest decision was made involving important people involved in a person's care.

Requires Improvement

Is the service caring?

Our findings

People said that the staff were kind and caring although some of them could be a little sharp. They said, "You always get the odd one that's not as nice but generally I would say all the staff are most pleasant". "The staff were a little abrupt and a little short sometimes". A relative also commented that "one staff member was a little sharp".

Some people felt that the staff did not always listen to them, they said, "No one listens to me", however other people said, "They always listen and always help if they can". "The staff always listen to me without fail".
We discussed these comments with the provider who was aware of these concerns and had spoken with the staff member to improve their skills and competencies.

Staff did not always record language that was respectful to people. People could sometimes become distressed and display behaviour that could be challenging to staff and others. Following one incident staff had written, 'I know she is in pain-but that is no excuse for her to blame me for something I haven't done.' Staff had not fully understood the reason for someone's behaviour, or responded in a compassionate manner.

Staff did not always respond in a considerate way to people. We observed the lunch time meal. One person's meal was placed in front of them and they were then left for over ten minutes without any staff interaction. The person sat in their chair, closed their eyes and made no attempt to start eating. Staff walked through the room multiple times during this ten minute period and did not stop and talk to the person, offer them encouragement to start eating or ask if they were tired and would like their lunch at a later time. After ten minutes one member of care staff asked a more senior member of staff if they could assist the person to eat. They then sat with the person, talking to them and offering encouragement. The person visibly brightened and began to eat their meal. We spoke to staff about this incident and they told us the person often needed encouragement to start eating, but this had not occurred at the start of their meal, as required.

Some people told us their privacy and dignity was promoted and they were encouraged to be as independent as possible. They said, "I like to dress on my own, so they help get my clothes and wait outside my room in case I get into trouble". Staff were observed knocking on people's doors before entering and giving people time to answer before entering. However, some people said they were kept waiting to go to the bathroom and staff told us that sometimes people had to wait which did not ensure people's dignity was being fully upheld.

Other people were positive about the staff and the kindness they received, they said, "I do feel everyone one of the staff is marvellous and so clever knowing how to help always". "The staff are very good, very good indeed". "I am well looked after I really am". "The carers know all about my family's and names and we have lovely discussions sometimes, it is not all rush rush, rush".

Staff knew people well and were able to chat to them about their previous lives. Staff were talking with a

person about their advice and knowledge of church ceremonies and thanked them for their guidance on church protocols. The person was supported to continue with their faith and on occasions the local church visited to carry out a service. They said, "I do miss my church going but we manage to have a service her which I take great pleasure in". "The staff all know that my faith is very important to me and they respect that and some of us have little meetings and we all discuss our beliefs or lack of".

Staff encouraged people to be involved in their care and express their views. Staff took time to communicate with people, they were patient and did not rush people when they needed to understand each other. They talked with people at the same level and used tools such as white boards to write down what was being said. This improved communication and people felt staff treated them with respect.

People's choices were promoted. Relatives commented, "The staff are always particular when putting things away in the cupboard or the drawers because they say my relative will tick them off if it is not done properly". "My relative likes her bath on a particular day and they always get it on that day and looks forward to it"

Staff described how one person used to insist on staying alone in their room all day but with encouragement was now out eating in the dining area and enjoying the company.

People's independence was promoted and they were encouraged to do as much as they could for themselves. Staff were observed supporting people to remain independent but stepping in in they needed support, one person said, "I don't need help with my meals but on an off day they will always help me and chop my meal up for me". "sometimes when I am not having a good day they will help me with my food".

Relatives and visitors said they were made welcome in the service. Relatives said there were no restrictions on their visiting hours and when one relative popped in at 9.30pm to deliver a book, staff had welcomed them and offered a hot drink too.

Since the last inspection the conservatory had been refurbished and people and their relatives were now able to meet in a pleasant private area. Relatives commented that it was now a lot better to meet in this area and have a private conversation.

People's confidential records were stored securely, and there was an area where staff had a desk by the conservatory where staff completed administration tasks and made calls to other professionals. This was an open area and could compromise people's confidentiality as people might hear staff talking on the phone about other people.

Requires Improvement

Is the service responsive?

Our findings

People and relatives told us they were involved in planning their care. They said, "The staff ask about my relative's specific needs and they are well catered for". "We do discuss the care plan often and slight changes and alterations can easily be tweaked where and when necessary they are most accommodating". "The staff know my relative well and chat about us their family and interests they remember which is so nice". "I do feel that myself and my family are involved with my care planning and they do make sure that things are the way I like them to be. For example, I chose this bright pink paint and then a carer helped me arrange all my music in the drawers to make it easier for me to get to when I wanted it".

At the last inspection it was noted that the care plans varied with detail and guidance for staff of how to fully meet people's needs. This was an area for improvement. At this inspection the plans remained the same. In some parts of the care plan there were details of people's personal preferences and choices. They showed what time they preferred to go to bed, whether people preferred to have a bath or shower, and how they liked to receive their personal care. However, in other areas the care plans were not detailed enough to show that people were receiving the care they needed. For example, when people had been given exercises from a health care professional these were not being monitored by staff. They told us that the person had capacity to complete their exercises, however they had medical conditions which needed additional support from staff to maintain their health. There was no mention of these exercises in the care plan, no risk assessment to ensure they were being supported to do this safely and no records to confirm the person had been supported to do them safely every day. Staff were aware they had the exercise to do but could not confirm if the person had done them or not. There was no information or measures in place to feedback to health care professionals that the exercises were helping this person to remain as healthy as possible.

The care plans did not always reflect the care being provided. There was varied information to guide staff on how to support people with their needs. There was information about how people preferred their personal care. However, in some cases care plans stated, 'staff to prompt and encourage the person to complete their personal care and hygiene' but there was no guidance for staff to say how to tell staff what they could manage themselves. In other plans it was clearly stated such as 'the person can wash their hands and face'. The information recorded in the care plans was therefore inconsistent to reflect what care people were receiving.

Although care plans had been signed as reviewed they were not always accurate or updated with current needs. It was noted in one mobility plan how a person liked to walk to the shop on their own however staff told us that they did not go out on their own anymore. The care plan dated 2/6/2018 signed by the deputy manager clearly stated what staff should do when the person goes out, for example to monitor the time the person leaves the premises and if they don't return in half an hour further action is to be taken. However, on 31/1/18 the community mental health team advised the service that this person's capacity had deteriorated and they no longer had the capacity to go out alone but their care plan had not been updated to reflect this.

The provider had failed to ensure that people's health care needs were being fully met. This was a breach of Regulation 9 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider told us they were planning on introducing a dedicated activities co-ordinator to ensure people were fully engaged in a range of activities. This had not occurred. They told us that each individual member of staff had responsibility for activities.

On the second day of the inspection a singer visited the service and performed for people. People gathered in the lounge and visibly enjoyed the performance. People clapped and sang along. People talked about the singers who visited the homes and how they enjoyed joining in the songs. They said they had bingo and quizzes and could choose if they wished to take part.

The service had introduced a 'family tree' on the wall which brightened up the dining room. People talked about the tree and living in a 'family home'. They found this a positive experience and had been involved in adding their pictures on the wall. Staff did spend time with people chatting, and people watched television, however, there was a lack of consistent, planned activities designed around people's needs and wishes. Staff told us that people rarely left the service to access the community or visit local amenities.

The service was not currently supporting anyone at the end of their life. People living at the service were older, and some had underlying health conditions. Although some people had do not attempt cardio pulmonary resuscitation orders (DNACPR) in place staff had not discussed with people about what they wanted to happen at the end of their lives. Some people were confused and living with dementia, and staff had not discussed with their families about what people may want to happen at the end of their life. As these wishes had not been discussed or recorded there was a risk that people may not receive the support they would like, at this important time.

Although the complaints log was not up to date the provider told us that there had been two complaints raised which had been investigated and resolved. The provider told us how they spoke with all visitors to ask if they were happy with the service. When concerns were raised the provider encouraged the relative to raise a complaint and this was investigated and resolved. The complaints procedure was available in other formats to support people to understand how to complain. One person had commented that their laundry smelt different as the service had changed washing powders. When this was raised the provider responded and changed back to the original powder to ensure the person was happy with their laundry.

Inadequate

Is the service well-led?

Our findings

There were mixed views with regard to the service being well led. Some people felt that the management team knew what they were doing whilst others still felt improvements could be made to the service such as staffing. They felt that were staffing issues as many staff had left and new staff did not stay at the service very long.

Some relatives did not have a lot of confidence in the ability of the provider to run the service, whilst other relatives thought the service was well led. They said, "I think that they do a very good job and it is well led from the top down". "Would say it is well led and I would also say that our recommendations are taken on board, listened to and acted on".

Staff felt that the provider did a good job and they would approach anyone in the management team for support and guidance. "We work as a team to make sure people get what they need". One member of staff said how the provider's knowledge had improved and how they absolutely supported the staff.

Meadow dean has been in special measures for a year now and only minor improvements have been made to the service. The provider still does not have a full understanding of the regulations and lacks the leadership skills to maintain compliance. They do not hold any qualifications in care and told us that they had signed up to complete the Diploma in Social Care Level 5 but had not had the time to do this so they withdrew their application. They said they had completed lots of training to enhance their skills but there was no evidence to confirm how this had benefited the service They had applied to Care Quality Commission (CQC) to become the registered manager and was waiting for a fit person's interview.

The management of the service had been unstable for nearly two years and historically there continued to be a lack of oversight and scrutiny of the service. A new manager was appointed in September 2017 and left in October 2017. Another manager was recruited and started work on 27 October 2017 but has since left the service. A registered manager had not been in post since August 2016. During this time senior staff had left the service which resulted in further gaps in the management structure. A new deputy manager was employed in January 2018 but left shortly after this inspection.

The provider had failed to comply with a condition applied to their registration requiring them to ensure the service is managed by an individual who is registered as a manager. This is a continued breach of Section 33 of the Health and Social Care Act 2008.

The provider told us that they had recognised that they needed additional support sought advice. They had contacted a consultant who had made an initial visit to the service and looked at the care plans and a plan of action. The consultant will be working on a part time basis, visiting every two weeks for four to five hours and will also be available on call for further advice and guidance. It was too early to see what impact this will have on the service to drive the necessary improvements.

We last inspected Meadow Dean in October 2017 when several continued breaches of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014 were identified and the overall rating was requires improvement with an inadequate rating in well led. The provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. The action plan had not been achieved and the provider continues to be non-complaint with the regulations.

At the last inspection, suitable systems and procedures were not effective to assess, monitor and drive improvement in the quality and safety of the service. Although additional audits had been implemented since the previous inspection the required improvements had not been made and the shortfalls noted in the report had not been identified.

There had been one care plan audit in six months which did not show who would be responsible for the actions to be taken and timescales when the work should be completed. There also remained a lack of detail in the risk assessments, personalised care, and timely referrals to health care professionals. Risks had not always been mitigated to ensure people were safe whilst being supported with their mobility. It was also noted that although accident and incident forms had been recorded there continued to be no analysis to identify patterns and trends to reduce the risk of further events.

There was a lack of effective management systems in place to continually evaluate and improve the governance of the service. There was no evidence that the service had learned from shortfalls identified in the previous inspections and had put systems in place to drive improvement.

Records were not always available, up to date or updated to reflect the care being provided. The provider did not have an overview of the training programme, records were not up to date to confirm what training had been provided. Two complaints were not recorded in the complaints log book.

The provider had not always recognised and reported potential safeguarding incidents to the local authority or CQC. People were having to wait at times to go to the bathroom which had an impact on people's dignity.

At the last inspection the provider had not ensured that staff were recruited safely. This remained the case at the time of this inspection.

The staff minutes, dated 3 April 2018, clearly shows that the provider and staff did not have a clear understanding of the CQC role and their role as a provider. The minutes referred to complying with a few regulations and it would take five minutes to read them. The provider and senior staff within the service lacked an understanding of the fundamental standards and regulations. We discussed with them how inspections were carried out and how we made our decisions. They were unaware of our inspection framework or how to keep informed regarding changes to CQC's methodology. The deputy manager told us, "To be honest I haven't read those."

The provider had failed to mitigate the risks relating to the health, safety and well-being of people. The provider had failed to keep an accurate, complete and contemporaneous record in respect of each person and staff member. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This enables us to check that appropriate action had been taken. The provider had not made CQC aware when they failed to report an incident to the local authority safeguarding team.

The provider had failed to notify CQC of notifiable events in a timely manner. This is a breach of Regulation 18 Registration Regulations 2009 Notifications of other incidents

People and relatives were asked for their feedback about the service being provided. On relative commented, "We had a questionnaire to fill in last week asking us what we liked and didn't like and asking if there were any changes that we thought could be made". The surveys had been collated but the responses had not been analysed. The provider told us they had, 'glanced' at them, they had not yet collated or analysed them fully.

We reviewed the responses of the feedback and some people had reported instances of concern. Staff had been described as, 'A bit rough when handling me' and 'brusque' and one person had reported having to wait at night.' We discussed these responses with the provider and they told us they had not yet read them as the deadline for surveys was early July, a month after our inspection. There was no system in place to check feedback received and ensure people and their relatives had not raised any cause for concern. Had we not discussed these incidents with the provider there was a risk that no action would be taken to safeguard people or investigate the time people had to wait at night for some time. We asked the provider to send us the results of the investigation and confirm what action they have taken to make sure people are safe.

Repairs and maintenance to the premises had not been completed in line with the maintenance plan. The provider told us that they were concentrating on the improvements they had made since the last inspection.

The plan identified that the garden gates should have been repaired by December 2017. The work on the laundry room which should have been completed in January 2018 and had been started but not finished. The bathroom upstairs was due to be refurbished by January 2018, the downstairs bathroom by June 2018 and this had not been completed. The plan also stated to replace the windows by June 2018. This work had just started at the time of the inspection. The painting of the premises outside was also due to be completed by April/May 2018 but this had not started at the time of the inspection. The provider told us that they had concentrated on improving areas of the service first where people spent most of their time. They said they would continue to work through the plan as and when resources were available. The plan had not been reviewed or updated with new timescales to show when the work would be completed.

The staff meeting records showed that the provider shared the visons and values of the service and had discussed the importance of providing person centred care. Staff told us that the provider was approachable and had an open door policy to discuss any concerns.

The provider was trying to forge links with the community and had held an 'open' day to encourage local people to visit the service. There told us they were in the process of contacting the local schools for future events.

The provider told us that they had attended the local authority local workshops to improve their practice and had links with the skills network to try to keep up with current ways of working.

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

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC of notifiable events in a timely manner.

The enforcement action we took:

Notice of Proposal to cancel registrations

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Section 33 HSCA Failure to comply with a condition The provider had failed to comply with a condition applied to their registration requiring them to ensure that the service is managed by an individual who is registered as a manager. This is a continued breach of Section 33 of the Health and Social Care Act 2008.

The enforcement action we took:

Notice of Proposal to cancel registrations

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that people's health care needs were being fully met.

The enforcement action we took:

Notice of Proposal to cancel registrations

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have sufficient guidance in place to safely support people with their mobility. The provider had failed to ensure that people received safe support with their healthcare needs.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008. (Regulated Activities) Regulation 2014.

The enforcement action we took:

Notice of Proposal to cancel registrations

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to assess, monitor and drive improvement in the quality and safety of the service were not effective. The provider had failed to mitigate the risks relating to the health, safety and well-being of people. The provider had failed to keep an accurate, complete and contemporaneous record in respect of each service user. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Notice of Proposal to cancel registrations

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to carry out the relevant recruitment checks to ensure that staff were suitable to work at the service. This was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The enforcement action we took:

Notice of Proposal to cancel registrations

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to provide management staff with an induction programme that prepares staff for their role

The enforcement action we took:

Notice of Proposal to cancel registrations