Tamaris Care Properties Limited

The Meadows Care Home

Inspection report

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09 March 2016
15 March 2016
19 March 2016
22 March 2016

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

Summary of findings

Overall summary

The inspection took place on 9, 15, 19 and 22 March 2016 and was unannounced. The first day of inspection was a focused inspection to look at the care of people assessed as at high risk of choking. We then carried out a comprehensive inspection. We last inspected The Meadows in May 2015 and found it was not meeting all the legal requirements we inspected against. In particular training supervision and appraisals were not up to date. Care was not planned to meet people's specific needs and preferences. During this inspection we found the registered provider had made some progress with training and supervision but not with personalised care and support.

The Meadows Care Home is registered to provide nursing or personal care for up to 69 people. At the time of our inspection there were 66 people living at the home, some of whom were living with dementia.

The home did not have a registered manager. The manager at the time of our inspection had applied to register to become the registered manager with the Care Quality Commission. The application was granted shortly after the completion of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we found the registered provider had breached regulations 9, 11, 12, 14, 17, 18 and 19. Due to a lack of management oversight the quality of the service had not been monitored effectively to ensure issues relating to people's care and welfare were identified and investigated in a timely manner. Staff had not followed some policies and procedures and important aspects of the service were overdue, such as the deployment of a consistent staff team. Care staff and family members described a "divided home" following the admission of a number people from a different home. The dependency tool used to determine staffing levels was based on inaccurate information. The registered provider had not acted on the findings from quality checks carried out by the local authority commissioners. Systems and processes to maintain complete and accurate care records were ineffective.

There were shortfalls in the numbers of staff deployed to keep people safe and meet their needs in a timely manner. Some family members and care workers gave us negative feedback about staffing levels in the home. One family member commented there was a "shortage of staff, they don't have a full quota of staff". One care worker commented, "There is a lot of time when we are seriously under-staffed. We see some people [staff] are really down, on the point of leaving. If staff are on edge, residents are on edge. They can get quite aggressive." We observed throughout the four days of our inspection people were regularly left alone and unsupervised in communal areas. There was a lack of continuity of qualified nursing staff with seven different agency nurses working at the home during the four days of our inspection.

Records showed that people had been placed at increased risk due to staff not following the advice of health care professionals. Care documentation lacked sufficient information to provide staff with guidance

on meeting people's individual needs. Safe recruitment practices had not been followed particularly in relation to carrying out risk assessments to confirm staff were suitable to work with vulnerable people.

People were not supported to ensure their nutrition and hydration needs were met in a dignified manner. Some people had to wait a long time, often in wheel chairs, before receiving something to eat. One person did not receive the consistent one to one support they needed. Staff were not always proactive in offering help and support to people. The meal time experience lacked coordination and was disorganised. People's food and fluid charts were not always completed or accurate.

The registered provider was not following the requirements of the Mental Capacity Act (MCA) 2005 to support people to make decisions about their care. Some decisions had not been made in line with the MCA, such as for the administration of medicines covertly and the use of bedrails to keep people safe.

The registered provider did not have effective infection control procedures. We saw pull cords in bathrooms were not plastic coated so they could not be wiped clean to reduce the risk of infection. During our inspection we detected unpleasant odours in areas of the home. We found these were present throughout the four days of our inspection.

Information was not always provided in appropriate formats to help people make choices. We asked one care worker whether information was appropriate. They said, "It probably isn't." They acknowledged "pictures could also be useful" to help people with making their own choices about what they would like to eat. Staff did not always have the time to have meaningful one to one time with people. One care worker said, "Staff feel quite stressed. It is quite a rush, we have no time for one to one conversation."

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

People told us they received good care from kind considerate and caring staff. One person told us, "It is very, very nice. If I looked around I wouldn't find a nicer home." One family member commented, "Yes, definitely well cared for. Brilliant, fantastic like home from home."

Staff knew how to report safeguarding and whistle blowing concerns. They said they would report concerns straightaway. One staff member told us, "Hand on heart I have never seen anything bad. They would be quite quick to deal with anything like that. They deal with things quickly."

The registered provider carried out health and safety checks which were up to date at the time of our inspection. One care worker commented, "[Staff] conform to the health and safety rules, we are not allowed to get away with not following the rules." Incidents and accidents were logged with details recorded of any action taken to help keep people safe.

Most care workers told us they felt supported working at the home. One staff member commented, "The manager is excellent, he is a lovely bloke." Training was up to date and recent supervisions had been carried out. Appraisals were overdue for all staff.

There were opportunities for people, visitors and family members to give feedback about the home through attending relative's meetings or using the online feedback system located in the home. One family member said, "We go to relative's meetings to find out what is going on with the home. We can put our concerns across. If we have anything to say we just say it." Most anonymous feedback provided had been positive.

The registered provider had a complaints procedure which people and family members knew about. One family member said, "I know about the complaints procedure. I haven't got one complaint." There had been no formal complaints received.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The 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.
Staffing levels were insufficient to meet people's needs in a timely manner.

Safe recruitment practices had not been followed. Medicines records were not always accurate.

Staff had a good knowledge of safeguarding and whistle blowing, including how to report concerns.

Health and safety checks were up to date. Incidents and accidents were logged and investigated.

Is the service effective?

Inadequate

The service was not effective.
People were not supported to have enough to eat and drink.

The registered provider was not following the requirements of the Mental Capacity Act MCA (2005).

Records showed staff had not always followed the advice given by health care professionals.

Staff said they felt well supported.

Is the service caring?

Requires Improvement

The service was not always caring.
People did not always receive meaningful one to one time with staff. Information was not available in formats appropriate to people's needs.

People told us they were happy with their care.

People said staff were kind and caring.

Care worker's interacted positively with people.

Is the service responsive?

Inadequate

The service was not responsive.
Care plans lacked personalised information about people's needs.

There were opportunities for people, family members and visitors to give feedback about the home.

People and family members knew how to make a complaint.

Is the service well-led?

Inadequate

The service was not well led.
The quality of the service had not been monitored effectively to ensure issues were identified and investigated in a timely manner.

Care records were inaccurate and did not reflect people's current needs.

There had been a lack of leadership and management at the service resulting in important areas of care delivery becoming overdue.

At the time of the inspection the home did not have a registered manager.

The Meadows Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 9, 15, 19 and 22 March 2016 and was unannounced.

The inspection was carried out by three adult social care inspectors and a specialist professional adviser with a nursing background.

Before the inspection we reviewed information we held about the home, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We liaised with the local authority commissioners of the service throughout the inspection.

We spoke with three people who used the service and five family members. We also spoke with senior management, the manager not yet registered, three agency nurses, a qualified nurse, a senior care worker and four care workers. We looked at the care records for five people who used the service, medicines records and recruitment records for five staff. We also reviewed supervision and training information and records relating to the management of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

Medicines records did not support the safe administration of medicines. One person's medicines records advised staff to monitor their blood sugar each tea-time. We viewed these records which showed the person's blood sugar had not been checked for the period 15 January 2016 to 28 February 2016. Nor had it been checked on 1 March 2016, 3 March 2016, 4 March 2016, 9 March 2016, 10 March 2016, 16 March 2016 and 21 March 2016. We asked the registered provider about these blood sugar checks. The registered provider's representative was unable to confirm these checks had been carried out. This meant the person was place at an increased risk of developing health problems as checks to maintain their health had not been carried out as required.

The registered provider used a system of 'daily medication check lists' to confirm the accuracy of medicines records and to check people had been given their prescribed medicines. We viewed a selection of 'daily medication check lists'. We found there were gaps in these daily records. Other daily checks showed a high number of unexplained gaps on people's Medicines Administration Records (MARs). This meant we could not be certain had received their medicines when they were due.

Whilst observing people's care we saw two care workers used an unsafe method to support a person to transfer into their wheel chair. We raised our concerns with the relevant staff during our inspection. Although the person was unharmed, we raised our concerns about this poor practice with management.

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

There were not enough staff deployed to meet people's needs in a timely manner. Some family members gave us negative feedback about staffing levels. One family member commented there was a "shortage of staff, they don't have a full quota of staff". Another family member said, "It is brilliant but on a weekend I don't know what happens. They are getting a lot of bank in, unfamiliar faces. I hope it gets better on a weekend. I came later on Saturday and [my relative] was literally soaked. It was two hours before they could change [my relative]." A third family member told us, "There are not enough staff. [My relative] cannot walk. Sometimes [we have] waited half an hour to three quarters of an hour before somebody has come." One family member said if they complain about anything they are told "we are under-staffed".

Some care workers we spoke with also gave negative feedback about staffing levels. Care workers said there were routinely shortages of suitable staff to provide the care people needed. They told us there was low morale in the staff team and some staff were considering leaving their employment. One care worker commented, "There is a lot of time when we are seriously under-staffed. We see some people [staff] are really down, on the point of leaving. If staff are on edge, residents are on edge. They can get quite aggressive." Another care worker told us, "When we have a full quota [of staff] up here we do [have enough staff], two on each side and one floating. I have been on where there is only three." A third care worker said, "Very stressful, dependency needs to be looked at. Staff feel quite stressed, quite a rush. There is no time for one to one conversation." A fourth care worker told us, "Most carers would say there should be more staff to

give a higher level of care." A fifth staff member commented, "[Staffing levels] always a problem, there is a lot of staff sickness. I don't know what the staffing levels are."

We observed throughout the four days of our inspection people were left unsupervised in communal areas whilst staff were busy seeing to other people's needs. For example, at one point we observed 12 people with complex needs had been left unsupervised in the upstairs dining room with no care workers available to keep people safe. On one occasion when a care worker was in a communal lounge with people, a family member who regularly visited the home commented, "That is unusual."

We observed many occasions throughout our inspection that staffing levels were insufficient to meet people's needs. For example, during a breakfast time observation people waited a long time, sometimes over 30 minutes, before receiving help. We heard one person comment, "You could die of starvation, couldn't you." On another occasion we heard one person who was unable to get out of bed unaided shouting for assistance. We went to alert a staff member as no staff were available to help.

We found there was a lack of continuity of qualified nursing staff. There were seven different agency nurses deployed during the four days of our inspection. For example, when we arrived at the home both nightshift nurses were agency nurses. One agency nurse told us that had been their first shift, whilst the other agency nurse said that was their second shift at the home. Agency nurses told us they did not received an in-depth handover when they started their shift. One agency nurse said they felt unsafe with the practice and procedures they were expected to follow. They said there was "an inadequate handover and no list of service users and room numbers". They went on to say, "At the beginning of the shift I was handed the keys, shown the treatment room and told to get on." Giving medicines was a problem too when people's photos were out of date. The agency nurse said they had to rely on care assistants to identify the service user. Another agency nurse said they "didn't receive a detailed handover, it was generic." They said they expected "a list of clients" they were responsible for and their room numbers but they were not given this.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had not always followed effective recruitment practices. We saw a Disclosure and Barring Service (DBS) check had not been verified for one staff member. DBS checks are carried out to confirm whether prospective new staff members have criminal records or are barred from working with vulnerable people. The DBS check carried out for one staff member showed they had a conviction. The manager told us, "This should have been taken through HR (Human Resources Department)." We found no evidence to show this had been done, nor was there evidence of a risk assessment having been carried out to confirm the staff member was suitable to work with vulnerable adults. References had been requested and received for all five staff.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider did not have effective infection control procedures. We saw pull cords in bathrooms were not plastic coated so they could not be wiped clean to reduce the risk of infection. During our inspection we detected unpleasant odours in areas of the home. We found these were present throughout the four days of our inspection.

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

All of the staff we spoke with felt people were safe living in the home. One care worker commented, "Pretty safe, I haven't seen anything." Another care worker said, "The staff keep the place safe."

Staff showed a good understanding of safeguarding adults, including how to report any concerns they had. They could tell us about the various types of abuse and potential warning signs. Staff told us they would report concerns straightaway.

Staff knew about the registered provider's whistle blowing procedure. All staff we spoke with said they did not have concerns about people's safety. They said the registered provider would deal with concerns appropriately. One staff member told us, "Hand on heart I have never seen anything bad. They would be quite quick to deal with anything like that. They deal with things quickly."

A range of health and safety checks were carried out to help keep the premises safe for people to use. This included fire safety checks and checks of specialist equipment used for moving and assisting purposes. These were up to date at the time of our inspection. One care worker commented, "[Staff] conform to the health and safety rules, we are not allowed to get away with not following the rules."

Incidents and accidents were logged and investigated with the action taken in response to incidents recorded. For example, action taken included contacting emergency services, treating minor injuries and increased monitoring. All incidents and accidents were quality checked by a manager to confirm the appropriate action had been taken.

Inadequate

Is the service effective?

Our findings

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, and whether any conditions on authorisations to deprive a person of their liberty were being met. People had been assessed in line with the MCA to determine whether a DoLS authorisation was required. Applications had been submitted to the local authority for all relevant people and authorisations had been granted accordingly.

We found some decisions had not been made in line with the MCA. The Mental Capacity Act 2005 Code of Practice, made under the Mental Capacity Act 2005, provides guidance to anyone who is working with and caring for adults who may lack capacity to make certain decisions. The code of practice states 'assessing capacity correctly is vitally important to everyone affected by the Act. Someone who is assessed as lacking capacity may be denied their right to make a specific decision – particularly if others think that the decision would not be in their best interests or could cause harm. Also, if a person lacks capacity to make specific decisions, that person might make decisions they do not really understand. Again, this could cause harm or put the person at risk. So it is important to carry out an assessment when a person's capacity is in doubt.' Some people who lacked capacity had been assessed as needing their medicines to be given without their knowledge (covertly) and others needed bedrails to keep them safe. We saw these decisions had been made without first carrying out a current MCA assessment and best interest decision. Where MCA assessments were in place for covert medicines these had been made when people lived at different homes and were now out of date.

Although some people were nursed in bed, it was not always evident whether people had consented to this. For example, one person told us they did not have the opportunity to get out of bed. However, when we spoke with staff they said the person had capacity and it was their choice. However, the person's care records suggested otherwise. The decision to nurse the person in bed had not been made in the line with the MCA. There were no records available to show the person had consented to this or the decision had been made in their best interests. This meant the person may have been unlawfully restricted.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not receive the support they needed to meet their nutrition and hygiene needs. Some people

had food and fluid charts in place to monitor how much they had eaten and drank. Staff randomly cleared away people's plates without noting down people's food and fluid intake. Food and fluid charts had not been completed in line with the guidance specified on the document. For example, staff did not record portion sizes, the number of scoops used or the number of slices of meat eaten and did not total people's fluid intake for the day. Fluid charts showed people went for long periods of time without being offered or given a drink.

People requiring special diets did not always receive these appropriately. We heard one family member comment, "[My relative] can't eat this, [my relative] will aspirate." The person had been assessed as at high risk of choking and required a specific consistency of food. The puree they had been given was too thin. We raised this concern with a regional manager who arranged for the purees for all people to de redone. The registered provider told us additional checks had been put in place to prevent future problems. Other family members gave us negative feedback about how pureed food was presented to people. One family member said, "The food is sub-standard." They went on to say "the puree had to be sent back as it wasn't pureed properly." Another family member said the meals were like "a dog's dinner, it is all mixed together." We observed pureed food was poorly presented with no moulds used to shape people's meals to make them look appetising for people to eat.

We carried out observations of people's meal times to help us understand their experience. We found some people waited a long time before receiving something to eat. For example, on one occasion we heard one person in the upstairs dining room, "What am I sitting here for." A care worker, who was providing full assistance to another person said, "Shall I get you some breakfast." The care worker left the person they were assisting to get the other person some breakfast. We saw on some occasions people were left sitting in wheel chairs for over 30 minutes before receiving any assistance. On one occasion during lunch time we saw people sat in the dining room for over 40 minutes before the food trolley arrived. We heard one person ask "when is our dinner coming". Another person sat for over 50 minutes in a wheel chair facing the wall before being given anything to eat.

Staff were not always vigilant in ensuring people had the support they needed. We observed one person was given their meal which was placed in front of them without further assistance from care workers. We saw the person picked up a knife and attempted to eat a pea for over 10 minutes. We also saw no assistance was given to the person until a senior staff member prompted a care worker to help the person. The care worker placed a fork in the person's hand which they were then able to use much more successfully.

The meal time experience was disorganised. People were given their meals by choice and not by table. Some people were waiting for their meal whilst others at the table were eating. Some meals for people who required full assistance were placed in front of them with a cover on to be given to them later when staff were available to provide assistance. Another person was supported to the dining room by a staff member, they were given breakfast but were unable to eat it as staff had not helped them with their oral hygiene needs. The person had to be taken out of the dining room for additional support.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found care records did not accurately reflect the recommendation of health care professionals placing people at risk of receiving unsafe care. One person had been assessed by the dermatologist. The dermatologist recommended the person should have their blood sugars checked daily. Further advice from their GP directed the person's blood sugars and blood pressure should be checked twice weekly and their temperature checked daily whilst they were taking a particular medicine. We found no record of these

checks having been carried out. We asked the registered provider for confirmation these checks had been carried out. The registered provider's representative confirmed there was no record of these checks having been being carried out because the checks had not been done. Another person had been assessed by a speech and language therapist (SALT). The SALT advised the person should have stage 3 thickener in all drinks and medicines. We found the person's nutrition care plan did not reflect these recommendations. A third person had been assessed by a dietitian. The dietitian recommended they should have 'two to four fortified milkshakes daily', and be offered 'snacks in between meals' to maintain their weight. The person's 'diet notification sheet' did not reflect these recommendations. The person was also not on a 'food or fluid chart' to monitor their nutritional intake and there were gaps in the weekly weight records. We saw from care records blood glucose monitoring was not recorded daily as required for a person who had a specific health condition.

We found the 'Choking Risk Assessment Analysis' dated 12 June 2015 which was displayed on the notice board in the nurse's office was inaccurate and out of date. The analysis was a quick summary of people's potential risk of choking and the current dietary advice applicable to the person. For example, the analysis identified one person was on a normal diet and fluids. However, the person's care records stated the person 'now has stage 3 thickened fluids' and 'diet thick puree.' Another person had been assessed as at 'high' risk of choking but the analysis stated 'NA' for the date of SALT referral. The analysis went on to identify the person was on a 'normal diet and fluids. The choking risk analysis stated all staff were aware of people's dietary needs. However, only three staff members had signed to confirm they had read the choking risk analysis.

We found people did not have 'hospital passports' or Emergency Health Care Plans in place to guide care workers as to people's future care wishes, such as whether or not the person wished to be admitted to hospital. This meant there was a risk of a mistake being made by a member of staff who did not know the person and was unfamiliar as to their preferred course of action. One agency staff member told us about a recent situation whereby they had great difficulty with a resident admitted to hospital. They said there were two other agency nurses on duty to try and find out relevant information from. They said they eventually rang the person's relatives and then the doctor before being able to make the appropriate decision about the person's care. We found out during a staff handover that the hospital had phoned the home to confirm how best to communicate with the person.

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

Most care workers told us they felt supported in their role. One staff member commented, "The manager is excellent, he is a lovely bloke." Another care worker commented, "[Manager] seems a nice bloke." A third care worker, told us, "[Manager] is excellent." A fourth staff member commented, "[Manager] is alright. I would go to him if I have concerns." Records we viewed showed staff training was up to date. Most staff had received a recent supervision. However, records showed appraisals were overdue for all staff.

Staff told us they would ask people for consent before providing care. They went on to say they would respect a person's right to refuse. One care worker commented, "We wouldn't force anybody."

Requires Improvement

Is the service caring?

Our findings

Information was not always provided in a format appropriate to people's needs to help them make informed choices. We noted the menus displayed outside the dining room were in a written format only. We asked a care worker if this format for the menu was accessible for people using the service. They said "It probably isn't." They acknowledged that "pictures could also be useful" to help people with making their own choices about what they would like to eat.

Staff did not always have time to spend one to one time with people. One care worker said, "Staff feel quite stressed. It is quite a rush, we have no time for one to one conversation." Another care worker told us they wished they had "more time to sit with residents and chat". A third care worker commented, "There is not much time for one to one." We overheard one person during the breakfast time comment, "We say what we want and they give us something different. They know best."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and some family members gave us positive feedback about the care provided at the home. One person said, "It's very nice in here." Another person told us, "It is very, very nice. If I looked around I wouldn't find a nicer home." One family member commented, "Yes, definitely well cared for. Brilliant, fantastic like home from home."

We received good feedback about the caring approach of care workers. One person commented, "Nurses, they are very good. I like to know they are round about." Another person said, "It's the staff. If you find a place where the staff are nice, you are settled. I have been very happy in here." They are very kind, it is a lovely relaxed home." One family member said, "The staff are brilliant. They are all lovely." Another family member told us, "The staff are really nice."

People and family members told us care workers knew people's needs well. One family member said, "The staff know [my relative's] needs well. They do a marvellous job with [my relative]."

We carried out observations in communal lounge areas. We saw care workers adopted a kind and caring approach toward the people they cared for. They were courteous and professional in their interactions with people. For example, we saw staff checked whether people were alright and whether they needed anything. We heard one care worker say to a person "can I help you [person's name], can you manage alright." We heard another care worker say to a person "right [person's name] we will get you into a comfy chair. Right [person's name] up we go." Another staff member asked a person of they would like to go for a shave. The person agreed they would and the care worker supported them out of the lounge.

Staff described to us how they delivered care in a respectful and dignified manner. This included explaining to the person what they were doing, gaining their consent and keeping them covered up as much as possible to promote privacy and dignity.

Inadequate

Is the service responsive?

Our findings

People did not always receive the care they needed to help keep them healthy. Records of positional changes for people at risk of skin damage were not consistent with people's care plans. One person's records showed they required two hourly positional changes. We saw from the care records that over a period of three days there were only seven entries recorded. For another person there were no entries recorded for a period of over five hours and positional changes in excess of two hours for the period 19 March 2016 to 22 March 2016. This meant people who had been assessed as at a high risk of skin damage were placed at a greater risk.

There was a risk that care plans might not reflect people's current needs as care plan evaluations were not up to date. For example, some care plans for one person had not been evaluated since December 2015. Another person's care plan did not reflect their current needs. One person was nursed completely in bed. The person's care plan had been written when they lived in a previous care home and had not been updated since moving to The Meadows. The care plan stated the person could 'spend short periods of up to 4 – 6 hours in their chair for pressure relieving purposes.' The person's care records stated the person remained at high risk of pressure damage and that 'staff are advised to continue with the plan of care in place.' However, this information was inaccurate as the person was now nursed in bed. A care worker told us, "I have never seen [person] out of bed since [person] moved here."

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

People had limited opportunities to take part in meaningful activities. Records of activities were incomplete and showed that some people did not have access to regular activities that were appropriate to their needs and preferences. One person, who was being nursed in bed, said, "I used to love [looking at] pictures with the Queen on. I haven't seen any of those for a while. I used to watch tennis, I loved it. I do love music, I haven't got a radio. I used to like a little sing song." They went on to say, "This is my trouble, there is nobody to talk to. I have really enjoyed chatting. Now that is what I have missed somebody to talk to." We viewed this person's 'My Journal' record which showed they had not had opportunities to fulfil their interests. Between 4 March 2016 and 21 March 2016 the person had only had two recorded 'chats' with the activity co-ordinator. For other days the records confirmed that either the activity coordinator was either unwell, the person was asleep or nothing had been recorded.

Family members told us there were not enough activities available to ensure people were appropriately occupied. One family member commented, "Activities, no not every day.". Another family member said, "Activities are non-existent. There should have been three (activity co-ordinators) on yesterday, not one turned up. The residents are bored stiff." Another family member commented, "I have never seen any activities. Nothing they just get stuck in the lounge. They leave her in her wheel chair. Why can't she sit in a comfortable chair."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Family members had the opportunity to attend relative's meetings. Although some family members did tell us some meetings had been cancelled recently. One family member said, "We go to relative's meetings to find out what is going on with the home. We can put our concerns across. If we have anything to say we just say it." The registered provider used a real time electronic system for gathering feedback from people, family members and visitors using iPads located in the reception areas. This meant feedback could be given anonymously at any time and analysed immediately by the registered provider. We viewed recent feedback which had been positive.

The registered provider had a complaints procedure for people to access if they wanted to complain about their care. People and family members knew how to complain. One family member said, "I know about the complaints procedure. I haven't got one complaint." There had been no formal complaints made about the home.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection the home did not have a registered manager. The manager had applied to the Care Quality Commission to become the registered manager. The application was approved shortly after completion of the inspection.

Due to a lack of management oversight and leadership within the home staff had not followed some of the registered provider's policies, procedures and systems. These included the policy and procedure for care planning, ensuring sufficient staff had been deployed, ensuring people requiring a pureed diet received this safely and maintaining accurate records and operating an effective system for monitoring the quality of the service.

We also found that due to a lack of leadership and management oversight important aspects of the service had lapsed and were now overdue. For example, a consistent staff team had not been deployed for a significant period of time. Care workers and family members confirmed this was the case. However, the registered provider did not have a long term plan to improve this situation and stabilise the staff team. Care staff and family members spoke about a "divided home". This was due to the urgent admission of new people in December 2015 following the closure of Albany Care Home (Albany Care Home is another of the registered provider's care homes). We found the registered provider did not have a plan in place to integrate people and care workers from the respective homes. One family member said, "Albany [people] are in separate lounges. Staff put Meadows [people] in a chair but not always Albany." Another family member told us meetings for The Meadows people were cancelled whilst meetings for Albany people went ahead."

The registered provider did not have effective systems to assess, monitor and improve the quality and safety of the care people received. Although regular quality assurance audits had been carried out on regular basis, these had been unsuccessful in proactively identifying the concerns we identified during our inspection. In fact, following the first day of out inspection the registered provider told us they had tracked people's care plans and had identified in excess of 300 actions required to bring people's records up to date and to reflect people's current needs. This meant the registered provider had not been pro-active identifying these issues in a timely manner prior to the inspection of March 2016.

The registered provider used a specific dependency tool called CHESS to determine staffing levels in the home. The regional manager told us people were categorized into low, medium and high dependency based on their individual support plans. We found there was a risk that the staffing levels indicated from the analysis were inaccurate as service user's care plans were not up to date based on both our findings and the registered provider's own findings following the first day of our inspection.

We found the registered provider had failed to act on the findings from quality checks carried out by the local authority commissioners of the service. We found the commissioning team had reviewed The Meadows on 4 March 2015 and had described people's dining experience as 'poor' on both floors. We found the areas of concern we identified during our inspection were consistent with the commissioning team's findings. For example, food and fluid charts were not completed in a timely manner and gaps identified in

food and fluid charts.

The registered provider lacked effective systems and processes to maintain accurate and complete records relating to people's care. This placed people at risk of receiving unsafe or inappropriate care. We found people's care records were incomplete and inaccurate. There was also a lack of information in care records to evidence people had received the care they needed to keep them safe. Care plan did not contain the information required by staff to provide personalized care and support to people. We found the lack of accurate record keeping was endemic throughout the care records we viewed and showed a lack of management oversight.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.